MiHomecare Limited

MiHomecare - Carterton

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We undertook an announced inspection of MiHomecare - Carterton on 28 November 2017.

MiHomecare - Carterton is registered as a domiciliary care agency and as such provides personal care and support to people in their own homes. At the time of our inspection about 60 people were receiving services.

At the last inspection, the service was rated Good.

At this inspection we found the service remained Good.

Why the service is rated Good:

Appropriate actions were taken to ensure people's safety was maintained. Risks to people had been identified, assessed and were managed safely. People received their medicines as prescribed. The registered provider followed safe and robust recruitment procedures. There were sufficient numbers of staff to support people safely.

People received effective care. Staff were supported to undertake training needed for their professional development, including nationally recognised qualifications. Staff received regular supervisions and appraisals which enabled them to develop their understanding of good practice and to fulfil their roles effectively. Where people were unable to make certain decisions about their care, the legal requirements of the Mental Capacity Act 2005 were followed. People were supported to have their health needs met by health and social care professionals, including their GP and a speech and language therapist (SALT). People were offered a healthy balanced diet and when people required support to eat and drink, this was provided in line with relevant professionals' guidance.

The service continued to provide support in a caring way. Staff supported people with kindness and compassion. Staff protected people's privacy and dignity and treated them with respect. People had developed positive relationships with staff and were treated in a caring and respectful manner. People were supported to be as independent as they possibly could be.

The service continued to be responsive to people's needs and ensured people were supported in a personalised way. People's changing needs were responded to promptly. People and their relatives were aware of how to make a complaint. When concerns had been raised, they had been dealt with effectively to the complainants' satisfaction.

The service was led by an acting manager who promoted a service that put people at the forefront of all the service did. There was a positive culture that valued people, relatives and staff. Staff were given appropriate responsibility which was continuously monitored and checked by the registered manager. A system to monitor, maintain and improve the quality of the service was in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service remains Good.

Is the service effective?

Good

The service has improved to Good.

People received care from staff who were trained to meet their individual needs.

The provider acted in accordance with the Mental Capacity Act (2005) Code of Practice to protect people's rights.

People received the support they needed to maintain good health and have their nutritional needs met.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

MiHomecare - Carterton

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 checked 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 took place on 28 November 2017 and was announced. We gave the service 48 hours' notice of the inspection visit because the location provides a domiciliary care service and we needed to be sure that the management would be available in the office to assist with the inspection.

Inspection site visit activity started on 28 November 2017 and ended on 28 November 2017. It included reviewing records kept in the office and telephone interviews with people using the service. We visited the office location on 28 November 2017 to interview the manager and office staff, and to examine care records and policies and procedures.

The inspection was carried out 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. The expert-by-experience who assisted with this inspection had experience of working with elderly people and people living with dementia.

Before the inspection we reviewed the information we held about the service which included notifications they had sent us. Notifications are sent to the Care Quality Commission to inform us of events relating to the service which they must inform us of by law.

We asked health care professionals if they had any information to share with us about the services provided at the home. We used this information in our judgement.

On the day of our inspection we spoke with eleven people, five relatives and the acting manager. After the inspection we contacted five members of staff to obtain their opinion on the service. We reviewed care plans for five people, four staff files, training records and records relating to the management of the service such as audits, policies and procedures.

Good

Is the service safe?

Our findings

The service continued to provide safe care. People told us they felt safe receiving care from MiHomecare – Carterton. People's relatives told us they had no concerns about the safety of their family members using the service. One person using assistive technology told us, "I feel very safe when the carers are with me and they all know how to leave my phone on adaptation when they leave". Another person said, "They are nice and I feel safe with them". One person's relative told us, "I feel that my mother is safe especially with her regular carers".

Staff had received training in safeguarding adults and understood their responsibilities to identify and report any concerns. They were aware that incidents of potential abuse or neglect should be reported to the local authority. A member of staff told us, "If I witnessed or suspected abuse of a client, I would ensure they were safe and inform my manager immediately. If I was concerned that it was my manager who may be the abuser, I would go to my managing director".

