MiHomecare Limited

MiHomecare Brockley

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 20 and 23 October 2015 and was announced.

The service is registered to provide and personal care to people in their own homes. At the time of the inspection there were 580 people using the service ranging from people who received one visit per week to people who received visits four times a day.

The service had a registered manager in post at the time of the inspection. 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.

The service was registered in March 2015 and had not previously been inspected.

We received mixed reviews from people about the quality of care they receive from the service.

Summary of findings

Staff had sound knowledge of the people they supported and were aware of their individual needs and how to meet these. Care plans were in place yet did not always reflect people's changing needs.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and their responsibilities within the legislation. The service had policies and procedures relating to the MCA and DoLS.

People were supported to receive their medicines by trained staff. Staff administered or verbally prompted people to administer their own medicine in line with company policy and the G.P's instructions.

The service had robust systems in place to ensure that suitable staff were employed. This was ensured by carrying out the necessary safety checks prior to employment. For example, Disclosure and Barring Services (DBS) checks, which included checking whether people had a criminal record.

Staff received on-going support by regular supervisions and appraisals where their development needs were assessed and reviewed. Staff also received training in order to carry out their roles effectively.

We have made three recommendations about recording known risks, documenting accurate information, which can be found in 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?

Requires improvement

The service was not always safe. People did not always feel safe receiving care and support from the service because they did not always receive familiar staff.

People did not always receive familiar care workers to deliver their care.

Risk assessments did not always reflect people's changing needs.

People were supported to receive their medicines by trained staff. Staff administered or verbally prompted people to self-administer their medicine in line with company policy and the prescribing practitioner.

Staff were aware of the safeguarding policy and how to raise a safeguarding alert in order to protect people they support.

Is the service effective?

Requires improvement

The service was effective. Staff received training, supervision and appraisals to enable them to carry out effectively their roles and responsibilities.

Staff had sound knowledge of the MCA and DoLS legislation. This meant that people were supported against having restrictions placed on their liberty.

People were supported by staff who received regular supervisions.

People's consent was sought before care was provided.

People were supported to access sufficient amounts to eat and drink where identified in their care plan.

Is the service caring?

Requires improvement

The service was caring. Staff knew people well and had a good understanding of their needs.

Staff shared information with people in a manner they preferred and understood.

Staff understood the importance of maintaining people's confidentiality.

Is the service responsive?

Requires improvement

The service was not always responsive. Care plans were not person centred and did not always reflect people's changing needs.

We recommend that the service seek advice and guidance from a reputable source, regarding how to accurately record people's information.

People did not feel their concerns and complaints were listened to.

People were encouraged to make choices about the care they received.

Summary of findings

Is the service well-led?

The service was not always well-led. Systems and procedures in place to monitor and improve the quality and safety did not always highlight areas of concern.

The service carried out regular quality assurance procedures to obtain feedback on the service delivery.

The registered manager operated an 'open door' policy which meant people and staff could contact her at any time.

Requires improvement

MiHomecare Brockley

Detailed findings

Background to this inspection

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

The inspection took place on 20 and 23 October 2015. The inspection was carried out by three inspectors 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 provider was given 48 hours' notice because the location provides a service for people within their own home and we wanted the provider to have the opportunity to advise people who use the service. We asked the registered manager to contact people and where appropriate their relatives to see if they would speak with the expert by experience about the service they received from MiHomeCare.

Before the inspection we gathered information we held about the service and the provider. We looked at details of statutory notifications, safeguarding concerns, complaints, previous inspection reports and the registration details of the service. We also spoke with local authority commissioners.

During the inspection we spoke with ten people, eight care workers, two care co-ordinators, the registered manager and the compliance manager. We looked at 19 care records and 11 staff records, audits, policies and procedures, rotas and other documents related to the management of the service.

Requires improvement

Is the service safe?

Our findings

People did not always receive care and support from familiar and compassionate carers. We received mixed feedback regarding people feeling safe. One person's relative told us, "I do feel my [relative] is safe with her current carers. We had one carer who was a bit rough and I asked them not to send her again and they haven't." Another person told us, "They [staff] can be abrupt and they don't listen to me. They come here on their phones talking in their own language not wanting to talk or listen to you. Some have made me cry."

