Mi Care Southern Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 10 and 11 October 2018 and was announced. Our last inspection was in January 2016 where we rated the service Outstanding. There had been changes in management and the ownership of the service since this time. This inspection took place in response to concerns raised about staff punctuality and responses to incidents. We found that areas of outstanding practice had not been sustained and we found breaches of the legal requirements in relation to medicines, risk management and record keeping.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults.

Not everyone using Mi Care Southern Limited receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection, 63 people were receiving personal care.

There was not a registered manager in post. The registered manager had recently left and the regional manager was providing management support at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Shortfalls in record keeping meant people did not always receive their medicines safely. Staff did not always maintain accurate records relating to people's medicines. In some instances, records relating to risk were incomplete and lacked detail. Despite people's feedback reflecting that they received person centred care, records relating to care planning lacked person-centred information. The provider was in the process of addressing concerns with staff punctuality and call attendance. However, at the time of inspection there was no system in place to proactively monitor attendance of care calls.

People spoke highly of the staff that supported them. People said staff were kind and respectful and provided them with dignified care. Staff knew people well because they regularly supported the same people. People told us that the care they received was personalised and in most instances care planned reflected what was important to people. Staff had previously received the training for their roles and work was underway to ensure training and supervision was up to date.

Staff prepared food for people that they liked. Before people received a service, staff carried out an assessment of their needs and this information was added to care plans. Where people had specific healthcare needs, staff provided support to meet them. Where any accidents or incidents occurred, staff identified actions to prevent them from happening again. Where there had been concerns with how incidents were reported and responded to, we found improvements had been made in this area. There was

a complaints policy in place and the provider handled people's complaints in line with this.

People's consent was sought before staff provided care and people told us staff were respectful of their privacy and dignity when supporting them in their homes. People said communication had improved and the regional manager had made contact with everyone. Systems were in place to involve people and their relatives in the running of the service. Staff told us they had noted recent improvements and felt supported by management.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

We found instances where risks to people had not been clearly assessed and documented.

There were inconsistencies in records relating to people's medicines.

The provider was in the process of addressing concerns about staff punctuality and call times.

Where incidents had occurred, consideration was now being given to how to prevent them reoccurring. Staff understood their roles in safeguarding people from abuse and the new management team were being proactive in reporting these.

The provider had carried out appropriate checks on staff to ensure they were suitable for their roles.

Systems were in place to reduce the risk of the spread of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements to staff training and support were in progress and some staff were behind on training and supervision.

People were happy with the food prepared by staff and their dietary needs were met.

Staff supported people in a way that met their healthcare needs.

People received a thorough assessment of their needs before staff provided support to them.

Staff sought people's consent before delivering care.

Is the service caring?

Good

The service was caring.

People gave positive feedback about the caring nature of the staff who supported them.

Staff regularly visited the same people and got to know them well.

People's independence was encouraged as staff provided support that considered people's strengths and abilities.

Staff were respectful of people's privacy and dignity when providing personal care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

We found instances where care plans lacked detail about people's needs and what was important to them. Until recently the service had failed to respond appropriately when people's needs changed.

People spoke positively about the care they received from staff.

Support was in place to ensure people's wishes were met when receiving end of life care.

People knew how to raise a complaint and the provider was now responding to concerns raised in an open manner.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Improvements in response to recent concerns were in the process of being implemented with further work required on record keeping and staff support.

There were a variety of checks and audits in place but these required time to become embedded in the governance of the service.

Staff now felt supported by the new management team.

There were systems in place to involve people in the running of the service.

Mi Care Southern Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by concerns raised with CQC and the local authority about care calls not being fulfilled as planned and shortfalls in communication with people, relatives and staff. There was an ongoing large scale enquiry being conducted by the safeguarding team and CQC had been receiving regular action plans from the provider. This inspection was to check the progress of improvements made through this process.

This inspection took place on 10 and 11 October 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and office staff are often out of the office supporting staff or providing care. We needed to be sure that they would be in and wanted to talk with the new management team to assess their progress against their improvement plan.