Risks relating to the service and to individual people were assessed. These included risks associated with environment, mobility, skin care or eating and drinking. Risk assessments formed part of the support plan for each person. They provided clear guidance to staff and specified the least restrictive methods possible to keep people safe.

We asked people if there were enough staff and if staff attended their calls on time. One person told us, "I often have the same staff and that is so good as they know me well". Another person said, "They are punctual and they know my needs". One person's relative complimented staff, "The timing of their visits is perfect". However, some people told us that due to low staffing levels and recent staff turnover, sometimes staff members arrived late. One person remarked, "Sometimes they are late and when I ask why, they say that they are short of staff. But this does not bother me". Another person told us, ". Last week I had 22 different carers. I like the regular carers as I can sometimes have a fit and they know exactly what to do". We raised this issue with the acting manager who told us that they had recently introduced a number of incentive programmes to reduce the rotation of staff to minimum. The manager's statement was corroborated by the records we examined.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks. These checks identify if prospective staff were of good character and were suitable for their role. This allowed the registered manager to make safer recruitment decisions.

Equipment used in people's homes was always highlighted in the care plans and provided staff with knowledge of when and how to use it. For example, when people were using such pieces of equipment as wheelchairs, hoists, return belts, glide about commodes and shower chairs, this was clearly noted in their care plans and risk assessments. Return belts are used for sit-to-stand, transfer and walk applications.

The acting manager reviewed complaints and safeguarding reports regularly and these were looked into by

the provider's quality team as well on a monthly basis. These documents were also analysed during quality governance meetings at the board level and lessons learned were fed back to all branches of the provider. For example, the medication status of each who had an allergy had been incorporated into the provider's system as a result of a lesson learned at the company level.

Medicines were managed safely. There were medication risk assessment for people who self-administered their medicines or when the medicines were administered by their relatives. Medication profiles noted reasons for the medicines taken and possible side effects. Staff told us and records confirmed they had received training in safe management of medicines and their competencies in administering medicines were checked on regular basis. We examined the Medication Administration Record (MAR) and saw that there were no gaps in the recordings.

People were protected from the risk of infection. Staff received infection control training and told us they had access to personal protective equipment (PPE).

Accidents and incidents were recorded and investigated. They were also analysed to see if people's care needed to be reviewed. Reviews of people's care included referrals to appropriate healthcare professionals. For example, one person had been found to have difficulties with drinking fluids as staff and relatives reported instances when the person had been choking. The person was immediately referred to the speech and language therapist (SALT) who had assessed the person and the assessment outcome was included in the person's care files.

Good

Is the service effective?

Our findings

Most of people told us they were cared for by staff with the relevant skills and knowledge to meet their needs, which was also confirmed by people's relatives. One relative told us, "We have had the service for about two years and I cannot speak highly enough about them. They are willing and efficient". However, some of the relatives thought that due to the recent turnover of staff some of them were rushed into providing care and support to people. One relative told us, "They are caring on the whole, but sometimes I think that some carers need a little more training. I think that the shadowing time with new carers is too short". Another person's relative told us, "We feel safe with the regulars, but worry about the new ones and the short shadow time for them". We talked about this issue to the acting manager who informed us they had recently conducted more spot checks on staff to identify shortfalls and improve staff's induction and shadowing process. Records confirmed the number of spot checks had increased.

The acting manager demonstrated their commitment to ensuring staff could learn and develop their professional skills from the outset of their employment. New staff were supported to learn about the organisational policies and procedures as well as about peoples' needs. All new staff received an induction to ensure they were able to carry out their duties. All new staff were supported to complete the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. In addition to completing the induction training, new staff were provided with opportunities to shadow more experienced staff. Records confirmed that new members of staff were shadowing their more experienced colleagues for a period of five days.

The provider retained records of the training that staff had completed. These records showed that a comprehensive range of training was provided. This included safeguarding, food hygiene, administration of medicines, health and safety, and moving and handling. Training was refreshed regularly to ensure staff's knowledge was kept up to date. Staff told us that they were encouraged and supported by the registered manager to look for additional training courses. A member of staff praised the training opportunities offered by the service "All of the training I have received has been beneficial to me and prepared me as much as classroom based training can do for going out as a support worker. The refresher training I completed was just what I needed. It did exactly that, refreshed my memory and gave me the confidence to go back out and complete my duties as required".

