MiHomecare Limited

MiHomecare - Woodingdean

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**

Summary of findings

Overall summary

The inspection took place on 25 July and was announced. MiHomecare – Woodingdean is a domiciliary care service based in Brighton and East Sussex.The service provides support and personal care to people in their own homes and covers the Brighton and Hove, Eastbourne and Seaford areas. At the time of the inspection the service were supporting 198 people with a variety of health and social needs in their own homes.

The service was last inspected on 16 March 2015. We found one breach of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 where there were inconsistencies in the systems in place to manage, monitor and improve the quality of support provided to people in their own homes, which included some significant concerns regarding on-going incidents of late or missed calls. This was identified as a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the provider was asked to submit an action plan to address this.

We reviewed the systems in place to monitor, manage and improve the quality of support provided to people as part of this inspection. At this inspection we found that while some improvements had been made to services delivered in the Brighton and Hove area the monitoring and management of missed and late calls was not consistent. We also found that the systems and processes in place for the Eastbourne and Seaford areas were not sufficiently robust and there were significant concerns regarding on-going incidents of missed and late calls in the Eastbourne and Seaford areas.

The service had a registered manager. 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.'

Ten people and two relatives told us that they had experienced late or missed calls. One relative told us that their family member had missed meals and medication as a result of missed calls and another two relatives told us how late called had resulted in people taking their medicines later than prescribed. This meant that since the last inspection any improvements to the systems and processes had not consistently improved the experience of people and the provider continued to have a lack of oversight of the incidents of missed and late calls. This was identified as a continuing breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were trained to give medicines and their competency was checked prior to giving medicines to people in their own homes. However, medication was not always given at the time it had been prescribed due to late or missed calls and this was identified as a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment practices were not always robust. Two members of staff did not have full employment histories and one member of staff did not have a health declaration on file. In addition agency profiles did not

confirm pre-employment checks. This meant that the provider had not ensured that staff were suitable to work with people and this was identified as a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they could request a male or female carer but that their preference was not always respected. One relative told us that male care workers were often allocated their family member when they had expressed a preference for female carers only. The relative had complained to the registered manager but the agreed action plan had not been adhered to. This meant that people's preferences were not always taken into account when staff were allocated to calls and has been identified as breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints process in place but agreed actions were not always followed through. People told us that they found it difficult to contact the office with questions about their care and support. Two people told us that they had left messages and been promised a call back but that no one had got back to them. Nine people said that if they called the office to cancel a call the message did not get through to their care workers who turned up anyway. This meant that people did not always get the information they needed or feedback to the provider and this has been identified as breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was not consistently working within the principles of the Mental Capacity Act 2005 (MCA). There were mental capacity assessments in place with clear guidance to staff on how to support people to make every day decisions however where people lacked capacity it was not clear whether the person consenting to care had the legal right to represent them. One person's support plan had been signed by a relative to indicate consent to care. The person was assessed as having mental capacity but there was no explanation as to why the relative was giving consent on their behalf. This meant that the service was not seeking consent in line with the MCA and is an area that needs improvement.

Staff told us they were supported and understood their roles and responsibilities. Quality assurance systems were in place but were not employed consistently or effectively to monitor, manage and improve the quality of service and this is an area that needs improvement.

Staff understood their responsibilities in regards to keeping people safe from harm. They had received training in safeguarding adults and children and had access to policies and procedures to guide them if they needed to raise a concern. Staff were comfortable to raise concerns regarding poor practice with the registered manager who acted promptly and effectively to address any practice shortfalls.

Environmental and individual risks had been identified and care plans provided staff with clear guidance on how to manage those risks and meet people's needs. Staff wore uniforms and took appropriate measures to reduce the risk of cross infection.

New staff experienced a comprehensive induction to include essential training and competency checks in areas such as manual handling and medication practice prior to starting to work with people. There was a training plan in place to ensure that staff had the knowledge and skills to meet people's needs and four members of staff told us that they had received supervisions and felt supported in their roles.

People were supported to have sufficient to eat and drink. Staff prepared and served meals for some people and encouraged and supported others to maintain adequate hydration. Staff monitored people's health and wellbeing and any recommendations from health care professionals were incorporated into people's care plans and referred to by staff.

