

MiHomecare Limited

MiHomecare - Wiltshire

Inspection report

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Ratings

Overall rating for this service

Requires Improvement



Is the service safe?

Inadequate



Is the service effective?

Requires Improvement



Is the service caring?

Good



Is the service responsive?

Requires Improvement



Is the service well-led?

Requires Improvement



Overall summary

This inspection took place on 16, 26 January and 6 February 2015. This was an announced inspection which meant the provider knew two days before we would be visiting. This was because the location provides a domiciliary care service. We wanted to make sure the manager, or someone who could act on their behalf would be available to support our inspection.

MiHomecare-Wiltshire was established in July 2014 after the merger of MiHomecare-Melksham and MiHomecare-Chippenham. It is a large domiciliary care

agency which provides care and support to people in their own homes on a short and long term basis. The agency manages the local authority's Help to Live at Home contract. This was the first inspection of MiHomecare-Wiltshire and was undertaken in relation to concerning information we had received about missed visits to people who used the service.

The agency had a registered manager in place who previously managed MiHomecare-Chippenham. A registered manager is a person who has registered with

Summary of findings

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.

The agency did not have enough staff to meet people's needs and to cover the staff sickness being experienced. Staff were being asked to cover additional shifts and where there was no capacity for them to do so, office staff were undertaking the visits themselves. In addition, a nursing agency had been contracted to undertake visits, which could not be covered by MiHomecare-Wiltshire. This significantly impacted upon the consistency of care and people were being supported by staff who did not know them.

People told us that they had experienced occasions when staff had not turned up to support them. Staff confirmed this had happened and we identified one missed call on the system, which the manager was not aware of. The agency used an electronic call monitoring system, which alerted office staff to potential missed calls. However, not all staff had phones connected to the system. This meant that missed calls could occur without the awareness of the office staff, which placed people at risk of harm.

People told us they were at times supported by staff who were not aware of their needs. Staff confirmed they were not always given information about people before providing support. One member of staff told us they sometimes went into people 'blind' without any information. This placed the person and the member of staff at risk. Staff had undertaken training during their induction but had received limited training after this to support them to do their job effectively. Sessions in relation to people's health care conditions were in the process of being developed.

People were allocated their visit within a specific time frame rather than being given a clear time of arrival. Staff told us they tried to adhere to people's preferences and to ensure visit times were consistent throughout the week. However, this was not always possible. People told us they rarely knew what time staff would arrive, which caused anxiety and concern. They were not aware that

the allocation of visits, unless time critical, was based on timeframes. People felt staff were often late, particularly in the morning and the times of their visits were not always spaced well throughout the day.

Staff told us the manager was supportive. However, formal systems of supervision, where staff could discuss their performance, training, development and any issues, were not consistently taking place. Similarly, ways of assessing the service had not been embedded. There were minimal audits being undertaken and a clear system of gaining people's views was not in place. People told us they knew how to make a complaint but there were concerns raised about not being listened to. Some people did not have the confidence that their issues would be properly addressed, as their experiences of calling the agency, had not been positive.

People did not raise any concerns about the way in which their medicines were administered. However, the instructions for the medicine's use were not always written in full. The entries had been handwritten without being countersigned by another member of staff. This increased the risk of error. Medicine administration records were not consistently completed, to show people had taken their medicines as prescribed. Staff told us they had undertaken training in the safe handling of medicines during their induction. However, they had not completed updated training and their competency had not been assessed.

The manager and senior managers confirmed that the agency was not where they wanted it to be. They said the merger had presented challenges and they were working hard to address the issues. Senior managers explained that changes had been made to the management structure and new systems were being put in place. Staff and people who used the service were being arranged into clusters in order to enhance communication, scheduling of visits and overall consistency. In addition, new staff had been recruited and further recruitment was on going.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

There were not enough staff to meet people's needs and to cover for the staff sickness the agency was experiencing. Due to this, people were not assured consistency with their care and were not always supported by staff who knew them well.

People told us there were occasions when staff did not arrive to provide their support. The electronic call monitoring system in place was not available to all staff and due to this, there was the risk that missed calls would not be identified. This placed people at risk of not receiving a service.