People were not protected against all risks as risk assessments were not accurate. Risk assessments contained detailed historical and medical information; however, we found these did not correspond with what was stated in the care plans. For example one risk assessment we looked at, stated a person was not at risk of falls, however their care plan stated they had a history of falls. This meant that we could not be certain that the care provided was appropriate, safe and based on the needs of the individual.

People were not always protected against the risk of accidents and incidents reoccurring, as they were not always consistently documented. For example, we found that care plans had been adjusted to reflect an increase in people's behaviours that others may find challenging, however risk assessments did not always reflect these changes. This meant that there was inconsistent information available to staff to safely manage people's behaviours.

We recommend that the service seek advice and guidance from a reputable source, regarding how to accurately record identified risks to people.

People were protected against known risks within their own home. The service carried out comprehensive safety checks in the environment people lived. For example we saw evidence that checks relating to equipment such as hoists and walking aids were regularly assessed to reflect any changing risks.

Contingency plans to ensure people received care during emergencies were in place but were not detailed or clear. For instance, a risk to service interruption had been identified as 'ice conditions and Christmas season' by staff, but there was no information available on what the contingency arrangements were.

People were protected against the risk of abuse. Staff were aware of the process of reporting any instances and allegations of abuse and their responsibility within the process. Staff received training on safeguarding and whistleblowing. We spoke with staff that were able to give us examples of when they had raised safeguarding concerns and action taken by management to reduce the risk to people. Staff were also able to clearly identify the different types of abuse and how this may be identified.

People were supported to receive their medicines in line with their care plan and risk assessment. Medicine risk assessments included information on the level of comprehension of the person and how staff could administer medicines safely including checking stock and recording dosage on medication administration records (MARs). Staff confirmed people received support by either verbal prompting, providing people with a glass of water or telling someone where the box of medicines is.

People were supported by staff that were suitable to work in the service. We reviewed 11 staff files and found that appropriate pre-employment checks were carried out to ensure people were safe to work in the service. We saw evidence that disclosure and barring service checks (DBS) were undertaken. A DBS check is carried out by the police to ascertain people's criminal records. Staff also had two references, photographic identification and proof of address on their files. Records relating to people's eligibility to work in the UK were continually assessed in line with good practice.

People were supported by sufficient numbers of staff. The service had robust and comprehensive systems in place to ensure adequate numbers of staff were employed to carry out the delivery of care.

Requires improvement

Is the service effective?

Our findings

People were supported by skilled and knowledgeable staff. Staff were happy with the standard, quality and frequency of training and told us they had received training in safeguarding, dementia care, MCA and the administration of medicines. We looked at staff training files and found this confirmed that staff had received on-going training. Staff told us they could request additional training if they felt this would enhance the delivery of care.

People were supported by staff that were trained in MCA and DoLS The service had policies and procedures relating to Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with had good knowledge of the MCA and DoLS, staff confirmed they received training on these areas and could access completed assessments in people's care plans for clarification and guidance. Staff were aware that people's capacity can fluctuate and the reasons for this. For example, one staff member told us, "A urinary tract infection and/ or pressure sore could have impact on people's capacity for a limited time period, in these situations I would call GP/district nurse and get further advice".

People did not always have completed capacity assessments on file. We looked at records relating to MCA and found these were not always completed correctly. Six care plans we reviewed did not evidence a best interest meeting had taken place between relevant health care professionals and a mental capacity assessor. The registered manager told us they were reviewing the assessments to ensure all were completed in line with good practice.

We recommend that the service seek advice and guidance from a reputable source, regarding how to accurately record mental capacity assessments and their outcomes.

People were supported by staff who had undertaken a comprehensive induction programme. All new staff underwent a robust induction to ensure they were adequately trained and competent to deliver care to people. The registered manager told us that the induction process was comprehensive and followed the care certificate standards. The care certificate provides care workers with introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Staff confirmed that they shadowed a more experienced member of staff when first supporting people in their own homes.

People were supported by staff who received regular guidance and support from senior staff in the form of supervisions. We looked at staff files and found that staff received regular supervisions during which they discussed a wide range of topics including, job role, areas they required additional support and areas they felt additional training would be of benefit. One care worker we spoke with told us, "When you see someone who isn't doing a good job of individual care, managers seem reluctant to deal with it so it goes unchecked."