Positive relationships had developed between people and the staff who supported them.
People told us that their regular care workers were kind, helpful and supportive. Staff treated people as individuals and with respect. People were supported to live independently in their own homes and were encouraged by staff to continue to do as much as they were able. Staff told us that they explained what they were doing and sought consent from people before giving care and support.

Permanent staff knew people well and responded appropriately to people's changing needs. A member of staff told us how they stayed and chatted with a person who was, 'Down in the dumps.' And two members of staff described how they had supported people when they were unwell by contacting their GP.

We identified some breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Medicines were not always administered on time and as prescribed.

There were insufficient numbers of suitable staff employed to keep people safe and meet their needs and the provider had not always ensured that staff employed were suitable to work with people.

Staff had received training and understood their responsibilities regarding keeping people safe from harm.

Individual risks were identified and there was clear guidance to staff on how to manage these risks and meet people's needs safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not always followed the legislative requirements of the Mental Capacity Act 2005 (MCA) regarding consent to care.

There was a training plan in place and staff told us they received supervisions and appraisals and felt supported in their roles.

People were supported to have sufficient to eat and drink. Staff monitored people's health and wellbeing and supported people to access health services if required.

Is the service caring?

Good

The service was caring.

Positive relationships had developed between people and their regular care workers and people told us that their care workers were kind, helpful and supportive.

People said they felt in control of their care and staff told us that they asked people how they wanted to be supported and cared

for them as individuals.

Staff supported people to live independently in their own homes and treated people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's choices and preferences were not always respected.

There was a complaints process in place but people found it difficult to contact the service with questions about their care.

Staff knew people well and were responsive to people's changing needs.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a registered manager in place. Staff understood their roles and responsibilities and felt supported.

The systems and processes in place to monitor, manage and improve the quality of the service were not robust. Missed and late calls were not monitored and managed effectively and the quality of services were not monitored and improved.

There were quality assurance systems in place but they were not employed effectively to improve the quality of the service.

MiHomecare - Woodingdean

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 took place on 25 July 2016 and was announced. This was because we wanted to make sure that the registered manager would be available to support our inspection or someone who could act on their behalf.

The service was last inspected on 16 March 2015 where one breach of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified and the provider was asked to submit an action plan to address this breach. We looked at the effectiveness of this action plan as part of this inspection.

The inspection team consisted of an inspector, an inspection manager and an expert by experience in the care of older people and people living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at this and other information we held about the service. This included notifications. Notifications are changes, events or incidents that the service must inform us about. We also contacted stakeholders, including health and social care professionals involved in the service for their feedback to include local commissioners and two social workers working with people using the service.

During the inspection we spoke to two care coordinators, two care workers and one field care supervisor. We also spoke with the registered manager, the regional manager and the quality and performance manager.

As part of the inspection process we conducted telephone interviews with 26 people who used the service and four relatives. We also interviewed one care worker by telephone.

The service operates two separate scheduling systems. One system covered service users in the Brighton and Hove area and one system covered the Eastbourne and Seaford areas. Scheduling was managed and monitored by coordinators. We reviewed these systems with the coordinators in real time so that we could understand how late and missed calls were monitored and managed. We also reviewed four staff files, policies and procedures, accident and incident records, training plans and surveys undertaken by the provider. We looked at individual records relating to seven people, which included risk assessments and support plans.

Inadequate

Is the service safe?

Our findings

All the people that we spoke to told us that they felt safe and comfortable in the company of their regular carers and that their homes possessions were safe. However we found that the service provided was not consistently safe. One person said, "I'm quite happy with the regular girls." However, eight people said that they were unhappy with the quality of the agency staff and three relatives told us about late and missed calls which had resulted in missed or late administration of medicines.