Staff had regular supervision meetings with their manager. This gave them opportunity to discuss any concerns about people whom they supported as well as their own progress and training needs. Staff were asked to reflect on their own practice and on what their development needs were. The opinions and suggestions of staff gathered during supervision meetings were acted on by the service. For example, one person had a review by a speech and language therapist (SALT) arranged as a result of one of supervision meetings. A member of staff told us, "I have regular supervisions roughly every three months. I find them very useful".

People's care, treatment and support were delivered in line with current legislation and evidence based guidance to achieve positive outcomes. The provider's new policy system updated the policies in line with

the national institute for health and clinical excellence (NICE) guidance and mapped to the Care quality Commission's (CQC) key lines of enquiries. For example, the mental capacity policy referred to The Care Act 2014, Human Rights Act 1998, Mental Capacity Act 2005, Mental Capacity Code of Practice but also the Office of a Public Guardian and the Social Care Institute for Excellence.

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.

The acting manager and staff demonstrated a thorough understanding of the Mental Capacity Act (MCA) 2005. Staff recognised the principles of the MCA. A member of staff told us, "The MCA is to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment".

The management team and staff worked together to deliver effective care, support and treatment. The communication between staff and the office was efficient; the service used newsletters and organised regular meetings for the office staff and for the staff supporting people. The staff newsletter addressed general and minor issues, for example an instance of a fridge door left open after staff's visit. Information of higher importance was communicated directly to staff by the office team. People also received a regular newsletter with information about upcoming events. For example, about a 'Christmas Meet and Greet' event organised by the provider.

Each person had their needs assessed before the service commenced providing them with care. The aim was to make sure the service was able to meet the person's needs and expectations. Following the initial assessments, care plans were prepared to ensure staff had sufficient information about how people wanted their care needs to be met. When introducing a new package of care, the acting manager ensured they were advised of any required training needs. The service would not start the visits until staff received the task specific training. We saw evidence that staff received specialist training from district nurses before starting packages of care. People's preferences were recorded so that staff could learn about them. This included people's preferred names, and also their life stories. People's cultural and religious preferences were also met by the service. The acting manager told us, "This would all be covered on the initial assessment. The service user and/or the next of kin would be involved in all decisions. Any cultural or religious preferences would be detailed in the care plan and support workers made aware of any specifics before visiting service users. If identified, we would take advise from a dietician or a GP and use food or fluid diaries".

The equal opportunities policy was available at the service. People's cultural and religious backgrounds as well as people's gender and sexual orientation were recognized at the initial assessment stage and respected within the service. Staff received the training in equality and diversity.

Technology and equipment were used to enhance the quality of care, and to promote people's independence. An electronic call monitoring system was used to ensure people received their care on time, for the correct duration and with the right member of staff. One person was using assistive technology that enabled them to maintain their independence in spite of mobility issues. The assistive technology equipment had options programmed in, one of which was calling the service directly in case the person needed any urgent assistance. Some people had personal alarms and staff are fully aware of the importance of these.

People's needs in regard to food preparation, eating and drinking were assessed if this was part of the required care. People's preferences concerning food and drinks were recorded. If people required any special diet, for example due to diabetes, this was highlighted in their care files.
The acting manager told us and records confirmed that people were involved in making decisions about what they going to eat and drink. All the members of staff had completed food hygiene training.

The service actively contacted other services for advice and guidance, such as a SALT, the district nurse team, and the local safeguarding team. The service representatives had recently attended dementia friends meetings in order to expand their knowledge and pass this on to the wider team in order to deliver effective and supportive care.

