MiHomecare Limited

MiHomecare - Bristol

Inspection report

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Ratings

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

Overall summary

We undertook an announced inspection of MiHomecare - Bristol on Tuesday 10 March 2015. We told the provider on Friday 7 March 2015 that we would be coming to make sure that staff would be available in the office. When MiHomecare - Bristol was last inspected in September 2014 we found breaches of the legal requirements. The planning and delivery of care did not always ensure people's needs were met and the provider did not have sufficient staff on duty to meet the needs of people who used the service. In addition, the provider had failed to notify the Commission of a significant event within the service as required by law. At this inspection we found that actions to improve the service had not been completed.

MiHomecare - Bristol provides personal care and support to people in their own home within the Bristol and Weston-Super-Mare areas. At the time of our inspection the service provided personal care to 142 people.

A registered manager was not in post at the time of 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

Summary of findings

service is run. The provider had appointed a manager at the service who had been in post since December 2014. This manager was currently completing the application process to register as a manager with us.

People and their relatives did not feel completely safe with the care provided by the service. People spoke highly of the staff and their caring nature, however some people could not always rely on the service to deliver care at the time they needed it.

Staffing levels were insufficient at the service and people and their relatives gave examples of when calls were missed or late and how it impacted on their daily lives. The manager explained the service was currently recruiting and that new staff were completing an induction process.

When a risk to people was identified, the provider had not completed risk management guidance and some records were not stored correctly.

People were not fully protected from the risks associated with medicines as the provider did not have a system to monitor the administration and recording of medicines by staff. People's medicines records had not always been completed accurately.

There were no effective systems in place to obtain the views of people who used the service and people did not feel the service had an effective complaints process.

People spoke highly of the staff at the service and told us they were treated with dignity. We received mixed comments about the communication people received from the service to keep them informed about information relating to their care.

Where required, people were supported to eat and drink sufficient amounts. We did receive a negative comment from a person who required their meal at a specific time for medical purposes who said their needs had not always been met.

People received care in line with their wishes and preferences and staff ensured their needs were met before leaving.

The provider had a safeguarding adult's policy for staff that gave guidance on the identification and reporting of suspected abuse.

People spoke positively about the staff who provided their care, however negative comments were received about the level of experience of some staff. Staff received regular training and supervision from the provider.

Staff understood their obligations under the Mental Capacity Act 2005 and how it had an impact on their work.

People could see healthcare professionals when required and the service had made appropriate referrals when a concern had been identified.

We found multiple beaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which now correspond to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?

Inadequate

The service was not safe. Some people felt unsafe as they were not confident their assessed care needs would be met.

Staff were aware of how to identify and report suspected abuse.

There were not sufficient numbers of staff to meet people's care needs and provide continuity in their care.

People were not fully protected from the risks associated with medicines.

People's records were not always stored correctly.

Is the service effective?

Requires improvement

The service was not fully effective. People received care from staff that were appropriately trained however not experienced.

Staff knew their responsibilities under the Mental Capacity Act 2005.

Most people were supported to have sufficient to eat and drink, however a negative comment about nutritional support in line with medication needs was received.

Is the service caring?

Requires improvement

The service was not always caring. People spoke highly of the staff who provided their care.

People felt the staff treated them with dignity and respected their privacy.

People did not always feel they received sufficient communication about matters relating to their care.

Is the service responsive?

Requires improvement

The service was not always responsive. People felt that staff understood their needs.

People were involved in their care, however there was no evidence that reviews with people about their care had been completed.

People felt that complaints at the service were not listened to or acted upon.

Is the service well-led?

Inadequate

The service was not always well-led. People were not aware a new manager was in post.

There were no quality assurance systems in place to monitor people's welfare or records held by the service.

The manager had implemented the monitoring of care appointments.

MiHomecare - Bristol

Detailed findings

Background to this inspection

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

This inspection was carried out by two inspectors and an expert-by-experience who had experience of domiciliary care services. The expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

When MiHomecare - Bristol was last inspected in September 2014 we found breaches of the legal requirements. The planning and delivery of care did not always ensure people's needs were met and the provider did not have sufficient staff to meet the needs of people who used the service. In addition, the provider had failed to notify the Commission of a significant event within the service as required by law. The provider wrote to us in October 2014 to tell us how they would achieve compliance with the regulations. During this inspection, we found that although some improvements had been made, the service was still not meeting all of the legal requirements.

Before the inspection we reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

On the day of the inspection we spoke with 15 people who received care from MiHomecare and six people's relatives. We also spoke with five members of staff which included the person currently employed as the manager and a healthcare professional. We reviewed nine people's care and support records.