People did not always receive their medication as prescribed. One person told us that their care workers supported them to take their diabetic medicines and that they needed to be given on time in order to effectively manage their condition. They told us and records showed that they had received late morning calls on three occasions in the past week. This meant that they did not get their diabetic medicines on time and as prescribed which could put them at risk of harm. A relative told us how their family member was prescribed medicines to temporarily relieve their symptoms of dementia. They had not received their medicines on three occasions due to missed calls and therefore it is likely that their symptoms were not manged during this period. Another relative told us that they managed their family member's medication regime but could not give them unless they were up and had eaten. They described how their medication regime had been affected by late calls and explained how one evening their bedtime call was so late they had fallen asleep and forgotten to give their relative their medicines. The provider had therefore failed to ensure that people received their medicines safely and as prescribed and therefore we have identified this as a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff files for staff working in Brighton and Hove and in the Eastbourne and Seaford areas. There was a new recruitment process in place; however recruitment practices for both the old and the new processes were not always robust. Two members of staff did not have full employment histories and one member of staff did not have a health declaration on file. One member of staff's references and DBS check were dated a month after their start date. DBS checks identify if prospective staff have a criminal record or are barred from working with children or vulnerable people. This meant that the member of staff had been supporting people before the provider knew that they were safe to do so. Another member of staff's confirmation of dates of previous employment were not compatible with dates given on the application form, with no explanation provided. There was a character reference for this member of staff however sufficient checks had not been made to ensure that the member of staff was of good character and suitable to work with people. There was no evidence that for two agency staff being regulary employed by the provider to demonstrate that pre-employment checks had been carried out by the agency. This meant that the provider had not ensured that all staff employed were of good character and suitable to work with people and this has been identified as breach of Regulation 19 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider used a rolling rota system to allocate staff to visits and three members of staff told us that they supported the same people regularly and that sufficient travel time was allocated between calls. Allocation of staff was based on the availability of staff and area they worked in rather than their skills and experience particularly in the Eastbourne and Seaford areas where there were not always sufficient numbers of suitable

staff employed to keep people safe and meet their needs. The provider had employed a regional recruiter to support the registered manager however the recruitment of sufficient numbers of suitable staff in the Eastbourne and Seaford areas had proved challenging. The registered manager told us that agency staff were used to cover gaps in the rota and last minute sickness absence. The scheduling system showed that the provider was using agency regularly.17 people told us that they had received support from agency staff but that the care provided to them was not to the same standard as the care provided by regular carers. One person said, "Agency staff aren't very good, they're not really bothered. " A relative told us, "They don't know what they are doing. I have to help them." There was no robust system in place to quality assure the support delivered by agency staff and agency staff could not access the same system as regular staff to log calls that they had undertaken a visit. This meant that calls covered by agency staff were not consistently monitored or managed to ensure that calls were not late or missed and the registered manager told us that there had been occasions where the agency staff had said they had made a call when in reality they had not. The lack of a robust system to assess, monitor and mitigate the risks relating to the health, safety and welfare of people supported was therefore identified as a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were trained to administer medicines safely and their competency was checked before they began to give medicines to people. Care plans gave staff clear guidance on how to support people with their medications. A member of staff described how she gave medicines to a person and they explained that they watched them swallow their medicines so that they were sure that they had taken their medicines during the visit. Staff recognised and reported medication errors and took appropriate action to ensure that people were safe from harm. For example, one person was prescribed a medicine to be administered every other day but the person received this medication two days running. A member of staff had identified this error and reported it to the registered manager who contacted the person's GP for advice, took practical action to ensure that the error would not occur again and communicated this to the care workers involved in this person's care.

Staff had received training and understood how to recognised abuse and report any concerns. There was a safeguarding and whistle blowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation or directly to external organisations. The Whistle blowing Policy was included in the staff handbook and there was a confidential MiHomecare Whistle blowing telephone line for staff to call to report their concerns should they not wish to speak to their manager. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation or directly to external organisations.
One member of staff told us how they had raised a concern regarding poor practice with the registered manager. The member of staff was concerned that staff were not supporting people appropriately in very hot weather. They told us that the registered manager discussed this with the member of staff concerned and that their practice had improved. The registered manager also sent a communication out to all staff reminding them to open windows, give extra drinks and position people out of direct sunlight to reduce the risk of people becoming too hot or dehydrated.

Individual risk assessments identified environmental and individual risks. They were up to date with clear guidance in place for staff to manage these risks effectively. For example, one person's care plan instructed staff to ensure that they were wearing their lifeline as they had a history of falling over. Three people's records showed that a telephone review had taken place in the last three months and four people told us that they recalled having a review.