We conducted telephone interviews with people and relatives on 10 October 2018. The inspection site visit activity took place on 11 October 2018. It included reviews of records, interviews with management, office staff and care staff.

The inspection was carried out by two inspectors.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We asked for feedback from the local authority.

Due to the inspection being brought forward, we did not ask the provider to submit a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

As part of the inspection we spoke with six people and two relatives. We spoke with the regional manager, the regional director, two care co-ordinators and three care staff. We looked at care plans for six people including risk assessments daily notes. We also checked medicines records for five people.

We looked at a variety of recently introduced checks and audits as well as records of surveys and minutes of meetings of staff, people and relatives. We looked at five staff files and checked records of staff training and supervision.

Requires Improvement

Is the service safe?

Our findings

People told us that staff supported them safely. One person said, "They help me to shower and they always work safely to get me in and out." Another person said, "I can't stand or walk and they use an [equipment] stand to help me up and down safely." A relative told us, "It is absolutely safe, [person] gets on with them all [staff]."

Despite this feedback, we found risks to people that had not been assessed and planned for. Whilst in most cases we did find risk assessments relating to the personal risks people faced, we found instances where these did not cover every known risk to them. For example, one person had a condition that meant they should avoid certain foods. Staff were able to tell us about this but there was no assessment of this person's nutritional risks and no recorded plan to keep them safe. Another two people had risks associated with the integrity of their skin and there was no assessment or plan for these. We also noted some risk assessments had not been recently reviewed, one person had a risk assessment for their mobility which had not been reviewed since January 2017, despite their condition and mobility having changed since that time.

People did not always receive their medicines safely because medicines records lacked accuracy. We checked records relating to people's medicines and found information was missing or inconsistent. For example, one person's medicine administration record (MAR) contained multiple gaps and it was unclear when they had received their medicines. Staff had not signed to state when each dose had been administered which meant the person's medicines could not be accurately tracked or monitored. MARs were being sent back to the office to be checked but despite MARs being found to have gaps on them, these continued which showed robust action was not being taken to address this issue. We also found MARs did not contain information about people's allergies and where people received medicines on an 'as required' basis, there were no protocols in place to guide staff about when and how to administer them.

The lack of record keeping in relation to medicines and shortfalls in assessment of risks was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People did not always receive care at the times they were expecting it. Prior to the inspection, concerns were raised with CQC about punctuality of staff and missed calls. The provider had implemented an action plan to address this and people's feedback was that improvements had only been seen in the week prior to the inspection. People had also raised complaints with the provider that they did not receive their rotas in advance of care calls and staff sometimes arrived late. The provider showed evidence that their scheduling had improved and people's feedback supported this. Work was still underway and two people did tell us the provider was not yet able to meet their preferred call time, but they felt assured that this was being addressed. A relative told us, "It is in a state of flux but it is improving, we've started to receive a rota again."

However, there was no system in place for the provider to monitor that calls had been attended as planned. This meant that the provider was reliant on people calling in if they had a missed visit. This placed people living with dementia and those unable to use the telephone at risk of missed visits. The provider had carried out checks in response to the recent concerns and there had been no recent missed visits. There was a plan

to introduce an electronic system to monitor call attendance but this was not in place by the time of our visit. These actions formed part of an action plan already shared with CQC and we received updates in the weeks following the inspection to show these improvements were being implemented. We will follow up on the impact of these improvements at our next inspection.

Systems were now in place to monitor and respond to any accidents and incidents that occurred. Prior to the inspection CQC were made aware of an incident in which risk management plans for one person had not been robust. Our findings showed action had been taken to learn from that incident and introduce systems to learn from incidents that occurred. The provider had introduced a new system to record incidents that took place and the actions taken in response. Records showed that there had been very few recent incidents, but where they had occurred staff had taken action to ensure people's safety. For example, a recent incident in which a person had refused care highlighted a need for staff training in the Mental Capacity Act 2005. Records showed this had been discussed with staff and refresher training was arranged. The actions taken now showed an attitude of openness in which incidents were used to learn lessons when things went wrong.