We looked at records relating to the management of the service such as policies, incident and accident records, staff recruitment and training records, meeting minutes and audit reports.

Inadequate

Is the service safe?

Our findings

People felt safe in the company of the staff at the service, however they did not always feel safe or confident that their care would arrive on time and that their needs would be met. One person commented to us, "The staff are very, very good. I think it's perhaps the organisation that's not so good." A person who provided support to someone who used the service told us, "They [staff] can be up to 30 minutes late and [service user name] gets anxious. It does seem to have improved since Christmas though."

Identified risks to people did not demonstrate the service had planned care delivery to manage these risks effectively. This meant that people may receive inappropriate or unsafe care. Where the service had completed an assessment and it was identified there was a risk or staff intervention was required, a support plan had not been created. For example, one person's had a pre-existing medical condition. Although it was highlighted the person had this condition, there was no documented support and guidance for staff on how to assist the person in managing their condition or associated risks. Another person's record showed that the person used a hoist and wheelchair within their home. There was no guidance for staff on how to support this person using the equipment to ensure they were supported safely and in accordance with their wishes.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not always support people safely by having sufficient staff to meet people's needs. People and their relatives commented that the service were late for appointments, how appointments had been missed and that they did not receive the same regular staff. Although some people told us there had been improvements since Christmas, we were told that the service did not always meet people's assessed needs on time. We spoke with the manager who told us that a number of staff had been recruited and were currently going through their induction. The service still used agency staff, however the use of agency staff had been reduced dramatically since Christmas. The manager explained that although the service had been recruiting, there was still the equivalent of 16 full time posts vacant. This meant the service were unable to consistently meet people's assessed care needs.

People's and their relatives gave examples or when missed or late visits from the service had directly impacted on their lives. One person informed us, "We have only had care coming in since January. It was all very disorganised at first we were getting lots of different people. It is settling down a bit now, except for the evening visit that can be very unreliable." Another person explained how they were currently looking for a new care provider as the service sent "random" people to provide their care, meaning that different staff who didn't know the person would arrive unannounced. They told us that although things had improved since January, they felt they had been, "Frequently let down."

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not fully protected from the risks associated with medicines. People we spoke with told us they mainly received their medicines when they needed them. However, the management and recording of medicines had not identified errors within medicines records we identified during our inspection. We spoke with the manager about the current system in operation to monitor staff competence in the administration and recording of medicines. The manager told us that the service did not currently have any system in operation to monitor this. This meant that the service did not have a system to fully protect people from the risks associated with the recording and administration of medicines.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records relating to people's medicines were not accurate. We looked at the Medicine Administration Records (MAR) for two people. These records were inaccurate and showed numerous omissions through inconsistent recording. Another person's record showed that a person did not require any assistance from staff with their medicines. However, through speaking with the manager it was

Inadequate

Is the service safe?

established this person's needs had changed and they now required support from staff to support this. This meant the record was inaccurate and the person may have been at risk of inappropriate or unsafe care.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's records and information associated with their identified risks were not always stored correctly. For example, within one person's care records there was a record that related to a different person. The record was a support plan that showed how the person to whom the record belonged to liked to be cared for. The two people had very similar surnames but different care needs. The incorrect location of these records presented a risk that people could receive inappropriate or unsafe care.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had appropriate arrangements to identify and respond to the risk of abuse. Safeguarding and whistleblowing policies were available for staff. The safeguarding policy gave guidance for staff on the different types of abuse and actions to take when reporting abuse. Staff were knowledgeable about safeguarding and showed a clear understanding of reporting procedures. Staff were familiar with the concept of whistleblowing and how to report poor practice to external agencies in confidence if they had any concerns.

Safe recruitment processes were undertaken. Staff completed an application form and provided information for employment and character references. Recruitment files showed these references had been obtained by the home and formal proof of the person's identity had been obtained. A Disclosure and Barring Service (DBS) check had been completed for staff which ensures that people barred from working with certain groups such as vulnerable adults are identified.

Requires improvement

Is the service effective?

Our findings

People felt safe with the staff who provided their care, however some negative comments were received about the experience of some staff. One person explained to us how they required hoisting and said, "They [staff] know how to hoist me and I always feel comfortable." A person told us, "I feel they [staff] are well trained. I always feel safe with them and if they get stuck they can always ask."

One person explained the negative impact of new and inexperienced staff. "We keep training new staff, in particular helping them find their way around the place. This all takes time and has an impact on the family. The mornings can be a challenge trying to get [family member] sorted and then having to show different people [new staff] where things are and constantly having them asking questions. It is not the staff's fault but it would be good to keep the same ones for a while."