The medicine administration records did not ensure people were given their medicines safely.

Inadequate



Is the service effective?

The service was not effective.

People were often supported by members of staff who were not familiar with their needs. Staff were not always given information about people before supporting them.

Staff had received training when they first started in their role but updated training was limited. Training related to people's needs and their healthcare conditions had not taken place although was in the process of being implemented.

Whilst staff received support from the manager and the rest of the team, a formal supervision system, to discuss work individual work issues and on-going development, was not consistently taking place.

Requires Improvement



Is the service caring?

The service was caring.

Staff cared about the people they supported and were committed to providing a good service.

Staff involved people in their care and were clear about their responsibility of promoting people's rights.

Good



Is the service responsive?

The service was not responsive.

People had care plans in place but the quality of the documents varied considerably. Information did not detail people's health care conditions and how this impacted on their daily lives.

Requires Improvement



Summary of findings

People told us the support they received met their needs although there were concerns about the timing and length of their visits.

People and their relatives knew how to raise a concern but were not confident they would be listened to or their issues would be properly addressed.

Is the service well-led?

The service was not well led.

Whilst the manager was reported to be supportive, they were not fully informed of issues such as missed calls.

Some systems had been newly implemented but had not been embedded to ensure success. There was not a clear auditing system to assess areas such as missed and late calls, medicine administration and care planning. A formal system to gain people's views about the service was not established.

A new structure had been introduced to strengthen the management team of the agency. Clusters of teams were in the process of being developed to enhance responsibility and accountability.

Requires Improvement



MiHomecare - Wiltshire

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.

This inspection was announced and took place on 16, 26 January and 6 February 2015. The inspection was brought forward, in response to concerns we had received. The inspection was undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with 21 people who used the service, 4 relatives and 4 staff on the telephone. We spoke with 12 staff in the

office, including support staff, care co-ordinators and supervisors, the registered manager and two senior managers. We looked at people's paper and electronic records and documentation in relation to the management of the agency. This included staff supervision, training and recruitment records, quality auditing processes and policies and procedures.

Before our inspection, we looked at notifications we had received from the service. Services tell us about important events relating to the care they provide by sending us a notification. As this inspection was undertaken at short notice in response to concerns we had received, we did not on this occasion request the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Is the service safe?

Our findings

There were not enough staff to keep people safe and meet their needs. One member of staff showed us that all work had been allocated for the forthcoming weekend but there was no spare capacity. This meant that if a member of staff went sick or if there was an emergency, there were no staff to provide cover. The member of staff told us that in this situation, on call staff would undertake the visits. This did not enable consistency and did not enable people to be supported by staff who were knowledgeable about their needs.

Staff and the registered manager told us there was a very high level of staff sickness. One member of staff told us that during the weekend of 31 January and 1 February, five staff called in sick. This significantly impacted upon the service provided and some staff undertook over 20 visits in a day to people, to ensure the service was maintained. The member of staff said that this was not an unusual occurrence. They said in the event of staff sickness during the week, if there were no staff to cover the visits, the office staff would undertake the visits themselves. The manager told us covering people's visits was priority, so all staff were required to help cover any shortfalls.

The registered manager confirmed that the agency was short staffed. They said this was due to high staff sickness and many staff had left at the time of the merger. The registered manager confirmed that the situation was getting better, as new staff were being appointed and the agency's procedures were being implemented in terms of staff sickness. The registered manager told us that meeting with staff formally after their sickness in the form of a 'return to work' interview, had seen a reduction in staff absence. In addition, a nursing agency was being used to undertake people's visits, if there was insufficient capacity within MiHomecare-Wiltshire. People had not been informed of this. Whilst this enabled visits to be covered, staff did not always know the people they were supporting. This meant that staff were not familiar with individual preferences and routines and were not able to recognise potential changes in the person's health.

Five people told us about occasions during the past month when they had opened the door to find a care worker from a different Agency, wearing different uniforms, who were covering for staff absences. One person said "I opened the front door and the young lady told me that she had come

from a different agency to help out because of shortages. She didn't know anything about me and I had to explain to her what I needed doing. She was very helpful, but, at the end of her visit I had to help her with directions because she didn't know this part of the country. She told me she had travelled down from Cardiff that morning and it was her first time in Wiltshire."