People benefited from the outcome focused health assessments carried out by the service. Both people and, where appropriate, their relatives were involved in preparing these assessments. For example, one person's expected outcome was to maintain personal hygiene and feel comfortable while another person's expected outcome was to be able to live independently in their own home as long as possible. Records confirmed people had access to a GP, a SALT and a district nurse and could attend appointments when required. We saw people's changing needs were monitored, and changes in health needs were responded to promptly.

Good

Is the service caring?

Our findings

The service continued to provide a caring service to people who benefitted from caring relationships with the staff. One person said, "They are very caring people and they know I like to put my TV on my favourite programs. We laugh and banter together. I think that jokes are the best medicine". Another person told us, "I like the banter with the carers".

People were supported by a dedicated staff team who had genuine warmth and affection for people. Both the registered manager and provider promoted a caring culture. People told us that staff knew them well and they were able to develop positive relationships with staff. One person told us, "I look forward to my carers coming to me. It is lovely to hear them ring the doorbell. We are all good friends". Another person told us, "They hoist me onto my exercise bike which I love as it helps to keep my legs going. I treat a lot of them as my friends".

People were involved in planning their care and the day to day support they received. One staff member said, "We are trying to encourage and support individuals to do as much as possible in all aspects of life and daily activities. Also, to enable and support a person to maintain an active mind and body as much as possible within their abilities, such as personal care and engaging people in activities". Another member of staff told us, "Our clients have rights to control their lives and make informed choices about the services they receive. They or their families are fully involved in planning their care".

Staff told us how they treated people with dignity and respect. A member of staff told us, "I always treat my clients with respect. I ensure the curtains are drawn and cover the clients with a towel when providing personal care. I gain consent to carry out all task and I do not discuss the clients with anyone other than my seniors or other professionals". Another member of staff said, "I would protect a person's dignity, privacy and confidentiality by keeping them covered during personal care, closing curtains, doors and asking other people to leave the room should there be anyone. I would also leave the person in privacy should they want to. I would not discuss this client anywhere or to anyone apart from the necessary professionals with the clients permission". People were treated with dignity and respect. One person told us, "The carers are all good. They respect my dignity when they shower me, by using towels to keep me warm and private". One of the relatives praised staff's attitude towards people saying, "They are caring and respectful".

People's confidential information was protected. The provider's policy and procedures on confidentiality were available to people, relatives and staff. Care plans and other personal records were stored securely.

Good

Is the service responsive?

Our findings

The service continued to be responsive. Care records contained detailed information on people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs.

Staff treated people as individuals. For example, when people asked specifically for female care staff to support them, this was respected by the service. When people had individual wishes, these were accommodated by the service. One person's relative told us, "They come early on Sunday to help get her ready for church".

People's diverse needs relating to protected characteristics were respected. The provider's equality and diversity policy promoted the value of tolerance. A member of staff told us, "If I was supporting a person of different sexual orientation, I would not treat them any different than any other person".

The staff ensured they used relevant means of communication that met people's needs. One person was unable to communicate verbally due to their condition. The service together with the person's family members had introduced flash cards and communication cards in order to accommodate the person's communication needs. A flash card is a card bearing information, as words or numbers, on either or both sides. Flashcards are widely used as a learning drill to aid memorization by way of spaced repetition. Communication cards contain symbols and phrases for use in a specific situation.

People were able to easily access any information relating to their care. People were able to read their care plans and other documents. We spoke to the acting manager and saw evidence that large print versions of these documents were readily available to people. The acting manager told us that if needed they could provide people with Braille's version of their documents. Where people had difficulty, staff sat with people and explained documents to ensure people understood.

Care plans and risk assessments were regularly reviewed to reflect people's changing needs. A member of staff told us, "We have a client whose skin gets itchy when using soap. He now prefers to be washed with soapy water, then rinsed with pure water to ensure no soap is left on his skin. This has been reflected in his care plan". The serviced worked closely with the person's health care professionals and the records were updated to reflect the person's current support needs.

