

MiHomecare Limited

MiHomecare - Finchley

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 6 and 12 October 2016. This was an announced inspection. We gave the provider 48 hours' notice of the inspection as this is a domiciliary care agency and we wanted to ensure the manager was available in the office to meet us. This service was last inspected on 12 May 2015 where it was rated as a Good service.

MiHomecare – Finchley is a domiciliary care service run by MiHomecare Limited. The service was providing personal care to over 400 people at the time of the inspection. They support people with dementia, mental health needs, a physical disability, learning disability or autistic spectrum disorder, sensory impairment and older people in their own homes.

The service had a registered manager which 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.

Most people using the service and their relatives told us they found staff caring and friendly. They usually received the same staff which they found helpful. Commissioners and the local authority integrated care quality team provided good feedback about the service and its impact on people's quality of life. However, some people and their relatives told us they were not happy with staff's punctuality. Staff were not always attending care visits on time and staff working in pairs did not arrive at the same time raising concerns regarding safe care delivery. People did not always receive medicines on time and there were several gaps in the care delivery and medicines administration records (MAR). The service did not fully implement required infection control practices.

Staff were well-trained and able to demonstrate their understanding of the needs and preferences of the people they cared for by giving examples of how they supported people. Staff told us they were supported well. However, records of staff supervision showed not all staff were receiving regular supervision.

Care plans recorded people's individual needs, likes and dislikes. However, they did not give personalised guidance on how staff were to meet people's needs and preferences and some sections were not fully completed. Risk assessments were detailed but did not always give sufficient information on the safe management of identified risks.

Most people were happy with the support they received around nutrition and hydration needs.

The service followed appropriate safeguarding procedures and staff demonstrated a good understanding of protecting people against abuse and their role in promptly reporting poor care and abuse.

Appropriate recruitment checks of new staff took place before they worked with people. However, some

staff's criminal record checks were not up-to-date which did not ensure people's safety.

The service implemented good procedures around Mental Capacity Act 2005 but practice indicated staff did not sufficiently understand the principles to uphold the practice.

The service lacked robust systems and processes to consistently assess, monitor and improve the quality and safety of service provided. Monitoring checks did not effectively pick up on inconsistencies and gaps in the records, practices and care delivery.

The service had a robust complaints procedure but did not always follow it and did not make the complaints processes sufficiently accessible at all stages.

We found that the provider was not meeting legal requirements and there were overall six breaches of the Regulations 2014 in relation to need for consent, safe care and treatment, staff supervision, acting on complaints, safe recruitment practices, record-keeping and systems and processes to improve the quality of the services.

As a result of our findings the provider has agreed to have conditions added to their registration requiring them to carry out specific audits of the service and report back to us actions they are taking to address issues identified. We will use this to check that the required improvements are being made.

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 safe. There was mixed feedback from people and their relatives about safety. The service was not reliable as staff did not always arrive on time. We found that people were not always given medicines on time and staff were not provided with appropriate information on medicines administration.

The service had individualised risk assessments but not all were fully completed and regularly reviewed.

Staff were able to identify abuse and knew the correct procedures to follow if they suspected any abuse or neglect.

The service was not always undertaking timely recruitment checks to ensure people using services were supplied with safe and suitable staff.

There were inconsistencies in implementation of infection control practices.

Is the service effective?

Requires Improvement ●

The service was not consistently effective. People told us their health and care needs were met. Not all staff received regular supervision and appraisal.

Staff received suitable induction and additional relevant training and found it useful.

Staff understood people's right to make choices about their care. The service did not consistently follow legal requirements of the Mental Capacity Act 2005 meant people who lacked capacity to consent to the care services were not being fully supported as per their needs.

People were referred to health and social care professionals as required.

Is the service caring?

Good ●

The service was caring. People and their relatives found staff caring and attentive towards their needs. Staff were able to

describe people's needs and wishes and spoke about them in a caring manner.

People mostly received the same staff which then helped form positive and trusting relationships.

People told us they were treated with dignity and respect.

Is the service responsive?

The service was not consistently responsive. People told us their care plans were not always followed. We found some care plans were not individualised and not regularly reviewed. This did not support staff to provide person-centred care.

People and relatives' complaints were not always acted on promptly. The service did not fully follow their complaints procedure, and complaints processes were not sufficiently accessible at all stages.

Requires Improvement ●

Is the service well-led?

The service was not consistently well-led. The service did not effectively carry out audits and checks to monitor the quality of care. There were several gaps in care delivery and medicines records, care plans and risk assessments that had not been identified by audits. The service's filing system was ineffective as it was not easy for staff to locate documents promptly.