Three people told us they had experienced missed calls. We spoke to one person at 3.30pm on 2 February 2015 and they said that staff had not turned up for their morning call. This meant that they had not received the assistance they required with their personal care. A member of staff told us the visit had been allocated but there was a communication error, which caused the visit to be missed. They said the person had called the office asking for the whereabouts of the staff member and then declined the visit, as it was getting too late. The person told us when they called the office they were informed that the agency was having problems. The missed visit was identified on the electronic system but there was no explanation as to why it had not taken place.

There were further comments about missed calls. One person told us "My elderly disabled wife had to help me get washed and dressed the other morning because no one came. They eventually arrived at midday and were surprised because I was dressed. It's not fair to expect me to wait all morning when I don't know whether they will come at all. It would be nice to have some life away from worrying about whether the carer will arrive when she is supposed to." Another person told us "I have a carer help me each day with my shower because I had a nasty fall a few months ago and I like to have someone around just to keep an eye on me. My carer was due to arrive on Sunday morning but by 11:30 there had been no call. I had to ring my daughter, who lives nearby and she was able to come round to make sure that I was alright. If she hadn't been able to I would've had to go without a shower all day." Another person said "my wife is supposed to have two carers particularly in the morning to help with her showering and hoisting out of bed. Very often one carer will arrive and she will end up sitting in her car for some considerable time waiting for the second carer. On more than one occasion she has given up waiting and has asked me if I will help her to care for my wife so that she can get on. I have done this because I want to make sure that my

Is the service safe?

wife gets seen to, rather than having to wait indefinitely for the second carer to arrive. However, I am not that well myself and don't know how much longer I will be able to help them for."

Staff told us this was not an isolated occasion and unfortunately it could happen, as it was difficult for carers to arrive at the same time. The registered manager and senior managers told us they had acknowledged this as an issue and were in the process of addressing it. They said they were developing 'double runs' so selected staff could work together throughout their shift and only visit people who required the assistance of two staff. The senior managers said this would maximise the best use of time which in turn, would enhance people's safety.

The registered manager told us they were not aware of any missed visits. They said the electronic monitoring system in place would identify any visits, which were not allocated to staff, so any missed calls would be quickly identified. However, one member of staff told us they had not been allocated a phone, which was connected to the electronic monitoring system. We asked them how the office would identify if a call was missed. They said "they wouldn't unless I told them or the person rang to tell them no one had arrived". The member of staff confirmed there was a risk that missed calls could go unnoticed, without the use of the electronic monitoring system. This presented a risk to people's safety. To minimise this risk, the registered manager told us that staff who did not have a work phone allocated to them due to being new in post, were required to text the office after each of their visits, on their personal phone. However, staff told us this was not consistent practice. On further discussion with the registered manager, it was identified that approximately 20 staff had not been equipped with the electronic call monitoring system. This presented further risk that missed calls would not be identified. The registered manager said they would chase the instalment of the phones. However, they told us in their previous agency, electronic call monitoring was not used so they did not believe it was not essential to the service. They believed communication was a key factor, which they would aim to improve.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some people required staff to prompt or administer their medicines. Staff told us for people to be able to receive this support their medicines had to be stored in a monitored

dosage system such as a dosette box. They said this minimised the risk of error. Staff described how they administered people's medicines in a safe and organised manner. However, not all medicine administration records were consistently completed. Some did not show the full instructions for the medicine's administration. Others did not demonstrate the medicines had been given. The records had been handwritten and were not countersigned by another member of staff. This meant that if the member of staff had written an instruction in error, it may not have been noted. This presented risks to the person's safety. Staff told us they had received training in the safe administration of medicines during their induction. They said they had not received updated training and their competency to administer medicines safely had not been assessed. There were no details in personnel files to show that staff had completed updated training in the safe handling of medicines or that their competency had been assessed.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had a number of assessments on their file, which identified potential risks to their safety.