People's views were obtained so that permission to receive care and support was given. Staff told us they tried to share information so that people were informed at all times however this could sometimes be difficult due to people's level of understanding. Staff were aware of people's preferred communication and this was well documented in their care plans. The registered manager told us, "Staff seek people's consent at each visit; [staff] ask if the person wants to receive the care and support".

People were supported to have enough to eat and drink. Staff supported people to prepare meals of their choice and in line with the care plan. Some people required direct support with eating their meals where as others require support with the preparation of food. Staff were aware of the importance of people having access to sufficient food and drink at all times.

Requires improvement

Is the service caring?

Our findings

We received mixed reviews regarding the care received. When asked if people felt they were treated with respect and compassion they told us, “Not all of them [staff] do, they can be abrupt and they don’t listen to me. They come here on their phones talking in their own language not wanting to talk or listen to you.” Another person told us, “The male staff that support me are great; they have really helped me come along”. A relative told us, “We asked for one staff to not give us care and the office made sure this didn’t happen. Another person told us, “I like my carer; they [staff] do a terrific job”.

People’s privacy and dignity was promoted and respected. One person told us, “[Staff] close the doors so no one can see when they are helping me dress”. Staff were aware of the importance of maintaining people’s dignity and privacy at all times.

People’s confidentiality was maintained. Staff were aware of the importance of maintaining people’s confidentiality and how best to ensure this was not breached. Staff told us, “We do not speak about people to others or share information with people who do not need to know”. Staff received training during their induction on the company policy on confidentiality and were aware of the impact on people if their confidentiality is breached.

People were encouraged to maintain their independence at all times. One person we spoke with told us, “[Staff] have me up and about and exercising, this isn’t something I could imagine a year ago, and I’m really pleased”. Staff were positive about supporting people’s independence and being on hand if support was required. One staff member told us, “It’s important to let people do things and we are there to help”.

Staff we spoke with were able to tell us in detail how they were able to communicate with each person by adapting the way they spoke so that each individual could understand them. For instance, one staff member told us that facial expressions are very important to a person they supported with dementia and they used these to ensure the person felt comforted during their visits. Staff were aware that people’s communication needs could change and that they would endeavour to inform the office as and when this occurred.

Staff spoke of the people they supported with kindness and compassion. Staff told us, “I’m passionate about this job; people’s lives are in our hands and we must do our very best”. The staff member went on to say they would use the service for a family member. Another staff member we spoke with told us, “It’s important to have a relationship with the people you support, knowing who they are and what they like or dislike”. This meant that people were supported by staff that had their best interests at the forefront of the care they delivered.

Requires improvement

Is the service responsive?

Our findings

People did not always have care records that reflected their current needs. We looked at 19 care records and found not all were completed accurately to record people's changing needs and how these were to be addressed. We also found that guidelines for staff did not always reflect the finding of the local authority assessments conducted as part of the service agreements.

People did not receive care that was person centred. Care plans were not person centred and were primarily task-based. For example, records showed people's preferences and wishes of how they wanted to receive care was not always clear. . Life histories or 'pen pictures' were not always completed and sections such as 'What is important to me' were completed sporadically with little information. The outcomes for what people hoped to get out of their care package were not documented. We spoke with a staff member about this, they said, "The need for promoting independence is well understood by a lot of care staff but it's very inconsistent between carers.

Care plans were not always completed accurately and legibly. We found inconsistencies in the recording of the advance directives of people, such as Do Not Resuscitate (DNAR) orders. In four care plans we saw that staff had ticked a box to state that a DNAR was in place but then commented that the person wanted to be resuscitated in the event of a cardiac arrest. This meant that it was not clear if staff understood the purpose of a DNAR or how to check if someone had an order in place.

We recommend that the service seek advice and guidance from a reputable source, regarding how to accurately record people's information.

People were encouraged to make choices about the care they received. People told us, "They [staff] ask me what it is I would like to do. They do ask me but they are aware if they don't I would tell them so". Staff had a clear understanding of the importance of giving people choices and the positive impact this can have.

People gave us mixed reviews regarding the office based staff. People told us, "It can be hard to understand what [office staff] are saying and they find it hard to understand me". Another person told us, "You can't always make sense of what is being said, they don't always get back to you". Another person told us, "The carers are doing their job but they can be interrupted by calls from the office staff up to six times per visit". This was also reported by another person we spoke with. We spoke with the registered manager who told us they would be addressing this with the office staff to ensure care workers are not interrupted during visits unless in an emergency.