Staff told us the management team were approachable and that they felt supported. However, their concerns were not always adequately addressed.

The service worked well in partnership with the integrated care quality team to improve the quality of the service.

Requires Improvement ●

MiHomecare - Finchley

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 6 and 12 October 2016. This was an announced inspection. We gave the provider 48 hours' notice of the first day of inspection as this was a domiciliary care agency and we wanted to ensure the manager was available in the office to meet us.

The inspection was carried out by four adult social care inspectors and three experts 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. They phoned people using the service and their relatives to ask them their views on service quality.

Prior to our inspection, we reviewed information we held about the service, including previous reports and notifications sent to us at the Care Quality Commission. A notification is information about important events which the service is required to send us by law. We contacted local authority commissioners and the safeguarding team about their views of the quality of care delivered by the service.

There were 400 people receiving personal care support from the service, and 200 staff, at the time of our inspection. During our visit to the office we spoke with the registered manager, two team leaders, one care coordinator and one field supervisor. We looked at 21 care plans and eight staff personnel files including recruitment, training and supervision records, and staff rosters. We also reviewed the service's accidents / incidents and complaints records, stakeholder surveys, spot checks which are carried out by senior staff at people's home with their permission to check on the staff member without the staff member knowing in advance, and care delivery records for people using the service.

Following our inspection visit, we spoke with 22 people, five relatives and eight care staff. We arranged to visit six people at their home with their prior consent, spoke to two relatives and looked at their care plans and care delivery records. We also reviewed the documents that were provided by the registered manager

(on our request) after the inspection. These included policies and procedures, staff meeting minutes and the staff handbook. In total, we gained the views of 28 people, seven relatives, 12 staff, two commissioners, one integrated quality care team professional and one community healthcare professional.

Is the service safe?

Our findings

We received mixed feedback from people using the service and their relatives about safety. Some people told us they felt safe with staff and got on well with them. Their comments included, "Carers are very good. I feel safe, we get on very well" and "Yes, they are nice girls and they listen to me which makes me feel safe." However, some people told us staff did not always listen to them and did not support them in a safe way to meet their needs and hence, did not feel comfortable and safe with them. One person said, "Well that is the thing, I have a problem with the evening carers. They insist I make it quick and rush in and out. They treat me mostly like a vegetable." One relative told us that for their family member who needed two staff to visit together, "They never worked together." This risked the person not receiving the care they needed in a safe way, for example, not having their continence pad changed in a timely manner. Another relative said that staff were not reliable, especially over the weekends. On one weekend they found their father had not received the morning care visit and "he had not eaten or drank anything since the previous evening; he was starving."

Some people and relatives told us staff visits were not usually reliable and punctual. They had to contact the office when staff did not turn up and the office staff would then allocate another staff member, however they would not call people back to tell them which staff member was going to visit and at what time. Some people and their relatives said they found office staff communication "poor" and "frustrating." Out of eight staff we spoke with five told us their visits schedules made it difficult for them to visit people at the required time as there was not enough time allocated between some visits. One staff member said they were not always given "enough time between two visits and means I am late." Another staff member commented, "I had to advise the care coordinator to allocate another staff member who lived closer to the person than me as I lived on the other side of the borough." We viewed some staff visit records and they demonstrated lack of consideration of travel time. For example, one staff visit record we saw showed it took the staff member about 25 minutes to get from person A to person B according to the electronic visit records but they were allocated only five minutes on their schedule. We saw this was recorded on two separate occasions.

The registered manager told us that the provider had a designated team that monitored all visits to people where staff had facility to electronically scan a device on the agency's folder into their work-supplied phone. This set-up was in place for the majority of people. The checks took place live between the hours of 0700 and 2200, and so enabled any late visits to be checked on and addressed as needed. The registered manager said that a report on these checks was supplied to them every Monday. The registered manager told us that no missed visits had occurred in the last few weeks as far as they knew, however, the complaints file showed there had been one missed visit. We looked at the service's electronic visit records and found numerous occasions where staff had turned up considerably later and at times earlier than the agreed time. The records also showed three occasions when two staff were allocated to work together with the same person but the second staff member had turned up much later than the first one thereby putting the person at risk of harm. For example, we found one person's second staff member turned up late on eight occasions out of 56 care visits which meant the person did not receive agreed personal care on time and could not receive all aspects of their care safely. Another person's visit records showed, staff arriving two hours late for the morning visit than their agreed visit time and staying for only 13 minutes for a 45 minute care visit. This

meant the person did not receive their medicines at the prescribed time and could not receive all aspects of their care on time.