These included environmental risks and the risk of falling, malnutrition and developing pressure ulceration. Whilst the assessments were in place, plans to minimise the risk were not consistently identified. For example, it was stated that a person required a wheelchair whilst in the community to minimise their risk of falling. The assessment did not identify how the risks were to be minimised whilst the person was at home.

Staff told us they would immediately report a suspicion or allegation of abuse to the manager. They said they would have no hesitation in doing this and felt confident any issue would be satisfactorily addressed. Staff told us they had received training in safeguarding vulnerable people. However, records did not show that the training had been undertaken recently. Policies and procedures in relation to keeping people safe were in place and clearly accessible to staff.

Staff were subject to a robust recruitment procedure when they first applied for their position with the agency. They completed an application form, attended a detailed interview and were required to supply the names of two people, who would support their application for the job.

Is the service safe?

Staff were offered the position subject to satisfactory references and a disclosure and barring service check. This ensured they were suitable to work with vulnerable people. The registered manager confirmed that the recruitment process had to be recorded on the system and be authorised before the new member of staff could start

employment. This ensured that a robust procedure was followed. Records were in place to demonstrate this although there was limited detail within two applications. This lack of information presented the risk of employing staff who were not appropriate for their role, which could compromise people's safety.

Is the service effective?

Our findings

Some people told us their visits were generally undertaken by the same staff. However, many people said they received a variety of staff, some of whom, they had not met before. This did not enable consistency and staff were not aware of people's needs. One person explained that they had an unpredictable health care condition, which staff did not understand. They said this impacted on their safety and they repeatedly had to explain the assistance they required. A relative told us they were concerned as staff did not appear to know how to approach their family member, to achieve the best outcome. They said their family member would tell staff they had already eaten in response to the question "would you like some lunch?" However, if the question was rephrased to "what would you like for your lunch? Shall we go and find something?" the person would eat quite happily. The relative told us they had spoken to staff about this but changes had not been made. Another relative told us that staff had no understanding of the complexity of their family member's needs. They said that staff treated them as a "usual service user" not someone who was very unwell and at the end of their life with complicated health care conditions. One relative told us the inconsistency of staff impacted upon their ability to recognise any changes in their family member. They said "I happened to visit my mother just as the carer was leaving. I found my mother to be quite lethargic and not wanting to do anything. This was not like her at all. When I looked at the paperwork that the carer had filled in, she had just said that it was a normal visit and nothing to report. As it was, my mother soon recovered, but I would've expected her to have written something about her condition before she left."

Staff told us they tried to find out as much as they could about people before visiting them. However, they said there were times when the information was not available and they "went in blind". Staff consistently told us they would always read the person's care plan and the last entries within the daily notes, before providing support. However, there was some concern that this sometimes impacted on the time they had available with people. One member of staff told us they supported a person who displayed behaviours of frustration and self-harm. They said they had not been informed about how to manage

these behaviours and had not received training in this area. The member of staff told us they drew on experience and training from their previous role in order to support the person effectively although this was not always successful.

Staff told us varying information about the training offered to them by the agency. Some staff said the training available to them was good. They said they could ask the manager for any training they required and this would be accessed and arranged. One member of staff told us they had received training when they started at the agency but had not undertaken anything since. They said their training had been a "whistle stop tour of subjects" which had been good although they now wanted training of greater depth. Another member of staff told us their training had been limited, as the focus had been on providing a service to people. The registered manager told us that the staff training matrix was not up to date. They said there had been some training but not all staff were up to date with all areas they required. Personnel files showed the training staff had taken during their induction. However, there was little evidence of any training which had been recently undertaken. The registered manager told us training in relation to people's needs such as Stroke awareness, Parkinson's disease and Epilepsy were in the process of being arranged. Staff were aware of this and looking forward to attending.

A training manager told us the main principles of the Mental Capacity Act 2005 were discussed within various training sessions including dementia care and safeguarding. Staff were aware of encouraging people to be involved with making day to day choices and decisions. However, staff's knowledge about mental capacity was limited. Most of the staff could not recall having any training about the Mental Capacity Act. This training was not detailed in any records or on the staff training plan. This presented a risk that staff would not be aware of what processes to follow if they felt a person's freedom and rights were being significantly restricted.

