# Inspection Report

***We are the regulator:*** *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

# MiHomecare Bristol

45 Northumbria Drive, Bristol, BS9 4HN

Tel: 01179898520

Date of Inspections: 15 September 2014
10 September 2014

Date of Publication: October 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

| | |
|---|---|
| **Care and welfare of people who use services** | ✖ Action needed |
| **Staffing** | ✖ Action needed |
| **Notification of other incidents** | ✖ Action needed |

## Details about this location

| | |
|---|---|
| Registered Provider | MiHomecare Limited |
| Overview of the service | MiHomecare Bristol is regulated to provide personal care in people's homes. It provides services to people who live in Bristol, South Gloucestershire and North Somerset. |
| Type of services | Domiciliary care service<br>Supported living service |
| Regulated activity | Personal care |

# Contents

*When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.*

## Summary of this inspection

### Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an announced inspection.

### How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 10 September 2014 and 15 September 2014, talked with people who use the service and talked with carers and / or family members. We talked with staff and reviewed information given to us by the provider.

### What people told us and what we found

Prior to this inspection we had received information of concern on Monday 8 September 2014, stating that the service currently had insufficient staffing levels to meet the needs of the people who used the service. We had also received information of concern that care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare. We undertook a responsive inspection of the service on Wednesday 10 September 2014. The service does not currently have a registered manager and recruitment is being undertaken for this.

During the inspection we spoke with the regional director responsible for the service and the provider had appointed a project manager to oversee the operation of the service in the absence of a registered manager. During the inspection, the regional director told us that as a result of current staffing issues, the service had voluntarily placed a stop on undertaking new care packages or significantly increasing existing care packages. This has been done to ensure that a safe and manageable delivery of current care packages was achieved. The regional director also sent us formal correspondence that confirmed this following the inspection.

Is the service safe?

Some aspects of the service were not safe and these had not been identified or addressed by the provider.

The planning and delivery of care was not always safe. People and their relatives told us that on occasions, care appointments at their home had been cancelled at very short notice and that staff were sometimes late.

The service had missed visits to people's homes through the absence of robust systems and poor staff practice. The missed visits had resulted in people not receiving the care they needed, for example being prompted to take their prescribed medicines.

The provider had not ensured there was always a safe level of suitably trained and skilled

staff on duty to meet people's care needs.  As a result, appointments had been missed, cancelled or attended late.

We have asked the provider to tell us what they are going to do to meet the requirements of the law and the improvements they intend to make in relation to the planning and delivery of care and ensuring the service has the correct number of staff to provide safe care.

Is the service caring?

Some aspects of the service did not demonstrate the provider had ensured the highest level of care possible had been delivered to people.

People who used the service and their relatives told us the staff that provided the care to them in their homes delivered good quality care. One person told us, "They (the staff) are very good, I can't fault them."  Another person we spoke with described the care staff as "kind and polite" and one person told us the staff were "lovely" and spoke highly of the care they received.

Examples of where people had not received the support they needed were identified.  We found that people had missed medicines due to staff not attending their homes to meet their needs.  Other people had cancelled appointments as the service had failed to provide their agreed care on time and some people had called the service concerned at the amount of different staff they received care from.

Staff we spoke with told us that due to the current demands placed on them, agreed appointment times had sometimes been shortened to ensure all appointments could be made.  Staff told us they currently have very little opportunity to spend time with people and speak with them, and others told us they were currently very rushed when providing care.

We have asked the provider to tell us what they are going to do to meet the requirements of the law and the improvements they intend to make in relation to improving the continuity of care provided.

Is the service well led?

Some aspects of the service were not well led as action had not been taken to rectify shortfalls.

Systems available within the service to monitor the delivery of care were not being used effectively.

Where staff failings in relation to attendances at care appointments had been identified, no action had been taken to address this to assist in the monitoring of care delivery.

Where the provider had a legal requirement to notify the Care Quality Commission of a specific incident, they had failed to do this.

We have asked the provider to tell us what they are going to do to meet the requirements of the law and the improvements they intend to make in relation to monitoring staff delivery of care and notifications.

You can see our judgements on the front page of this report.

## What we have told the provider to do

We have asked the provider to send us a report by 22 October 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

## More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

## Our judgements for each standard inspected

**Care and welfare of people who use services** ✖ Action needed

**People should get safe and appropriate care that meets their needs and supports their rights**

### Our judgement

The provider was not meeting this standard.