There was a process in place to record and monitor accidents and incidents. The registered manager had oversight of any incidents which were then tracked to ensure that appropriate actions had been taken and

plans put in place to minimise the risks of recurrence.

People told us that staff wore uniforms and three people confirmed that staff took appropriate precautions to prevent the spread of infection, such as the use of personal protective clothing. One member of staff told us that they always washed their hands before and after supporting a person and another said that they wore gloves and an apron when supporting people with personal care.

Requires Improvement

Is the service effective?

Our findings

Everyone that we spoke to confirmed that their regular carers had the knowledge, skills and personal characteristics to provide their care and support. One person said, "The carers are damned good." A relative told us, "The regular carers are fantastic and they give great support." However we found that the service was not always working within the principles of the Mental Capacity Act 2005 (MCA) regarding obtaining consent to care and support.

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. We checked whether the service was working within the principles of the MCA.

Staff had received training in the MCA. Individual support plans contained a mental capacity checklist and there was guidance to staff on how to support people to make day to day decisions such as what they wanted to eat or wear. Three members of staff told us they explained the person's care to them and gained their consent before carrying out any care and support and all the people and relatives that we spoke to confirmed that this was the case. However, two people were assessed as having mental capacity to consent to care and support but their relatives had signed the support plan on their behalf without documented evidence of their permission; for example, where a person is able to agree to care and support but is physically unable to they may ask a relative to sign on their behalf. In addition to this where people did not have capacity it was not always clear whether the person agreeing to their support plan had the legal right to do so. This meant that the provider was not always seeking consent appropriately and had not acted in accordance with the MCA and was identified as an area that needs improvement.

A senior member of staff working in the Eastbourne and Seaford area told us that supervisions and appraisals had fallen behind but there was a plan in place to address this. The registered manager, manager of the Eastbourne and Seaford service and supervisors undertook supervisions and appraisals and four members of staff told us that they received had supervisions recently. Staff told us that they felt supported in their roles and that they felt comfortable to raise concerns with their line manager or the registered manager if required.

There was a robust and effective induction programme in place for new staff which involved a week of classroom learning followed by shadow shifts until deemed competent by a senior member of staff. Staff completed competency checks in manual handling and administering medicines prior to working with people and a new member of staff told us that their supervisor had carried out spot checks in the first few months to observe their practice. All staff had completed the Common Induction Standards or were working towards the Care Certificate. The Care Certificate is a set of nationally recognised minimum standards for health and social care workers.

There was a training plan in place to ensure that staff had the knowledge and skills to meet people's needs.

This included essential training such as health and safety and basic food hygiene and the majority of staff had received dementia awareness training. One person said, "I feel quite comfortable when my regular girls are here, they understand my condition and how to help me."

People were supported to have sufficient to eat and drink by their care workers. Staff prepared and served food to people needed. One person told us that their care worker heated up their meal and served it to them. Another said in an email to the registered manager, 'She made a good tasty breakfast and prepared a perfect lunch for me." Two members of staff told us that they would ask people and check for evidence that people were eating and drinking and would raise a concern if they thought a person was losing weight. Another member of staff said they would monitor how much a person had eaten and record this in the daily notes. One member of staff told us how the person they supported was at risk of harm due to dehydration. At every visit they ensured that the person had a full glass of water by their chair, their bed and in the kitchen. They said that they made sure the person drank a glass of water during their visit and reminded them to drink when they left.

Staff monitored people's health and wellbeing and took action if people were unwell. A member of staff told us that if someone was unwell they would arrange for the GP to visit when a care worker was present. They explained that they would document their concerns in the care plan for the care worker and the GP to read. Another member of staff told us that a person they supported had a suspected urinary tract infection. They had telephoned the GP surgery on the person's behalf and had dropped a urine sample into the surgery on their way to their next call. A coordinator explained that staff call the office if they are concerned about a person's wellbeing and that office staff inform the GP or next of kin as required.

Recommendations from health care professionals were included and referred to in individual care plans for example one person had been referred to an Occupational Therapist who had made recommendations on how this person should be supported to move using specific equipment. The care plan gave detailed guidance to staff on how to support this person to move and referred them to the Occupational Therapist's assessment which was available in the care plan for staff to read.

Good

Is the service caring?