Staff told us they felt well supported by the registered manager and the team. There were positive comments such as "we work well together", "we all support each other" and "we look out for each other, we're a good team, very supportive". However, there were some concerns about lone working and the difficulties of gaining advice via the telephone. One member of staff told us whilst the registered manager was extremely supportive, it was

Is the service effective?

sometimes difficult to meet with her due to her busy schedule. Staff told us formal supervision, where they met with their manager to discuss any issues, was inconsistent and had not taken place recently. Two members of staff told us they had never had a formal supervision session. Records within staff personnel files did not demonstrate an effective staff supervision and appraisal system.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they tried to offer as many choices as possible whilst supporting people at mealtimes. One member of staff told us “it is difficult when the time’s limited but it’s important to do something the person fancies, so that they

eat”. Another member of staff told us “when you go to a person regularly, you get to know what people like. I’m going to Mr and Mrs X later and they like my bacon and eggs so they always have that while I’m there”. Another member of staff told us “it varies what people want according to when they like their main meal. Some people like a hot meal at lunch time with sandwiches later. Others may like it the other way around. It just depends what people are used to”. Staff told us people were often supported to have hot snacks such as soup, beans on toast or pre-packed microwaved meals for the main meals of the day. Staff told us if they noted a person was not eating, they would offer alternatives and would inform the office.

Is the service caring?

Our findings

Staff told us they were committed to providing a good service and they cared about the people they supported. One member of staff told us it was a privilege to work with people and they really enjoyed their job. Another member of staff said “none of us ever leave at the end of the day without ensuring everything is done and all visits are covered. We take the job seriously and ensure people are supported in the best way possible, as we’re only here because of them”.

Staff told us they felt ensuring people’s privacy and dignity was an essential part of their work. They gave us a range of examples, which showed how they promoted people’s rights. This included always making sure people were covered when being assisted with personal care, closing doors and curtains and being aware of how it might feel to be supported. One member of staff said “it’s all about putting yourself in the person’s shoes. It must be very difficult to have someone helping you with your intimate personal care. I wouldn’t want it.” Another member of staff told us “I always try to enable the person to do as much as they can for themselves. This includes enabling the person to wash their intimate areas themselves if they can. I also wait outside the bathroom whilst people use the toilet. It’s important to give people space.”

One member of staff told us promoting people’s privacy and dignity went further than the time spent with individuals. They said “it’s more than that. It’s about respecting confidentiality and not talking about people with others or in public spaces.” They gave examples of when they had heard staff from other agencies or care homes talking about their work whilst in supermarkets or pubs. The staff member acknowledged that this practice was totally unacceptable.

Staff told us they respected the fact that they were in the person’s own home. One member of staff said “we’re a guest and need to respect that. Without the people we

support, we wouldn’t have a job.” Another member of staff told us “it’s about respecting the person, as a person.” They explained they often took note of people’s possessions around them such as photographs, in an unobtrusive way. They said they were then able to make conversation about what was important to the person. The member of staff told us about how talking about one person’s working life with them had drawn similarities, which the person enjoyed. Another member of staff told us respect was about recognising the person as an individual, with individual preferences and ways. They told us “if it’s important to the person that you take your shoes off before entering their house, that’s what you do”.

Staff told us they tried to involve people in their care. They said they always asked people what support they needed such as whether they wanted a bath or a shower. One member of staff told us they always asked people for consent to do things. This included “is it alright to get the bathroom ready for you?” or “can I look in the cupboard to get your clothes?” They said they never presumed but always asked for permission. Another member of staff told us they always informed people what they were doing and encouraged people to take their time. They said “it’s difficult as we have time constraints because we need to get to the next person but I won’t rush anyone, it’s not fair. I try to make my time up between visits if possible so people have what they need.”

Staff told us they liked to support people they knew to ensure consistency. One member of staff said “it’s important to get to know people and you can only do this if you go to them regularly.” Another member of staff told us “you get to know people and know the little things that are important to them if you go to them often. How do you get to know people if you see them once and then don’t go for ages?” Another member of staff told us that consistency of visits enabled them to get to know the person and also their family. They said this improved communication and helped to ensure everyone was happy with the care being given.

Is the service responsive?