The registered manager told us they were shocked with the figures and would investigate the discrepancies in the care visits and inform us of their investigation outcome. The registered manager provided us with the initial investigation outcome which showed some of the missed and late visits were due to staff not using the system correctly to log-in their arrival and departure times. However, most of the late and missed visits needed further investigation.

Staff demonstrated a good understanding of people's health and care needs, and the risks and their management involved in their care delivery. The service maintained detailed risk assessments that identified risks to people and measures for their safe management. However, not all risk assessments were fully completed, for example one person's care file had blank risk assessments for personal care, pressure ulcers and meals. This person had reduced mobility and needed assistance with personal care. We found that risk assessments recognised people's individual needs and health conditions, however did not always give information on how to manage the conditions. For example, one person's care file mentioned the person had epilepsy but there was no description as to how seizures presented, therefore it was difficult to know if this was a significant risk or not. There was no separate epilepsy risk assessment although it was named as a factor in the falls risk assessment. Therefore the risk assessment did not give sufficient information to staff to safely manage identified risks. Risk assessments were for areas such as medicines, skin care, moving and handling, environment, nutrition, falls and personal care. Some aspects of risk assessments were not fully completed, such as for skin integrity assessment. Some skin integrity assessments had scores against each point however, did not always have a total score. Some assessments had total scores, but were not followed by any actions for how to reduce the risk. For example, one person's skin integrity risk assessment assessed them to be at a medium risk however, did not follow it up with any actions on how to reduce the risk especially where the person was with reduced mobility and mainly bed bound. There were no instructions to staff if they required to turn the person at regular intervals throughout the day or use of any specialist equipment such as a pressure mattress. This meant the person was not being supported safely to meet their individual health needs.

The registered manager told us that the risk assessments were reviewed every year and during the year if people's needs changed. However, we saw not all risk assessments were updated. For example, one person's risk assessments were not updated since 2014. The registered manager told us they were in middle of reviewing the current risk assessments.

The service provided gloves and aprons to their staff to enable them to safely assist people with their personal care. People and relatives told us staff always used gloves and aprons whilst supporting them with personal care. However, they said that the staff were not good at disposing of used gloves, aprons and dirty incontinence pads in a safe manner. When we visited one person, their relatives showed us the rubbish bin where the staff had disposed of gloves, aprons and dirty incontinence pads. The gloves were not rolled inside out and the dirty incontinence pads were not folded. The relatives told us they had asked staff to put them in a plastic bag before throwing them in the rubbish bin, but this was not done. Another relative told us, "One day we came in and saw faeces on the carpet and staff had left all the dirty clothes in a pile on the floor for the family to clean. When part of the care plan is to put a wash on." The relative did not make an official complaint about this incident and hence, the registered manager was not aware of this incident.

Some people and their relatives told us they did not always receive their medicines on time and sometimes not at all. For example, one person's relative commented they did not think staff consistently supported the person to take their inhaler, as there were "loads in the cupboard." When we checked the person's care plan

and medicines risk assessment in their home and their recent medicines administration record (MAR) sheet, there was no reference to the inhaler. It was occasionally recorded within care delivery records, but not consistently. There was a risk that the person was not properly supported to take this medicine. The relative further added that tablets from the weekly dosette box were not always given. When we checked the person's most recent MAR, there were numerous occasions when staff had failed to sign that they had given the prescribed medicines from the dosette box. This included nine occasions across a 67 day period when none of the four daily medicines had been signed for. We also noted that the MAR sheet did not state what the medicines were.

Another relative told us that the staff were not regularly giving their family member their prescribed medicines and at times they had visited their family member and found medicines for the previous day still in the blister pack. They also said that staff were not giving medicines as per the instructed time including the person's pain relief tablet. Therefore, the person was not receiving effective pain relief. When we checked the person's recent MAR sheets at their home, we found the staff had failed to sign that they had given the prescribed medicines from the blister pack seven times across a 62 day period. Records and feedback did not indicate that people were supported to take their medicines safely and as prescribed.

The above evidence demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection visit to the service's office, we were not able to view medicines administration record (MAR) sheets for all the people receiving support with medicines. The registered manager told us the daily care records and MAR sheets were collected on a regular basis if not monthly. However, they were not able to locate MAR sheets for the rest of the people and told us they were at people's homes. The MAR sheets that were viewed were not fully prepared and missed out on key information such as people's allergies, lists of medicines and instructions to staff on how to administer medicines. Staff were able to explain how they administered medicines. However, they told us they relied on the instructions on people's blister packs and dosette boxes as the service's records did not always list medicines and instructions on how to administer them on the MAR sheet.