Our findings

People told us that their regular care workers were kind, helpful and supportive. One person said, "They are lovely, the carer who comes,very attentive and caring." Another told us, "The carers are fantastic, my two regulars come every day and I look forward to them coming."

People told us that staff who regularly supported them knew them well and that they had built positive relationships with them. Eight people told us that they were happy with the care provided by their regular care workers. One person said, "I have a very pleasant man, he knows me well and I know him so it works." Another said, "The carers are damned good." However some people in the Eastbourne and Seaford areas were frequently cared for by agency staff which limited their opportunities to develop positive caring relationships with the people supporting them.

A member of staff told us that when they arrived at a person's house for the first time they would introduce themselves and tell them where they came from. They said they would check the support plan then ask the person how they would like to start. Another staff member told us that when giving people care and support they would explain to people what they were doing and why they were doing it. Two staff members said that it was important to support people at their own pace and not rush them. People were treated as individuals, for example, one member of staff explained that one person they supported did not like to be told what to do. They told us how they distracted them by chatting about day to day things whilst and invited them rather than told them to accept their support to get up in the morning. A member of staff said, "Everyone is an individual and we treat them as individuals."

One member of staff told us that she read in a person's care plan that she was a professional musician. They said they asked the person questions about the instrument they had played and an animated conversation had ensued. The member of staff told us that as she left the person with a smile on their face and as they left the person thanked them for taking the time to chat to her. Another member of staff told us that a person they were supporting had told them they were feeling, 'Down in the dumps.' They contacted the person's social worker to let them know and spent a little longer chatting to the person to try to lift their spirits.

Staff supported people to remain independent in their own homes. One member of staff told us that they encouraged people to do as much as they were able. They said that that when giving personal care to people she gave them the opportunity to wash their own face and hands and any other areas that they were able and wanted to do themselves.

Seven people told us that they felt staff respected and promoted their dignity and privacy. One member of staff told us how they made sure that the person they were supporting were always covered and not unduly exposed when they supported them.

All the people that we spoke to felt that their regular care workers supported them how they wanted them to and three people referred to the purple folder where their support plans and daily records were kept. Each person supported by the service was provided with a Service Guide which explained how care and support

would be delivered and what people could expect from the service. The Service Guide included useful telephone numbers such as the out of hours / emergency contact number for the service as well as contact details for the local authority and the Care Quality Commission (CQC). The provider had also produced a newsletter in June for people in the Brighton and Hove area. This included advice for keeping well in a heat wave and upcoming local events. The registered manager told us there were plans to produce a similar newsletter for the Eastbourne and Seaford areas in September 2016.

Requires Improvement

Is the service responsive?

Our findings

Staff we spoke to knew the people they supported well and treated them as individuals. However we found that people's preferences and wishes were not always respected when calls were scheduled. One person was unable to communicate their preferences but their family member knew them well and understood that they did not like to be supported by male care workers. They told us that their family member became upset and anxious after receiving support from male care workers. The relative told us that his family member's preference for female care workers had not been respected and had made a complaint. They had met with a senior manager who agreed that only female care workers would be allocated to their family member. It was also agreed that should the provider be unable to allocate only female care workers, for example if a female care worker was off sick at short notice, then the provider would telephone the relative in advance so that they could let their family member know. The relative told us that the provider had not honoured this arrangement and that in the week of our inspection male care workers had provided support to their family member on three separate occasions without notice. Other people told us that they could request a male or female care worker and that this was generally respected with the exception of weekends and bank holidays. Therefore the allocation of staff was not monitored, managed and improved to ensure that people's preferences were respected and this is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints procedure which was included in the Service Guide for people and on display in the office. The staff handbook also included a section on supporting people to complain should they wish to. Complaints were dealt with in a timely manner however agreed actions were not always sustained or followed through and people said they did not feel listened to by the provider. One person and a relative said that they had had difficulties contacting the office when they had a query about their calls. Eight people told us they had called the office to cancel a call but that their care worker had turned up anyway. One person said, "I feel sorry for the girls because they turn up here when they could be helping someone who needs them." Three people and a relative told us that they left messages on the office answer machine but their calls had not been returned. Three people told us that when they called to ask about their calls they were promised a call back that never came. One of these people said, "They never call you back" Another person said, "I don't think they care about me." People were therefore not responded to in an appropriate and timely manner which meant that the provider was not acting on feedback which is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke to knew people well and were responsive to their changing needs. A member of staff explained that they knew the people they visited regularly very well so if something was not quite right they would pick up on it. One member of staff told us that they had noticed that a person's memory was deteriorating over time. They contacted the person's GP and accompanied them to their appointment so that their condition could be diagnosed and treated before it deteriorated any further. A member of the office team told us how staff reported that a person's needs had changed so that they needed more support. They contacted the local authority to arrange a review and the person's care package was increased to meet their needs.