Our findings

People told us they were generally happy with the care they received. They said the service met their needs although there were concerns about the timing of their visits. Each person spoken with told us they had not been asked about or offered specific times for each of their calls. They all said they experienced wide variations in time on a daily basis and would only experience some continuity if a staff member was allocated for more than one day a week. This caused anxiety and concern. One person told us "if the same carer is due to come back the next day, she will try and tell me roughly what time I can expect her. But even then, I can't guarantee that it will be convenient for me. I don't like having to get up at 7am in the morning, as I don't sleep well and it also makes the day so terribly long." Another person told us "I told them I liked to go to my day centre twice a week and the taxi arrives for me at 9am. During the last 2 months, I've only been able to attend a handful of times because the carers don't get to me until much later in the morning." Another person told us "I don't like to go to bed too early, but at the same time I don't really want to be put to bed at 11pm at night. It would be nice just to know when somebody would be coming because sometimes I do worry as it gets later that no one will come at all and I will have to spend the night in my armchair." People's comments indicated the service was not responsive to individual needs. The planning of visits did not support people to develop a routine to promote their independence. There were occasions when rather than enabling, the visits were impacting upon confidence and restricting involvement in other activities. This conflicted with the agency's ethos of enabling people to live an independent and fulfilling life, as possible.

Relatives of people who used the service also raised concerns about the unpredictability of visit times. One relative told us "my wife has severe dementia and has to wear continence pads. She really needs an early morning visit because her pad is ready to be changed by then. However often the carers will not come until gone 11am, by which time she is soaking wet and needs to be cleaned up thoroughly. Then that carer will leave and instead of the next carer coming three hours later to change the pad she will arrive too early just as my wife has settled again. I don't understand why they can't space the visits out. I've asked them to sort it out, but nothing has changed. They are no real help at all." Another relative told us "I am in my 90s and

try to help look after my wife who is also in her early 90s. She is due to have four visits per day, but, because I never know what time they will arrive I find it very difficult to be able to even have my shower or use the toilet or get on with any jobs around the house because I know if the doorbell goes I need to be there quickly to let them in. It makes it really difficult to plan to do anything during the day when you never know when the next call will come. It becomes really frustrating when we end up having a late morning call, then the lunchtime carer will arrive only a few minutes after the morning carer has departed. It makes no sense and doesn't help me because I end up doing a lot of the jobs that the carers are supposed to do." Relative's comments gave further evidence that the planning of visits was not responsive to people's needs. Visits close together impacted on key aspects of people's care such as nutrition and healthy skin. For example, if a person had a late breakfast, they would probably eat a lesser amount at lunch time, especially if their lunch time visit was early. They may then become hungry later. Similarly, if a person required support to get out of bed and their morning visit was late, this increased the time they were in the same position, which increased their risk of pressure ulceration. Inconsistency of visits, impacted upon those people requiring assistance to use the bathroom. A late visit increased the risk of incontinence, as well as general anxiety and the loss of dignity. There was a risk that some medicines would not be effective if administered inconsistently in time.

The registered manager and senior managers told us that work was being undertaken around the scheduling of people's visits. They said staff were being grouped into clusters and they would then visit people in a specific geographical area. The registered manager and senior managers told us they hoped this would minimise time spent on travelling so the service would be more effective. In addition, they said the clusters would enable people greater consistency with their visits.

Some staff told us there were occasions when they arrived to support people later than expected. They said this generally occurred when they were allocated additional visits due to staff sickness. However, other staff and the registered manager told us people's visits were generally within the specified timescales and rarely late. They told us people were not given specific times for their visit unless it was time critical. People were allocated a timeframe such as a morning call which could be between 7am and 11am,

Is the service responsive?

with a flexible half hour either side for hold ups such as traffic. The registered manager told us lunchtime calls were from 11.30am - 2pm, teatime calls were 4pm - 6.30pm and evening calls were from 6.30pm onwards. A member of staff who scheduled visits told us people's time preferences were accommodated if at all possible and they tried to ensure consistency from one day to another.