The provider had carried out appropriate checks on staff to ensure they were suitable for their roles. Staff files contained evidence of references, employment histories, proof of right to work in the UK and a check with the Disclosure & Barring Service (DBS). The DBS carries out criminal record checks and holds a database of staff who would not be suitable to work in social care.

Staff understood their roles in safeguarding people from abuse. Staff had completed training in safeguarding adults and understood how to escalate concerns when we spoke with them. We saw evidence of staff escalating safeguarding concerns when they had them and the provider was working with the local authority where call punctuality had been raised as a safeguarding concern.

Systems were in place to mitigate the risk of the spread of infection. People told us that staff regularly washed their hands and used personal protective equipment (PPE), such as gloves and aprons, when supporting with care tasks. The provider had a stock of PPE and staff were observed collecting these to take to people's homes. Staff had received training in infection control and demonstrated a good understanding of how to reduce the risk of the spread of infection when we spoke with them.

Requires Improvement

Is the service effective?

Our findings

People told us that the staff that supported them were well trained. One person said, "I think they [staff] have good training, they seem very 'with it'." Another person said, "On the whole they all seem very well trained." A relative told us, "The girl we have frequently is absolutely splendid."

Despite these comments, we did find there were areas for improvement with regards to staff training and support. The provider kept a record of all staff training and this showed that some staff had not had recent training in important areas such as dementia care and fire safety. The provider was already aware of this and staff training was part of their action plan. There had been some issues as a result of a change to training provider's which had contributed to delays in courses taking place. At the time of our visit, we could see training had been sourced and was booked for staff.

Some staff had not had recent one to one supervisions or spot checks. Two staff files showed they had not had supervision for over 12 months. The shortfalls in supervision had also been picked up by the provider and there was an action plan in place for this. The provider shared action plans with CQC in the weeks following the inspection which showed that staff had received supervision, we will follow up on the impact of these improvements at our next inspection.

People said they liked the food that staff prepared for them. One person said, "They make me whatever I want. They often make an omelette and it's good." People's care plans documented their favourite foods, as well as their nutritional needs to enable staff to support them to maintain nutrition and hydration. Aside from the example highlighted in Safe, we found instances where people's food preferences and dietary needs were clearly documented. For example, one person liked foods such as seafood and this was clearly recorded in their care plan so staff could prepare them meals they liked at home. The person had time allocated to go shopping with staff to ensure they were involved in choosing foods staff could prepare for them. Another person used a device to maintain their nutrition and there was detailed guidance for staff, with input from healthcare professionals, on how to use it. Staff also kept accurate daily records regarding their use of the device.

Staff supported people to meet their healthcare needs. One person said, "When I had a hospital appointment, they were able to support it." We saw evidence of healthcare professionals where necessary and people gave us examples where staff had supported them to access healthcare professionals. One person told us staff had called their GP for them when they were unwell. We saw records of where staff had contacted healthcare professionals or emergency services when they were concerned about people's health. Where people had ongoing treatment, we saw evidence of staff supporting with this. For example, one person had the support of an occupational therapist (OT) due to their mobility. Information on how to support the person to move safely, using prescribed equipment, was within the person's care plan.

People told us that they had received an assessment of their needs before receiving a service. Records showed that the provider carried out a detailed assessment of people's needs and preferences and used these to create person centred care plans for people. For example, one person's assessment picked up

some dietary needs they had as well as equipment they used to support them to breathe. This information was used to guide staff about how to support the person to eat and use the equipment. We did note instances where people's assessments were not available due to shortfalls in record keeping which we have reported on further in the Well-led domain.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether staff understood the MCA and found they were able to describe when it would apply. One staff member told us how people may require an assessment of their ability to make individual decisions and was able to describe the principals of the MCA. At the time of our visit, all people had been able to consent to their care. People told us that staff asked for permission before carrying out care tasks and the provider had kept a record of people's consent to receive care from the service. We did note that some staff had not received recent MCA training and we will expect this to form part of the provider's action plan with regards to staff training.