People did not always feel their complaints were noted and acted upon. People told us, "When I was very unhappy with the service they did improve it but they still make aggravating mistakes but do their best to resolve issues." Another person we spoke with told us, "Nothing improves so their [management] are not learning from complaints". We spoke with the registered manager who told us as a result of this being highlighted during the inspection; they would be implementing a triage system for office staff receiving people's concerns and complaints. This would then enable office staff to ascertain if people were raising a concern or an official complaint. We looked at the complaints file and found comprehensive records detailing, the nature of the complaint, what action was taken and steps taken to minimise the risk of a repeat incident. Complaints were shared with appropriate organisations if required and documentation was consistent with the service policy.

People's cultural needs were acknowledged and taken in to account when matching staff to deliver care. We spoke with a care co-ordinator who told us, "We try to match people with staff that can meet their cultural needs". For example, one person requested a specialist Nigerian diet and the service was able to allocate a Nigerian care worker to support who was able to prepare meals in line with the person's dietary request.

Requires improvement

Is the service well-led?

Our findings

People told us they didn't always know the management structure within the service. One person told us, "Management could be better. I have had dealings with two of the managers who say they will look into things and nothing happens. You have to ring several times to get things sorted". Another person told us, "I have not had much contact with the managers but when it has been necessary they do listen to me and do what is required to resolve the issues if possible." Another person told us, "They [management] seem to be well led. I only spoke to a manager the other day when she phoned me and asked similar questions to you."

Staff gave a mixed response about the registered manager, for example, one staff member told us, "We have nothing to hide here, and the managers are very open with us about their expectations". They went on to say, "I like the ethos and culture of the company, it's very much focused on the people we look after". Whereas another staff member told us, "Working relationships and concerns are not clearly supported by managers. If a person raises even the smallest issue, disciplinary and investigations begin – this is very much a blame culture. Whereas if we raise a concern about the safety of caring for someone who is drunk or aggressive, nothing happens."

There were systems in place to check the quality of the care provided. Quality assurance questionnaires were carried out by senior staff members where they conducted monthly telephone surveys with people to ask if they were happy with their care. Senior staff also carried out 'spot checks' where they would visit unannounced at locations to ensure staff arrived at the allocated time and carried out planned care.

Audits carried out to check the quality of care visits was not always acted on in a timely manner. Care workers told us they thought spot-checks were important to ensure care was being delivered appropriately but the way the information was used was not always useful. For example, one care worker said, "It takes ages to get feedback from a spot-check because the supervisor doing it reports back to the manager then we have to come into the office weeks later to hear about it. It is not a supportive process to help us improve; they [managers] use it as a disciplinary tool. By the time they get round to telling us what the spot-check results are, its weeks later and we've forgotten." Another care worker said, "Spot-checks can highlight some really minor issues, things that are very easy to fix. But the company policy means that managers bring these up again six months later, it's totally unnecessary."

The monthly audit of the daily records of people were not all completed correctly. For example, many of the daily records we looked at were illegible due to the standard of handwriting but the monthly audits did not reflect this. We saw that N/A (not applicable) was recorded in the 'Are all entries legible?' section on a number of audits, indicating that auditors did not routinely review the legibility of entries. This meant that daily records could not be effectively used by staff to assess the care provided to people on a daily basis.

We looked at the records of five spot-checks. We found that the process used was task-based and did not always include support or direction for the member of staff where problems were found. For instance, one spot-check record indicated that the care worker had arrived late, was improperly dressed, was wearing excessive jewellery and they did not complete visit paperwork correctly. The feedback for the member of staff was confusing and unintelligible and it was not clear if the issues indicated had been addressed.

The registered manager told us that the service operates in an open and transparent manner; information was shared with external health care professionals as and when required. This was confirmed when we spoke with health care monitoring services who spoke positively about the changes being made to the service and care people are receiving. However staff told us, "There is a consistent lack of transparency from managers. I often have a new carer shadowing me but no-one bothers to ask the [people] if they mind having an extra person in their home. It really shouldn't be left up to me to organise it and often people just refuse to let the new trainees in."

This section is primarily information for the provider

Enforcement actions

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