Some people were not clear about their visits and how long they were allocated. One person told us "one day she will be here for 15 minutes in the morning and the next day it could be 30 minutes. It makes it really difficult to know what I can ask her to do for me when I don't know if she will be rushing off any minute." Another person told us "I know I am only contributing towards the cost, but each day is different and at my age it is difficult to keep track of things." The registered manager and staff explained that the variable length of people's calls depended on outcomes as the service was 'outcome based'. For example, if a person required help with having a shower, the staff member would be able to leave after the shower had been completed. They would not need to stay until a particular timescale had elapsed. Whilst acknowledging this philosophy, it was evident that people using the service were not aware of this way of working.

Whilst some people were not happy about the length of their support, there were some concerns about the recording of the visits. One relative told us "I happened to be visiting my mother when the carer arrived. She stayed for 15 minutes and then filled in the paperwork and left. When I looked at the paperwork she had signed to say she was here for 45 minutes. This can't be right can it?" The registered manager confirmed that the recording of visits and the time spent with people was currently based on trust. The electronic monitoring system did not enable visits to be analysed. The registered manager told us that they had plans for specific staff to be trained to do this. They said the member of staff would then monitor the duration and punctuality of the visits.

The majority of people we spoke to recalled having conversations with Social Services about their care needs. This information was then passed to MiHomecare-Wiltshire who allocated staff to provide the support. People were not introduced to the agency before their care package started. One person told us "I hadn't met anyone from the agency before the first morning of my care. My Social Worker arranged everything and all the completed paperwork

came with the folder that my carer fills in each time she visits." This did not enable people to be familiar with those staff supporting them or enable any questions or concerns about their care to be answered.

There was little recognition of the term 'care plan' with only one relative saying that she had been asked to contribute to it, after it had been written. The relative told us "when my mother had her first visit I was shown this plan and asked whether I agreed with it or not. It was the first time I had seen it. It looked about right so I said I was happy with it." This indicated that people and those important to them were not fully involved in discussing, deciding upon and directing their care. Within records, there was little evidence that the support people received had been reviewed to ensure it was responsive to people's needs. Only six people we spoke with had been with the agency longer than 6-7 months. Whilst those people recalled having reviews previously, no one had had a review within the last year, either by way of face to face meetings or over the phone.

The registered manager told us that they were aware the standard of people's care plans was not consistent. They said work was being done to transfer the information to standard formats so the plans were clearer and easier to read. Some care plans contained detailed information, which showed people's preferences and the support they required. Other plans were limited in their detail and not dated. One person's file and two other care plans could not be located. There was information about people's health care conditions but this was not specific to the individual person. The information did not detail how the person's condition impacted on their daily life. For example, one person received insulin for their diabetes. Details of this and possible symptoms of high or low blood sugar levels were not recorded in the person's care plan. There was no guidance for staff in response to managing these conditions. Another person experienced "vacant episodes" and could become agitated and disorientated when they woke. The support the person required in relation to this was not stated, which impacted on their wellbeing.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they knew how to make a formal complaint but had not done so. One person told us they had left the agency as they were fed up not with not knowing when or if someone was coming, how long they would stay and what

Is the service responsive?

they would do during the visit. The person told us they never had regular carers, which was important to ensure consistency and the stress was making them ill. The person continued to tell us that they had raised these issues but had not received an appropriate response. Other people told us they did not feel listened to and had not complained as they did not see the point in doing so.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In addition to not feeling listened to, people and their relatives told us the office staff were not responsive to their issues or concerns. People found that telephones were not answered or if they did get through, they were told they would get a call back but this did not happen. One person told us "I have no confidence in the office staff. On a number of occasions I have tried to ring to find out if my carer is going to arrive. They simply tell me they will phone me back and they never have". Another person told us "the weekend telephone number very rarely gets answered and if it does, I am told that they will have to contact somebody else who will get back to me and that is all they can do".

Another person told us "my family were going to take me out on Sunday for a meal. I had mentioned to the carers that I needed to be ready by 11am on the previous day. However by 10.30am, no one had arrived and I could not get the agency to pick up the phone on the number that I was told to call over the weekend. I ended up having to ring my daughter up who came round to help me get dressed and ready. If she hadn't have been able to I would've missed the family lunch."