The provider conducted annual service user surveys which asked people their opinions on their care workers, the quality of their care and their contact with the office staff. For example, people were asked if they were involved in their care planning, if their care worker was punctual and if any changes were communicated to them in a timely manner. The results of the survey were collated and actions included on the improvement plan for example, an action to improve people's experience of contacting the office.

Requires Improvement

Is the service well-led?

Our findings

The service was last inspected on 16 March 2015. We found one breach of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 where there were inconsistencies in the systems in place to manage, monitor and improve the care and support provided to people in their own homes, which included some significant concerns regarding ongoing incidents of late or missed calls. At this inspection we found a continuing breach of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding the monitoring, management and improvement of missed and late calls which were found to be frequent and ongoing.

At the last inspection MiHomecare – Woodingdean provided domiciliary care services to the Brighton and Hove area only. Since the last inspection MiHomecare Woodingdean had absorbed services covering the Eastbourne and Seaford areas. This meant that all activities for the Brighton and Hove and Eastbourne and Seaford areas were carried out and managed from MiHomecare – Woodingdean.

During the inspection we found that that the systems and processes in place to monitor, manage and improve the quality and safety of services were not robust. 11 people told us that they had experienced late or missed calls for some people this was an ongoing concern. People and relatives told us how this impacted the health and wellbeing of people and their families. One relative told us how in the previous week a call was 50 minutes late which meant that their family member was late getting ready and getting their breakfast. They explained that this made them late too which impacted on their wellbeing as they are diabetic and need to eat regularly.

There was a real time system for monitoring calls in the Eastbourne and Seaford areas which was delivered by an external company. The system was dependent on staff logging in when they arrived at a call. The registered manager told us that the service was using up to 160 hours of agency staff per day and that the majority were employed to cover calls in the Eastbourne and Seaford areas however agency staff were unable to log in to demonstrate that they had arrived at a call so calls made by agency staff could not be monitored as effectively. The registered manager told us that on one occasion a relative raised a concern about a missed call but the agency member of staff said that they had made the call. The person they were supporting was unable to confirm whether the call had been completed or not due to their condition and there was no other system in place to monitor this. People also reported calls that were too early or too close together in the Eastbourne and Seaford areas.

Staff who were in charge of scheduling and overseeing the Eastbourne and Seaford areas were asked for the data on how they monitored late and missed calls. The system did not enable them to have easy oversight of this data in order to effectively monitor late and missed calls. This meant that missed and late calls were an ongoing issue for some service users and any improvements were not sustained. For example, one person was living with dementia and relied on four calls a day for meal preparation, prompting and the administration of medicines. This person experienced two missed calls on the 9 July 2016 and one missed call on the 13 July 2016. These missed calls had not been managed or reported to the registered manager who only became aware of the missed calls when the person's daughter raised a concern. Another person

had time critical calls due to their diabetic medication. They told us that their calls were often late which meant that they did not receive their medicines as prescribed. We told the registered manager about this person's experience and they confirmed that calls had been late on two occasions and another call missed in the past two weeks.

The registered manager and staff told us that improvements had been made to the monitoring and management of missed and late calls for the Brighton and Hove area however the systems and processes in place to monitor and manage calls was inconsistent which meant that late and missed calls were not always picked up. Call reports were generated and were reviewed weekly by the registered manager. However, the day to day systems and processes for monitoring and managing missed were not always effective. For example on 7 July 2016 a person did not receive their usual morning call. Staff monitoring the calls did not pick up the missed call and therefore it was not managed. The registered manager did not know the call had been missed until the member of staff supporting the person on the evening call contacted them to report the missed call. A member of staff told us how they had changed the call times for the people they supported to save them travelling backwards and forwards across one area of Brighton. They said that the office did not know as they had not informed them and that no one they supported had complained that their call time had changed. This meant that the real time call monitoring system for Brighton and Hove was not effective as the member of staff told us they had been changing the times of calls for some time but this had not been picked up.