People did not always experience care, treatment and support that met their needs. The service did not always plan the delivery of care to meet people's needs and ensure their welfare and safety. People had experienced some missed and late appointments.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

### Reasons for our judgement

Prior to this inspection we had received information of concern that care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

We spoke with 13 people who used the service, one person's relative and 11 members of staff. People who used the service told us about the level of care they received and the number of visits they received during the week. We spoke with them about the planning and delivery of care they received from the service and the quality of the care delivered by the staff. The staff we spoke with told us about their experiences of the planning and management of the care appointments from the service.

People spoke positively about the staff employed at the service and the quality of care they received. One person told us, "They (the staff) are very good, I can't fault them." Another person we spoke with described the care staff as "kind and polite" and one person told us the staff were "lovely" and spoke highly of the care they received.

People's care records contained appropriate information for staff to meet people's needs and had been reviewed to establish if their level of care had changed. We looked at seven people's care records. The care records contained a person centred support plan that showed people's needs and the preferred routines staff should follow when providing care in the person's home. For example, people's needs for mobility were recorded, and if staff were required to hoist the person the required equipment was listed within the records.

People's individual medical conditions were recorded, for example if the person was diabetic and required a low sugar diet. Guidance for staff on how to assist people with

their medicines was recorded. For example, one record we looked at showed the person preferred staff to give them their medicine with a teaspoon, and that they preferred to hold a cup of water whilst the staff placed a straw in the person's mouth to assist them in swallowing their medicines.

The service did not have robust risk management systems in place to monitor the planning and delivery of care and ensure people's needs were met. The service used an electronic monitoring system that recorded the planned and completed appointments within the service. This system also recorded the number of appointments cancelled at the service. We requested a formal submission from the service for the number of appointments cancelled by the service due insufficient staffing levels. The submission told us that during the period we requested from Friday 15 August 2014 to Monday 8 September 2014, a total of 661 care appointments had been cancelled from the scheduled 5,371 over that same period.

The senior member of staff at the service who supplied the information told us the electronic recording system had not been used correctly during this period and no further explanation of the cancellation was recorded. For example, the cancelled appointment did not show if the service had cancelled the appointment due to insufficient staff, or the person themselves had cancelled the appointment due to holiday or a hospital admission. Some people we spoke with told us that they had cancelled appointments themselves due to the excessive lateness of the appointments. This meant the service had no effective risk management or monitoring system that ensured care was delivered timely and safely.

Staff attendance at appointments was not monitored effectively within the service. The services electronic care monitoring system had a feature programmed built into it to monitor the care delivery by the staff employed by the service. When staff attended a person's home to complete the care appointment, they were required to call a designated number to 'log in' on the electronic system which recorded their time of arrival and advised the care co-ordination staff they had arrived. Should the staff member have failed to call the designated number, an automatic message would be sent via text message to the 'on-call' member of staff to advise them the staff member had not logged in. This essentially advised this 'on-call' staff member that the person's care appointment had not been completed. We spoke with the senior member of staff at the service who told us that staff did not always log in as required and they told us they were aware of this situation. However, despite demonstrating awareness of this, there was no evidence that staff had been spoken with to address this. This meant the service had no way to monitor the delivery of care accurately and ensure people's appointments were completed.

The absence of care delivery monitoring had not ensured all care appointments had been completed. The most senior member of staff at the service told us that during the requested period of Friday 15 August 2014 to Monday 8 September 2014, a total of 3 care appointments had been missed by the service. During our inspection it was established that these missed calls were as a result of a staff member failing to arrive for work on the specific days. The absence of systems to ensure staff had commenced work had failed to identify the staff member had not commenced work. A missed appointment meant the service had not attended the person's home to provide care as arranged or required. This meant that people had not received care in line with their assessed and agreed needs.

The service had failed to ensure a person's medical needs were met as a result of missed calls. For example, we looked at the care records for one person whose care appointment had been missed by the service during the specified period. The care package showed

the person received three visits a day from the service and showed what level of assistance the person required. The care record showed the person's age and highlighted that due to their dementia they could get very confused. The person's care record stated that staff should always ensure the person takes their medicines. We looked at the person's current prescribed medicines which showed that as a result of the missed appointment by the service, the person did not receive two different prescribed medicines for their dementia and their hypertension. This meant the service had failed to meet the individual care needs of this person.