We viewed eight staff personnel files and most contained an application form, interview notes, and copies of documents confirming their identity and right to work in the UK. However, not all had Disclosure and Barring Service (DBS) criminal record checks. We found two staff personnel files without an appropriate DBS check. One staff member had a DBS check which was nine years old, which had been carried out by their previous employer. When we asked the registered manager they told us they would "right away apply for a DBS check" for the second staff member. The other staff member had a protection of vulnerable adults first check (POVA) which confirmed they were not formally barred from working with vulnerable people but their DBS check was still pending and they had been supporting people on care visits. The registered manager told us, they had explained the situation to the local authority who had said they were happy for the staff member to start working. They further stated that the staff member was mainly supporting people requiring help of two staff. The provider's human resources officer had advised the registered manager to ask people using the service if they were happy to have a staff member support them without a DBS check and they had confirmed that was okay. The registered manager told us the confirmations were recorded. However, during and following the inspection, the registered manager could not provide records confirming people using the service were happy to have a staff member support them without a DBS check.

The provider's policy stated that all DBS checks should be repeated every three years. The service was not following their policy and taking reasonable steps to ensure people's safety as they were failing to carry out appropriate criminal records checks.

The above evidence demonstrates a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received training in safeguarding and were able to describe the types and signs of abuse. They were able to demonstrate their role in identifying abuse and reporting it to the relevant parties including the management. New staff received training on abuse and how to report abuse before they began working with people. Existing staff received refresher training. The registered manager told us they provided staff with safeguarding and whistleblowing policies and procedures and the contact details of the provider's whistleblowing phone line, the local safeguarding team and Care Quality Commission (CQC). However, we found the safeguarding policy did not have the contact details for the local social services safeguarding team and it was missing in staff handbook. Hence, staff were not provided with sufficient information to enable them to take prompt actions if they suspected poor care or abuse thereby not robustly protecting people from abuse.

We checked safeguarding records, they were clear and accurate. The registered manager described one of the recent safeguarding cases and the process they had followed to raise the safeguarding alert. For example, one person had contacted the office informing the staff did not return correct change. The registered manager told us they reported the incident to the police, safeguarding team and notified CQC. Following that they removed the alleged staff member from working with the person, allocated another staff member to support the person and carried out investigation by interviewing relevant parties. The allegations were unsubstantiated. In order to prevent similar incidents the registered manager sent out a memo reminding staff of their professional boundaries in relation to people's finances and of the provider's finances management policy, and the importance of reporting and recording. Since then no similar incidents have been reported.

Is the service effective?

Our findings

Most people using the service and their relatives told us they were happy with the care provided by staff. Their comments included, "They [staff] do what they are supposed to and make sure that I am looked after. They take their time with me and will sometimes go over the time but make sure they dry me properly as I can get sore", "They wash me, make the beds, they are very helpful and will always ask or offer to help. They do what they go to do" and "Yes, she always makes sure I am well and looks out for me if I am under the weather." However not everyone felt that staff met their care needs. Two people said, "Not really. I dread them coming. They do not treat me like a person at all and don't want to do anything to help me" and "No, they need to have people [staff] with competent language skills and not work them so hard that they have become lethargic due to being so tired."

The office and care staff felt well supported. Supervisions and appraisals are important tools to ensure staff have structured opportunities to discuss their work, training and development needs with their line manager. The service's supervision policy for care staff stated that staff should receive supervision every quarter as a minimum. The registered manager told us office staff received supervision twice a year. We looked at the staff supervision records, and it showed that not all staff were receiving regular supervision to enable them to do their job effectively. For example, one established staff member's last supervision was over a year ago and one new staff member's last supervision was ten months ago. We could not evidence staff appraisal records, and during and following the inspection we were not provided with staff appraisal records. Following the inspection, the registered manager told us they had allocated care coordinators to do two supervisions every day to ensure staff received regular supervision and scheduling appraisal dates.

The above evidence demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most staff we spoke with were happy with the training they received from the service and found it useful. One staff member said the training had drastically improved under the new management and it was delivered via e-learning and in a classroom type setting. New staff had to complete an e-learning induction before attending a three-day induction course. The induction included training around policies and procedures, communication, safeguarding, moving and handling, health and safety and first aid. Staff were then required to shadow existing staff members before attending care visits on their own. A new staff member told us they found the induction very good and useful. They said, "E-learning training before going on induction was very helpful and the induction was very interesting."