Good

Is the service caring?

Our findings

People gave positive feedback about the caring nature of the staff who supported them. One person said, "They always chat and I get on well with them." Another person said, "Caring, kind and understanding. Full of common sense." Another person told us, "I've always had very nice girls, they're all very respectful and do anything for you." A relative told us, "They are very friendly and understanding, [person] can be forgetful."

People were supported by staff that knew them well. Despite recent issues with the punctuality of calls, people told us that they were supported by consistent staff that they got on well with. Three people told us that they had been committed to remaining with the service through recent issues because of the caring nature of the staff and how well they got on with them. Recent concerns had shown there had been shortfalls in how caring the service was. However, improvements had been implemented which demonstrated a commitment to creating a caring culture at the service. The provider had a system to schedule calls and we saw that people were allocated regular staff to support them. We noted staff had a good understanding of people's needs when we spoke with them and records showed a consistent staff team were visiting people each day.

Staff encouraged people to develop skills and independence. People told us that staff worked with them to carry out tasks. One person told us that staff regularly supported them to cook, they said they enjoyed cooking and this was important to them. Another person said they worked with staff to clean their home environment, with staff supporting them with physical tasks that they found difficult. Care plans documented specific personal care tasks that people could do for themselves, such as brushing their teeth or washing their face. Staff were knowledgeable about how to support people in a way that worked to their strengths and helped to empower them.

People were involved in their care. People told us that staff regularly offered them choices and that the provider asked them about their preferences. Records showed that these had been documented, such as the gender of staff people would like to support them and their food preferences and their routines. We did note two people told us that the provider was not able to facilitate their preferred call time. Both people told us that they were kept updated about this and were able to work around the current times staff could meet because they valued the staff who supported them and did not wish to change this. Meeting people's preferred call times was part of the provider's action plan on improving punctuality and we will follow up on this improvement at our next inspection.

Care was provided in a way that was respectful of people's privacy and dignity. One person said, "They treat me with dignity, the carers are all really good." All people told us that staff were respectful when entering their homes and provided dignified care. They told us their needs were always met and staff always offered to carry out extra tasks. People said staff ensured doors and curtains were closed for personal care and that staff always asked them for permission. Staff had received training in dignity and were able to describe to us how they provided care in a sensitive and respectful manner.

Requires Improvement

Is the service responsive?

Our findings

People told us that they received person centred care. One person said, "I can't stand or walk so they work with me and use equipment to get everything done." Another person said, "The care plan is very good, they were very thorough." Another person said, "When I ask for something, it's done. And the next time, they just do it without asking."

Whilst we did see care plans that covered a wide variety of needs, we also found examples where care plans lacked important information. One person had a learning disability and their care plan didn't contain information on their background and what type of learning disability they had and there was no information on what was important to them. Another person had a colostomy bag which was documented in their care plan. The plan documented staff were to 'help [person] to change the colostomy bag' with no information for staff about how to do this task. Whilst this showed the need had been considered, it did not provide enough information on how to deliver personalised care to the person.

Changes following reviews were not always clearly documented. We saw an example where a person's nutritional needs had changed and whilst it had been added to the care plan, the document was kept in a list format with the out of date information at the top. The provider had already identified this issue and had plans to introduce new care plan documents. We saw blank versions of these which had not yet been implemented and the new documentation provided prompts to staff to provide person-centred information.

People's feedback on the competence of staff and how care was provided was unanimously positive. People were supported by regular and consistent staff which reduced the impact of these shortfalls in record keeping. However, we will require action from the provider to ensure care plans provide staff with all the information they require to meet people's needs.