People told us appointments were routinely late and we heard examples of poor planning. Of the 13 people and one person's relative we spoke with, most told us they had experienced late appointments or appointment errors that had resulted from poor communication between staff at the service. For example, one person told us that when their regular carer went on holiday, the service had failed to provide timely care that met their needs. They told us that the staff covering their appointments had failed to arrive at the required time so they cancelled their appointment in order to get to work on time. However, despite them calling the service to cancel the appointment, a member of staff still arrived at their house shortly after they cancelled the call.

Another person gave an example of late calls having an impact on their care. They told us the staff from the service assisted in their catheter care in addition to the district nursing team who also visited daily to attend to their catheter. They told us that at times the service had been late which meant the district nursing team were unable to provide the specific care they attended for. The person told us they had contacted the service about this and were told the service had the wrong visit time recorded. One person also told how they rang the service following their morning appointment being one hour late. They told us the service informed them that the carer was on their way immediately. However, the person said they had to phone back over four hours later as staff had not arrived.

Staff told us the current care co-ordination did not ensure people's needs were always met timely and they told us of co-ordination errors that had occurred. We spoke with 11 staff, most of which told us that current standard of care co-ordination was, at times, problematic and unachievable. Most staff told us that the co-ordinating staff allowed approximately five minutes travel time between appointments and that this did not take into account the time of day or the distance staff needed to travel. They told us this very often resulted in appointments being late and had, on occasions, resulted in the person cancelling their appointment due to the lateness the appointment was running.

Staff also told us of occasions where poor planning had resulted in staffing errors. For example, one member of staff told us they had arrived at a care appointment only to find a member of staff already at the person's home. Another staff member told us of an occasion where they had attended a person's property who required two staff to assist with mobility. They told us the care co-ordinators had failed to arrange for a second staff member and they had to wait a considerable period of time until they could complete the care. This subsequently resulted in all future appointments running significantly late for the rest of their shift.

**Staffing** ✖ Action needed

**There should be enough members of staff to keep people safe and meet their health and welfare needs**

## Our judgement

The provider was not meeting this standard.

There were not always enough qualified, skilled and experienced staff to meet people's needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

## Reasons for our judgement

Prior to this inspection we had received information of concern that there were not always enough qualified, skilled and experienced staff to meet people's needs.

We spoke with the regional director and the senior member of staff employed at the branch who was currently responsible for the day to day care delivery. They told us they had recently experienced an unforeseen shortage of staff and that a recruitment process was being undertaken. They explained that this, together with frequent short notice of staff sickness had presented a recent challenge and had resulted in a direct impact on the timeliness of the care people received.

We asked the senior member of staff responsible to supply us with current information relating to staffing. This information showed that in the six months previous to our inspection, 19 staff had left the service, and this included the person managing the service. The information showed that out of the 19 staff no longer employed at the service, 17 staff had resigned and two had been dismissed from employment. The information supplied from the service projected that the current staff vacancies were the branch manager, one care co-ordinator, three field care supervisors and six full time care staff. The regional director told us that in the interim, additional office based and care staff from the provider's other services were being used as a contingency.

Insufficient staffing levels did not ensure continuity of care. We spoke with 13 people who used the service and one person's relative. We received mixed feedback from people about the staff who provided their care. Some people told us that they received the same regular staff, however others told us they were not always aware of who would be providing their care. For example, some people we spoke with told us that when the received their weekly care planning rota to show when their appointments were, the rota did not provide them with the staff members names and only showed the word 'relief'. This meant they were not aware of who would be providing their care until the staff member arrived.

One person's relative told us that recently staff had arrived who they had never seen before, and that the staff member was not aware of their relatives needs and it took a significant amount of time to explain this. Another person said they had received care from 'lots' of different staff and two other people told us they had called the service to express their concern about the number of different staff they received care from. This meant that people who used the service may receive care in their home, including personal care such as washing and dressing, from staff members they had never met before that day.