Staff also received additional training in medicines administration, dementia, nutrition and hydration. All staff went on mandatory refresher courses. The service had their own trainer this meant they had flexibility in how and when they delivered training sessions. We saw the staff training matrix and tracker that clearly detailed staff names, training courses staff were booked on and future training dates. The service introduced a new e-learning system that staff were encouraged to access remotely and undertake learning in their own time. The registered manager said they had computers for those staff who could not access e-learning system remotely and they also provided support to those staff who struggled using computers. Staff we

spoke to confirmed about the additional support available with the e-learning system.

People and their relatives told us staff gave them choices and asked permission before supporting them. Their comments included, "Oh yes, she always asks, never just does things", "Yes, they ask what I want for my lunch and dinner, they will heat it up for me and make me a cup of tea" and "Of course they do!"

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Staff understood people's right to make choices about their care. Staff told us they had received training on the MCA. Records showed that staff training on the MCA took place. The service had a detailed section on the MCA in people's care plans that field supervisors completed during the initial assessment. This section included information assessing people's ability to make decisions and who could make legal decisions on their behalf should they lack capacity to make a decision regarding their care. However, we noted MCA sections were not always completed and for some people were not appropriately completed. For example, out of 21 care files we looked at, 12 people's files had fully completed mental capacity assessment section this included information on people's capacity to make decisions on various aspects of their care, how to gain consent and if they had lasting power of attorney in place including financial and health and welfare. However, there was nothing in place for one person although their relative had signed their documents, their review form included staff explanation that the person "can't speak" and this person's consent section was crossed. Four people's care files did not have the lasting power of attorney sections filled out, so checks for details of a relevant lasting power of attorney that might influence the care package were bit documented.

The above demonstrates the service was not always following the legal requirements of the MCA in respect of people they were providing services to, which put people at risk of not having their legal right upheld. We found overall that the service was not working within the principles of the MCA.

The above evidence demonstrates a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service and their relatives told us their nutrition and hydration needs were met. They said staff were aware of their food preferences and supported well with their needs. Their comments included, "Yes, they make my breakfast, whatever I need, tea and cereal or toast", "Yes, my fridge has food in it which I have chosen and they will heat it up for me and make me a cup of tea" and "I am never left hungry. I always have something to eat and drink." We noted that staff were filling in a food and fluid intake chart for a person whose family wanted them to have a varied diet. We saw care plans made reference to people's food preferences and likes and dislikes. The service maintained nutritional risk assessments for people. A staff member from another agency told us of how good collaborative support had been provided to help one person with their pressure ulcer management, for which saw records confirming that this occurred.

Most of the people using the service and their relatives told us they did not require help with contacting health and care professionals. However, some people required that support and told us staff and management contacted health and care professionals as and when required. We saw records of

correspondence and referrals to various health and care professionals.

Is the service caring?

Our findings

People using the service and their relatives told us they found staff caring and friendly. People's comments included, "Wouldn't be without them [staff]. They are friendly and caring and they talk to me", "Yes, the carers are good, they talk to me and will ask if I am okay. They have a nice manner about them and are kind" and "Yes, they all are lovely ladies. We get on very well."

People told us they usually had the same staff support them, which was helpful as staff understood their needs. Their comments included, "I have known them a long time", "The carers are very kind, I have known them for ages, for the past two to three years" and "Same lady comes all the time unless on holiday." Records confirmed that people usually received the same staff member across the week and from week to week. Staff told us they visited some people regularly and that enabled them to establish and maintain positive working relationships.

The registered manager told us that they aimed to provide consistent care staff. They showed us records indicating that 89% of visits were 'templated', which means that staff were allocated to a standard roster for each person, which is automatically filled each week and hence the same staff attended each week at the same time. The 89% figure represented a strong degree of consistency, although we could see that the provider was aiming to improve on this further.

Staff told us they enjoyed their job and the relationship they had established with people they cared for. They were able to describe the individual needs, wishes and preferences of people they cared for. For example, one staff member told us, "The person I support enjoys cups of tea. I make sure he gets a fresh cup of tea every time I visit him. I support him three times a day."

The registered manager told us at the time of the initial referral the field supervisor engaged with people and their relatives to identify people's needs, wishes and preferences. This included staff gender preference for assisting with personal care. They further said the same process was followed once a year whilst reviewing people's care plans. People told us their request of gender preference was met. We saw references to gender preference made in people's care plans. One person said, "I always get a female carer, I would not want a male carer."