Senior managers told us they were aware that some people were not happy with their service and they did not feel listened to. They told us they would be visiting people and developing informal meetings so that any views and improvements required could be shared and discussed. The registered manager and service managers confirmed that the service was not currently running as they wanted it to but they were committed to making improvement. They said arrangements were being made for all telephone calls received and undertaken by the service to be recorded so that clearer monitoring and accountability could take place.

Is the service well-led?

Our findings

The registered manager told us that the merger of the two agencies to create MiHomecare-Wiltshire had not been easy. They said that although they had intended for there to be minimal impact on people who used the service and staff, some disruption had occurred. The registered manager and senior managers confirmed the agency was not working as they wanted it to. They said they knew where they wanted to get to, but were not there yet. They were aware improvements were required and had devised action plans to achieve them.

The registered manager and senior managers told us a reorganisation of the structure of the agency had taken place, to address the issues. Senior managers had been deployed to support the registered manager with the changes. They told us they were 'in it for the long haul' and were committed to making things better. New staff had been being recruited and further recruitment was on going. Senior managers told us they wanted to encourage people who were passionate about care to join the staff team in order to promote more person centred care. They said they felt it important to employ staff with the right attitude and enthusiasm, which could be further moulded and developed.

Senior managers told us the staff teams and people who used the service were being divided into clusters. Each team would have a team supervisor, a coordinator and community support workers so responsibility and accountability within the teams were clear. Senior managers told us they expected staff to communicate and address issues within the team rather than immediately going to the registered manager for support. They told us each team would support people in a specific geographical area. This meant that if a person had a concern or particular issue, they would know who to contact, to get it resolved. The registered manager and senior managers told us they believed the development of the clusters would develop communication and in turn enhance morale.

The registered manager told us that management systems such as quality auditing were in their infancy and had not been established. There was limited documentation to evidence the systems in place. For example, there were no audits of the medicine administration systems, care plans or staff training. The registered manager was not aware of information such as missed calls and there was no evidence of any investigations which had taken place. The manager told us they would look back at this information and would investigate what had happened. An analysis of complaints had not been taken to identify any trends and improvements required. Systems such as the electronic call monitoring system had not been fully installed.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us a senior manager had visited the agency on a monthly basis to assess the service provided. No records had been maintained. There were some records to show some people had been asked their views of the service via a telephone interview. There was no overview of the people spoken to and their feedback was not coordinated. There were no action plans to address the issues raised. Senior managers told us that the surveys usually sent out to people to gain their views were being revised. They said they would be using surveys but would also be visiting people to ensure a more informal way of gaining feedback. A senior manager told us a suggestion box was being put in the office entrance area so people could raise their views about the service anonymously.

Staff told us the registered manager was supportive and they had an 'open door' policy. They said the registered manager could be contacted at any time and their phone was always on. Staff said they were confident the registered manager would address any issues they had and would not except poor practice, in any form. They said the registered manager was experienced and had strong values, which they liked. Staff told us the registered manager readily promoted the agency's vision of providing high quality care to help people live independently in their own homes.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There was insufficient staff to meet people's needs effectively. People had not received consistency with the times of their visits or of the staff supporting them. Staff were not always aware of people's needs due to the inconsistency of visits.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Full details of medicines and their prescription were not clearly stated on the medicine administration records. Instructions were hand written without a counter-signatory to confirm accuracy. Staff were not consistently signing the records to evidence the medicines had been given. Staff had not received up to date medicine training and their competency had not been assessed.

Regulated activity	Regulation
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Staff were not fully informed of people's needs before providing support. Staff had not received up to date training to do their job effectively and did not consistently receive formal supervision to monitor and discuss their performance.

Regulated activity	Regulation
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This section is primarily information for the provider

Action we have told the provider to take

Personal care

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

The planning and allocation of people's visits did not consistently meet people's needs. Missed calls were not being identified with the current system in place. Care plans were inconsistent and did not reflect people's health care needs and the support they required.

Regulated activity

Regulation

Personal care

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

Auditing systems were not in place to assess the quality of the service and potential risks to people's health, welfare and safety. Missed calls were not being clearly identified. People did not feel listened to and were reluctant to raise their concerns as a result.