The shortfalls in record keeping related to people's care was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

In other instances, we found care plans contained person-centred information. For example, one person had mobility needs affecting one side of their body and there was detailed guidance for staff about how to provide personal care to them in a way that considered their mobility. Another person's care plan documented things that were important to them, such as their daily newspaper and cup of tea. Records showed staff supported them to have these each morning and people told us staff were considerate of things that were important to them.

People told us they knew how to complain and felt confident to raise any concerns that they had. One person said, "I rang once to comment on something they'd sent me and [previous manager] dealt with it very well. He was very understanding." There was a complaints policy in place which was provided to people when they started to receive a service. People were regularly asked for their feedback in order to identify any areas for improvement. The provider was also seeking people's feedback as part of the improvements to call

scheduling, which demonstrated an open approach to implementing improvements and involving people. The provider kept a record of complaints and these showed that there had been one recent complaint which was in the process of being actioned, within the provider's timescales set out in their policy.

Systems were in place to provide sensitive and personalised end of life care. At the time of our inspection, nobody was receiving end of life care. We discussed end of life care and saw that the provider had short term care plans that were ready to be used should they be required. These care plans provided prompts for staff on what was important to people at this stage of their lives and any specific needs they had. The provider told us how they would work with relevant healthcare professionals to ensure they could support people appropriately who wished to die at home.

Requires Improvement

Is the service well-led?

Our findings

People told us that they felt the service was well-led. One person said, "It is well organised, they are able to change things when needed." Another person said, "[Regional manager] sounds nice, he has made contact with me." Another person told us, "They are not too rigid and they listen."

There had been recent changes to the management at the service whilst the provider implemented their action plan. The provider had been taken over by a new company in November 2017 which had meant there were changes to regional management as well as systems at the service. There had also been two changes to the registered manager since our last visit. It had taken time to implement the changes and the transition had led to shortfalls in planning calls as well as record keeping and staff supervision. The provider had already shared their action plan with CQC and we were receiving frequent updates. This inspection found very recent improvements, but we did identify further shortfalls in record keeping which the provider was made aware of.

Record keeping systems were not always sufficient to show sustained good governance at the service. In some cases, the previous provider's paperwork was not accessible to management. With accidents and incidents, we saw a system to monitor these had been recently implemented but the system for historic accidents and incidents was not available. We found the same issue with records of complaints and audits. At the time of inspection, they were trying to find ways to access historic information but had not been able to. The new management team had introduced new systems which we saw were in place by the time of our visit.

Improvements to auditing were underway, but we did identify shortfalls that were yet to be addressed. As part of their action plan the provider had started a number of audits of areas such as training, documentation and call monitoring. There was a detailed action plan which showed that a number of issues had already been identified and addressed. For example, the provider had implemented new recording systems for complaints and staff training. Records of policies had been made available to staff and training had been booked.

However, the audits that were being implemented had not yet addressed the shortfalls we found in relation to record keeping and medicines. We shared our concerns about medicines and records with the provider and we saw a new system to audit medicines records and care plans had just been implemented. Our findings showed that the service was in a period of transition with temporary management arrangements in place to respond to recent concerns. The improvements will require time to become embedded and sustained and where we identified shortfalls within this report, further action will need to be taken by the provider.

The shortfalls relating to records and auditing were a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were involved in the running of the service. All people and relatives that we spoke with told us that

the regional manager had made contact with them all. In every instance where they said call punctuality had been a problem, they all felt they had been communicated with and felt the situation had improved over the last week or two. People and relatives were regularly sent surveys to complete to give their views on the service and they all told us they benefitted from good communication with the office.

Staff now felt supported by management, but recognised they were going through a period of change at the service. One staff member said, "There have been a lot of changes, changes don't happen overnight. It takes time to catch up with things." Staff said they had been involved in the recent changes at the service and we saw records of meetings which showed improvements were being discussed with staff and they had opportunities to contribute. Staff who had worked at the service for a long time had local knowledge and the provider understood the importance of this when moving forward.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always assessed and we found inconsistencies in records relating to people's medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were shortfalls in record keeping that meant important information about people's needs was not always available.