People and their relatives told us staff treated them with dignity and respect. Their comments included, "They respect my privacy and dignity when showering as it can be embarrassing" and "Staff are very polite and nice, treat me with dignity and respect." Relatives' comments included, "They are gentle with her and will turn her in the bed carefully and same with her wash and bath" and "I do pop in to see if mum is okay. The carers are fine and know what they are doing. They are gentle with mum and are always chatting to her, makes her feel comfortable."

Staff that we spoke with told us they respected people's privacy and provided care that maintained their dignity. They would close doors and cover people when assisting them with showering and personal care. The staff told us they talked to people politely, listened to their requests with patience and supported them

at their preferred pace.

People and their relatives said they were involved in planning and making decisions about their care and were supported to remain as independent as they could. One person said, "Staff make me coffee every morning and encourage me to make my own breakfast apart from Sundays when I ask them to make breakfast for me and they do." Another person mentioned, "I have showers three times a week. They let me do this myself."

Is the service responsive?

Our findings

We received mixed reviews regarding staff being responsive to people's needs. Some people and their relatives said that not all staff followed their care plans and assisted them in meeting their health and care needs. Their comments included, "They [staff] will always insist that what has been asked is not their job. One [staff] has refused to help with my physiotherapy using medical equipment. They said they can't do this or that. I feel bullied. It is in my care plan." One relative said that a staff member refused to shave their family member despite it being part of the care plan. They further said that the staff member did not keep them informed if supplies such as milk were running short. Instead they were contacted when things had run out, putting pressure on the relative to have to deal with the matter immediately, which was not always convenient. However some people were happy with the support they received from the staff and said "staff knew them well and supported them with their needs."

People and their relatives told us they were not happy with how complaints were managed. One relative told us they had raised concerns with the office but nothing had happened. Some people told us they had complained about staffing issues, and although they felt they were listened to, the management took too long to address their complaints. For example, one complaint was initially dealt with promptly by removing the staff member from further visits to the person using the service. However, the investigation process was then delayed. The letter asking the staff member to come into the office as part of the complaint investigation was dated 15 days later, and the meeting record was dated 29 days later. The provider's preferred target of resolving the complaint within 14 days was not achieved.

Complaint response letters gave a summary of the investigation results, and an apology where appropriate. However, they did not state how further action could be taken if the complainant was dissatisfied with the response, except to contact the agency. The provider's complaints policy stated that complaints could be escalated to the provider's head office which had a dedicated complaints department, to the industry regulator, or to the local authority ombudsman. However, information on that was not included in the response letters. The registered manager told us that this information was in the service user guide in people's homes. This was not sufficiently open and transparent to people making complaints; especially as we saw two response letters were sent to the person using the service when it was relatives who made the complaints. Additionally, we found files at three people's homes we visited had service user guide but they were two to three years old and included Care Quality Commission's old contact details which could no longer be used to contact us. The care plans also included eight to nine years old local authority complaints, compliments and monitoring leaflets that detailed old contact information. People were not supplied with the most updated contact details for external agencies they could contact to raise concerns and make complaints if they felt the need. Additionally, the provider's website did not give information on how to make complaints and how the complaints process worked. These matters failed to demonstrate that the provider's complaints system was accessible.

We noted that there was a good-practice record of contacting complainants once complaints were investigated, to check if they were happy with how matters were resolved. These forms also audited whether or not complaints had been resolved within 14 days the provider's preferred target within their complaints

policy, and a prompt to explain if the target had not been met. However, we saw an instance where this was ticked off as achieved when it had not been. In two recent cases, the responses took 21 and 23 days. There was a ten-day gap between acknowledging these two complaints and sending involved staff a letter inviting them into the office for investigation, despite the acknowledgement letter identifying concerns with the practice of the staff members.

The complaints file showed six cases of missed visits across the previous month, within a total of 11 complaints in 2016. The registered manager and office staff explained that this related to errors from the funding authority in allocating the visits on electronic records, and due to staff relying on rosters on their phones and not checking with the office when unexpected gaps occurred despite being told of allocated visits. We saw communications with the funding authority confirming this.

However, whilst this occurred across one weekend, we found that two more people in similar circumstances experienced missed visits at later dates. This did not demonstrate that sufficient learning had promptly taken place to minimise the risk of reoccurrence of the missed visits.