The service had systems in place to record, investigate and resolve complaints. During weekly telephone checks people were asked if they were familiar with the complaints procedure. People were also encouraged to voice their concerns during regular six weekly and six monthly reviews. One person told us, "I did make a complaint a few months ago about one of the carers. They took her off my list". Another person said, "I have never needed to make a complaint. I know the management and find the office people to be very good". There had been seven complaints received in 2017. We saw that when a complaint was raised, relevant action was undertaken to address the issue and improve the service. For example, there were additional competency checks after staff had missed administering one person's medicines and this was

also recorded in staff's supervision files.

End of life care plans detailed the level of care people required in the last days of their lives. The end of life care plans included, where required, re-positioning charts, instructions related to mouthcare and details of emotional support that was to be provided to the family.

Good

Is the service well-led?

Our findings

The service continued to be well-led. There was an acting manager who had applied to become the registered manager for 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.

People knew the acting manager and praised the office team for their work. One person told us, "The office are helpful". Another person said, "I know the management and find that the office people are very good". One of the relatives praised the management saying, "The office are good and remind the staff about things like my mother's clinical waste bins to be used". It was clear that positive relationships had been formed between people and the management team.

Staff told us they had confidence in the service and felt it was well-managed. One staff member said, "There have been a lot of changes in the business and shortages of staff. From my perspective though, things are improving. I have always been able to approach the office team and find them professional and helpful". Another member of staff told us, "Our branch office team are very understanding and also approachable. They do try to resolve problems wherever possible".

The service had a positive culture of openness and honesty. Staff were valued and people treated as individuals. When asked about the vision and values of the service, a member of staff told us, "We provide safe, effective and responsive care for all our clients, which improve wellbeing and independence of the people we care. We treat all clients with the same respect we would expect to be shown ourselves. We use best practice and feedback to improve our services".

The acting manager actively tried to involve people, the local community and staff in the running of the service. People were asked for their feedback during quality monitoring phone calls. Additionally, the service had recently organised a survey whose results had been analysed in order to improve the quality of care. The acting manager also contacted those people whom they had not met in person, either by visiting them with staff or by completing a telephone review with them. This was confirmed by people. One person told us, "The office is good. The office and the manager come and do regular surveys". We saw evidence that the service was planning a meeting at the local community centre for all people to come along and get familiar with the service and people using the service.

The acting manager monitored the quality of service. For example, medicine administration records (MAR) and daily records were reviewed monthly. Additionally, the acting manager had recently introduced monthly branch audits and bi-weekly self-assessments carried out by care co-ordinators. The self-assessments' purpose was to audit supervisions, spot checks and staff training.

The acting manager looked for continuous improvement. They recognised the need of retention of stable staff team who developed positive relationships with people. Shortly before our inspection the service had

introduced different incentive schemes to increase the number of regular staff members, boost staff's morale and encourage them to go above their duties. For example, there was a 'refer a friend' incentive scheme for staff to introduce new carers to the service. There was also a 'High 5' incentive scheme for staff going above their duties with monthly and annual awards.

Staff told us learning was shared at staff meetings, briefings and handovers. A staff member emphasized the value of staff meetings, "I feel that team meetings are a very good way of keeping in touch with all staff, and a chance for staff to meet each other and keep in contact. It also gives the staff the chance to offer advice or tips to other staff. As a whole, I believe team meetings have a positive outcome for all staff involved."

People's opinions were sought through surveys and regular quality monitoring phone calls. We saw the results of the last survey which were very positive. Where issues were raised, the service took action to resolve them. For example, when a person had been dissatisfied with staff's punctuality, information gathered with the electronic monitoring system was analysed to find a pattern of staff's lateness.

The service worked in partnership with local authorities, healthcare professionals, GPs and social services. One healthcare professional said, "I feel that I generally have a good rapport with this care agency, and try to ensure that good communication can help to minimise any issues".

There was a whistleblowing policy in place that was available to staff across the service. The policy contained contact details of relevant authorities for staff to turn to if they had any concerns. Staff were aware of the whistle blowing policy and said that they would have not hesitate report their concerns if they saw or suspected anything inappropriate was happening. A member of staff told us, "I do feel I am able to raise concerns and be able to whistleblow which I have done in the past".

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The acting manager was aware of their responsibilities and had systems in place to report appropriately to the CQC about reportable events.