Staff told us that although people's care needs were met, they were not always able to stay the correct length of time with people. We spoke with 11 members of staff regarding staffing levels at the service and the impact current staffing levels had on people's care. They all told us that although the service was currently understaffed they were able to meet people's needs, however care appointments were often cut short to achieve this. For example, one member of staff told us that they frequently reduced appointments to ensure they could attend all of their appointments. One member of staff told us, "There is no time to chat to people anymore. I just rush the care and go." Another staff member told us, "It's horrendous, we are expected to do everything fast."

Staff also told us that additional short notice appointments were given to them whilst they were on duty. Some staff we spoke with told us that despite having a set appointment schedule, they would often be called by the care co-ordinators to be informed that additional appointments had been added to their round at short notice due to staff shortage or sickness. They said that due to the care co-ordinators absence of knowledge about people's care needs, some complex appointments were booked at short notice and this then created a chain of events that lead to all subsequent appointments running significantly late.

**Notification of other incidents** ✖ Action needed

**The service must tell us about important events that affect people's wellbeing, health and safety**

## Our judgement

The provider was not meeting this standard.

The provider had failed to notify the Care Quality Commission (CQC) of a specific incident as required.

We have told the provider to take action. Please see the 'Action' section within this report.

## Reasons for our judgement

During our inspection it was established the provider had failed to notify the Care Quality Commission of a specific incident as required.

It was established that over the period of 6 and 7 September 2014, the service had cancelled and missed care appointments due to an insufficient number of suitably qualified, skilled and experienced staff being available to meet the needs of the people who used the service. The service had a legal duty to report this and had failed to do so.

**This section is primarily information for the provider**

## Action we have told the provider to take

### Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

| Regulated activity | Regulation |
|---|---|
| Personal care | **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Care and welfare of people who use services** |
| | **How the regulation was not being met:**<br><br>The planning and delivery of care from the service does not always make certain that a person's individual needs are met timely to ensure their safety and wellbeing. Regulations 9(1)(b)(i) and 9(1)(b)(ii) |
| Regulated activity | Regulation |
| Personal care | **Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Staffing** |
| | **How the regulation was not being met:**<br><br>There were not always a sufficient number of suitably qualified, skilled and experienced people on duty to safeguard the health, safety and welfare of people. Regulation 22. |
| Regulated activity | Regulation |
| Personal care | **Regulation 18 CQC (Registration) Regulations 2009**<br><br>**Notification of other incidents** |
| | **How the regulation was not being met:** |

**This section is primarily information for the provider**

| | |
|---|---|
| | The service had not notified the Commission of a specific incident as required. Regulation 18(2)(g)(i) |

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 22 October 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

## About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

## How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

| | |
|---|---|
| ✓ **Met this standard** | This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made. |
| ✖ **Action needed** | This means that the standard was not being met in that the provider was non-compliant with the regulation.<br>We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard.<br>We monitor the implementation of action plans in these reports and, if necessary, take further action.<br>We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete. |
| ✖ **Enforcement action taken** | If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people. |

## How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact -** people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact -** people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact -** people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

## Glossary of terms we use in this report

### Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

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|---|
| Respecting and involving people who use services - Outcome 1 (Regulation 17) |
| Consent to care and treatment - Outcome 2 (Regulation 18) |
| Care and welfare of people who use services - Outcome 4 (Regulation 9) |
| Meeting Nutritional Needs - Outcome 5 (Regulation 14) |
| Cooperating with other providers - Outcome 6 (Regulation 24) |
| Safeguarding people who use services from abuse - Outcome 7 (Regulation 11) |
| Cleanliness and infection control - Outcome 8 (Regulation 12) |
| Management of medicines - Outcome 9 (Regulation 13) |
| Safety and suitability of premises - Outcome 10 (Regulation 15) |
| Safety, availability and suitability of equipment - Outcome 11 (Regulation 16) |
| Requirements relating to workers - Outcome 12 (Regulation 21) |
| Staffing - Outcome 13 (Regulation 22) |
| Supporting Staff - Outcome 14 (Regulation 23) |
| Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10) |
| Complaints - Outcome 17 (Regulation 19) |
| Records - Outcome 21 (Regulation 20) |

### Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

## Glossary of terms we use in this report (continued)

**(Registered) Provider**

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

**Regulations**

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

**Responsive inspection**

This is carried out at any time in relation to identified concerns.

**Routine inspection**

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

**Themed inspection**

This is targeted to look at specific standards, sectors or types of care.

## Contact us

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