The above evidence demonstrates a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We viewed people's care plans and although the format was detailed, not all the sections of the care plans were consistently completed. Some care plans were task oriented with emphasis on the tasks that staff were expected to perform rather than being personalised. Not all care plans had a document titled 'person-centre support plan' but other care plans did not. We found some care plans had individualised information for example, one care plan at a person's home we visited informed staff to leave the person with access to a drink and the television remote control. Another care plan stipulated exactly what breakfast the person wanted. However, some care plans lacked basic personal information. For example; one care plan under the person's background and history section stated 'not applicable', but included information under person's medical history. Another care plan had no information under "what is not working well, what is important to me and my cultural and identity needs". We found nine out of 21 care plans did not state the care visit times, making it difficult for people to know when to expect staff visits. Staff told us they read people's care plans before they started supporting people, however, some staff said the care plans "could include more information" about the people they were supporting.

The registered manager told us the care plans were reviewed once a year and when people's needs changed. However, not all care plans that we viewed had been reviewed. One care plan at a person's home we visited was from 2014 although the person had received a care review visit from the field supervisor in 2016. Another person's care plan had not been reviewed since 2014 despite the electronic system we looked stated planning for a review three months later. We received mixed feedback on care reviews from people and their relatives; most people barring two told us their care plans were reviewed every year.

The registered manager told us they were going to review all the care plans and update them to make them more person-centred. They also said that all the care plans once reviewed would be approved and signed off by them to ensure they were completed as per the service's standards and requirements.

Staff were able to describe people's cultural and religious needs and how they supported them with those needs. For example, a staff member said one person they supported followed Hindu religion and this meant they had to ensure they did not consume beef or any beef by-product when they went out for meals. One person told us the staff member cooked the person's traditional food to the best of their ability and followed their instructions. The service tried to match staff to meet the needs of people from the same cultural backgrounds and preferred languages.

Is the service well-led?

Our findings

The service had a registered manager in post. The registered manager was managing another location for the provider, and when that service got amalgamated with this one, the registered manager took over managing this service. Not all the people and their relatives we spoke to were aware of the new registered manager. People who were aware that the service had a new registered manager spoke positively about them. They said the registered manager was "approachable and available." We received positive feedback from two local authorities' contract monitoring teams stating they were happy with the service's overall performance and that the registered manager had brought about improvements in the service.

The registered manager and office staff were not always able to find records and documents about people using the service easily. At the time of inspection, when we asked to see the file of one person who had started using the service seven days before our visit, it could not be found. Office staff later told us it was not yet set up, and supplied it to us later that morning. Another office staff member told us that maintaining office files was "an issue." We asked to see another person's care file but it could not be found. Following the inspection we were informed that the file was filed in a different filing cabinet. During the inspection, we asked the office staff to locate daily care records for one person as the last records they had in their file were for August 2015. We were told they could not find them and "did not know where they were." We were not assured that records about people using the service were kept in full and securely stored, which undermined good governance of the service.

At the time of inspection and following inspection, we looked at people's care plans, risk assessments, care delivery records and medicines administration (MAR) charts. We found several gaps in all those documents. The new care delivery record book had an audit sheet at the back of it to make it easier for the field supervisors to complete it when conducting an audit. However, care delivery records' audit sheets at four people's homes were neither completed nor signed by the field supervisor. There were several gaps in people's MAR charts and they did not give instructions on how to administer the medicines. The service had not picked up on the inconsistent recording of care delivery in people's homes and errors in MAR charts. This meant that care delivery risks were not being identified and addressed.

The provider's quality assurance policy stated, under their record keeping audits section, that monthly record-keeping audits should be carried out on 'daily record sheets, MAR charts, financial transactions and specialist record sheets.' The policy further stated that the areas of non-compliance would be noted and corrective action would be put in place to address areas identified. This could include retraining of staff, increased monitoring and/or a review of the service user's support plan and risk assessment. This meant the service was not adhering to the provider's quality assurance policy and was putting people using the service at a risk of harm by not monitoring the record keeping of care delivery.

The service was regularly visited by a quality and performance manager from the provider's head office who carried out audits across various aspects of the service delivery and created an improvement plan based on the audit. We looked at the last audit report; it included areas needing improvement and an improvement plan. However, there were several action points that had gone past their deadline. Despite our requests, we

were not given an update on the action points that were to be achieved off the improvement plan. This did not assure us that the audit had been effectively acted on, to bring about service improvement.

The service maintained various quality monitoring forms including quality monitoring visits, outcome monitoring, quality monitoring telephone calls and customer review forms. The provider's quality assurance policy stated that people using the service or their nominated representative would receive quarterly telephone calls to assess the quality of the service they were receiving. The registered manager confirmed that the office staff called people once every three months to seek their feedback. However, out of 21 care files that we checked, only three had completed quality monitoring telephone records while only seven had completed quality monitoring visit forms. Two care plans had completed customer review forms and one care plan had an outcome monitoring form. Additionally, people we spoke with told us they had not received telephone calls from the office staff. The service was not undertaking quality checks with people using the service at the frequency stipulated by the provider. This did not demonstrate effective governance.