The lack of systems and processes to effectively monitor and manage missed and late calls across the service and the failure to monitor agency staff meant that the registered manager had not effectively monitored and improved the quality of the service provided , including the quality of the experience of people receiving those services. This has been identified as a continuing breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was registered manager in place who registered with us on 1 June 2016. Prior to this they were managing Mihomecare – Woodingdean to deliver services to people in the Brighton and Hove area. There was a manager in place for services provided to people in the Eastbourne and Seaford area who moved to Mihomecare – Woodingdean when the services were combined in March 2016. The registered manager had not always been clear regarding their responsibility for the service provided to people in the Eastbourne and Seaford areas which they left to be managed by the existing manager. This meant that there was a period of time where the registered manager did not have control or oversight of services delivered to people in the Eastbourne and Seaford areas. The registered manager confirmed at inspection that they are now aware of their responsibility for all activities carried out from MI Homecare – Woodingdean to people in the Brighton and Hove and Eastbourne and Seaford areas.

The registered manager was supported by a manager of the Eastbourne and Seaford area, our coordinators and three field supervisors. The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). They had submitted notifications, in a timely manner, about any events or incidents they were required by law to tell us about. They were aware of the requirements following the implementation of the Care Act 2014. For example, the Duty of Candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment provided when specific incidents occur.

Quality was not consistently or effectively assured. For example one person's records showed that an audit of medication administration records had taken place for the period May 2015 to January 2016. This meant that errors or poor practice in the administration of medicines might not be picked up until six months after the error occurred and in the case of poor practice could result in further similar errors for that person and

others for up to six months. Spot checks to monitor staff practice were undertaken by senior staff and staff and records confirmed that they were taking place. However, one person told us that they had received several spot checks when they first started but had received none this year. A senior member of staff told us that spot checks in their area were behind and a new member of staff returning to work after a long period of unemployment did not receive a spot check until 3 months after their start date. Whilst accidents and incidents were monitored and followed up there was no trend analysis to identify areas where the service could improve.

There was a service improvement plan in place with evidence of completed and ongoing actions to improve the service. The provider had oversight of this plan through regular quality and performance monitoring visits. Quality and performance monitoring visits also included a review of complaints and spot checks. However, audits and spot checks were inconsistent or ineffective in monitoring and improving the quality of the service and this has been identified as an area that requires improvement.

Staff demonstrated confidence in the management team and the registered manager. One person told us how much the service was better organised in the Brighton and Hove areas since the arrival of the registered manager. A senior member of staff in the Eastbourne and Seaford area told us that things had improved they said, "We are getting there."

Staff meetings took place monthly with separate meetings for the Brighton and Hove and the Eastbourne and Seaford staff. Coordinators and supervisors also met on a regular basis. Staff reported that communication with the registered manager and office staff was good. Memos to staff were attached to payslips with text message reminders to staff as required, for example, tips for keeping people well in hot weather. Staff said they felt supported by the management team who they described as approachable and caring. One member of staff said, "(The manager) is so supportive and approachable." Another said, "We have fantastic support at the end of the phone." Staff saw themselves as part of a team and had a good understanding of their roles and responsibilities. One member of staff told us, "We work together well." Another member of staff said, "I absolutely love my job."

The provider had a scheme to reward staff who had made an outstanding contribution. A member of staff had been nominated for a Stars Award for, 'Dealing with an emergency situation without any hesitation and in a very professional manner.' The registered manage had also introduced an incentive scheme for the Brighton and Hove area to encourage staff to log their calls. Staff received a prize for consistently logging their calls.

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 The provider had not ensured that medicines were administered as prescribed.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that staff employed were of good character and suitable to work with people.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to assess, monitor and improve the quality of services provided or to mitigate the risks relating to the health, safety and welfare of people. The provider had not ensured that feedback from people was acted upon in order to improve the service.

The enforcement action we took:

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