The registered manager told us there was a policy of spot-checking each staff member's practice at someone's home every three months. However, out of eight staff files that were seen five did not have any records of spot checks.

Overall there was a lack of robust and efficient data management systems and processes to assess, monitor and improve the quality and safety of the care service delivery. If governance had taken place as per the provider's policy, the concerns that we have highlighted in this report may have been identified and addressed. As such, the provider's quality assurance policy was not being effectively followed.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's head office sent out survey questionnaires every August for the following year. However, last year's response rate was very low as the survey form was lengthy. We looked at the results and analysis from 2015's survey. It showed that only 54% people felt supported by the office staff, 71% people felt the service they received had positive impact on their physical and emotional well-being and 80% people felt staff were friendly, caring and that the care was delivered as agreed. However, during and following the inspection we were not provided with an improvement action plan based on the results of the survey.

Most people using the service and their relatives told us they were happy with the staff and the service. Their comments included, "I am happy with MiHomecare, very satisfied with the agency. The carers are lovely, they take their time with me", "It is a very, very good service overall, the agency do what they are supposed to. They watch over me like a mother would" and "They are very good, they do what needs to be done, and apart from the minor issues there are not problems. I would recommend them." However, some people said the service needed to improve and some mentioned "office staff were not always helpful".

Most people using the service and their relatives told us they felt comfortable calling the office to raise concerns. They felt their messages and calls were mostly returned on time. One person told us, "Yes, I have the contact numbers for the office. They are easy to get hold of." Another person said, "I would contact the agency, I have their numbers."

The registered manager explained they were working at improving the services and although mistakes did occur but that it was important to learn from them to prevent reoccurrence. They said that staff could come to meet them without an appointment, and that it was important to respect everyone involved in the service so as to produce a more open and responsive culture.

Most staff told us they felt well supported by the management and they felt comfortable in visiting the office unannounced. Staff's comments included, "The new management is better than before, the registered manager is respectful and I find it easier to talk to her", "Feels now there is a captain at the helm", and "So supportive, it is a really stressful environment. I can say I haven't stopped all day and need 10 minutes out. She will come and cover my phone or help me with my calls."

Staff told us they were comfortable raising their concerns and making suggestions. However, things did not always change. For example, some staff told us they had raised concerns regarding inefficient allocation of staff to care visits but nothing had changed. We spoke to the registered manager about this and they told us they were not aware of these concerns. They said these matters would be raised in the office team meeting they had arranged to address various issues related to care delivery.

The registered manager told us they aimed to have monthly team meetings for field supervisors and care coordinators however, due to work pressure they had not achieved this. There were also weekly informal office team meetings on Friday afternoons which she said were proving to be useful. One staff member mentioned that as the office environment was very busy they met as a group for a quick discussion if there was an issue and sometimes there were one to one catch-ups at staff's desks. We saw the staff meeting minutes for care staff and office staff that recorded discussions around training, risk assessments, care plans, staffing issues and complaints.

The registered manager said they worked with the local authority integrated quality care team to improve the quality of their services. The liaison person from this team told us the registered manager worked closely with them and had made improvements to the service in a short period of time.

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	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>The registered persons failed to ensure consent procedures were followed where people were unable to give such consent because they lacked capacity to do so, in accordance with The Mental Capacity Act 2005.</p> <p>Regulation 11(1)(3)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Care of people was not provided in a consistently safe way. This included failure to: assess the risks to the health and safety of service users of receiving care; doing all that is reasonably practicable to mitigate any such risks; ensuring the proper and safe management of medicines; assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.</p> <p>Regulation 12(1)(2)(a)(b)(g)(h)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints</p> <p>The registered persons did not fully investigate and undertake necessary and proportionate action in response to any failure identified by the complaint or investigation. The registered person failed to establish and operate</p>

effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.
Regulation 16(1)(2)

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered persons failed to effectively operate systems to: assess, monitor and improve the quality and safety of the services provided; assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others; accurately and completely maintain records in respect of each service user. Regulation 17(1)(2)(a)(b)(c)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>The registered persons failed to ensure that the following were available before employing anyone to provide care:</p> <ul style="list-style-type: none"> • <input type="checkbox"/> An appropriate criminal record certificate <p>Regulation 19(1)(a)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The registered persons failed to provide appropriate supervision and appraisal as is necessary to enable staff to carry out the duties they are employed to perform. Regulation 18(2)(a)</p>