Staff received regular training from the provider to complete their role effectively. The training records showed staff training was completed regularly in key areas such as moving and handling, safeguarding adults, food hygiene and nutrition. This ensured that staff had the skills and knowledge needed to effectively meet people's needs. Staff felt they received sufficient training to deliver the right level of care to people they supported.

A person's relative informed us of a recent event in which they felt demonstrated that staff were suitably trained. They explained how their relative had an incident within their home and stated the staff responded effectively to provide the appropriate level of care and support whilst waiting for professional medical intervention.

Staff received regular supervision approximately every two months and described the sessions as useful. Examples of supervisions showed matters such as performance objectives, achievements, policy changes and training were discussed.

The provider had an induction training programme to ensure new staff received sufficient training. The induction was completed over a 12 week period and involved blended learning via an e-learning package on the computer and practical classroom training. The induction included essential training such as their communication, safeguarding adults, dementia awareness and infection prevention.

Staff completed Mental Capacity Act 2005 (MCA) training and were aware of how this related to their work. The MCA provides a legal framework for acting on behalf of people who lack capacity to make their own decisions and ensuring their rights are protected. The provider had a policy on consent that incorporated the principles of the MCA. This policy gave staff guidance on the importance of obtaining consent from people and involving them in their care. It also gave guidance on the different types of consent they may encounter, for example written, implied or verbal consent.

Most people who were supported by staff with food and drink received the care they needed. However, the delivery of care had not consistently provided people with pre-existing medical conditions the nutritional support they needed. For example, a person who had diabetes highlighted that they had experienced problems receiving their meals. They told us they were looking for a new care provider as it was important they received their meal at a specific time due to their insulin administration. They said that they have previously had to ring the service to ensure they arrived on time so they could take her medication.

The service had ensured people's nutritional needs could be met by undertaking additional training where required. Some people within the service received liquid nutrition via a Percutaneous Endoscopic Gastrostomy (PEG). PEG feeding is the means of delivering liquid nutrition through a tube into the stomach. Some staff had undertaken training to ensure they were competent in the use and maintenance of the associated equipment.

Some people could contact their GP or other healthcare professional themselves should this be required. People's relatives could also contact a healthcare professional on their relative's behalf if required. Some people's records showed the service had also obtained the guidance of a medical professional when required. For example, a dietician had been contacted when it was identified a person had lost weight and the service communicated with local district nurses when required.

Requires improvement

Is the service caring?

Our findings

People told us that staff were caring and very positive comments were received. One person commented, “The girls that come are angels, they know me and what I like. They know what they are doing.” Another said, “They [staff] are very nice, I have no complaints about the carers.”

We received mixed responses relating to the communication people and their relatives received from the service. Some people felt the communication was not caring and said they were not always aware of important information relating to their care. One person commented, “We don’t know who is coming or when. I have spoken to the company they are not good at communicating. They don’t ring me I have to ring them. Communication is not what it should be.” Another person said, “They [staff] are not always on time particularly in the evening although it is not a problem. They don’t always get chance to let me know if it is traffic, sometimes I can be waiting a while. It has got better recently though.”

Other people felt they received sufficient communication from the service about matters relating to their care. One person commented, “I always feel safe and involved in my care. They are pretty much on time, have let me know if they are going to be late, have never let me down.” Another comment we received was, “They [staff] are pretty much on time; if they are going to be late they would let me know. Although they sometimes don’t come in the evening.”

People’s privacy and dignity was respected by the staff. We received positive comments about the caring nature and relationships people had with staff at the service. Comments we received from people included, “I am quite content with the service, they [staff] are giving me good care” and “All lovely girls, friendly and talkative. I’ve not found any to be rude.” A person’s relative reflected these comments and told us, “They [staff] are all pretty good once they understand what has to be done they just get on with it. They are always very pleasant.”

We spoke with a healthcare professional who provided community nursing care to a person who received care from staff at the service. They spoke positively about the relationship staff had formed with the person and told us they always communicated in a caring manner with the person and were pleasant and friendly.

Requires improvement

Is the service responsive?

Our findings

People received care in line with their needs and staff were responsive to their needs. People felt involved in their day to day care and told us that staff would always check if they needed anything else before leaving. People felt that staff understood their needs, however only three people said they had been involved in setting up their care planning and only two people were able to tell us they had been involved in a review of their care. One commented, "Someone came round a while ago. They reviewed my care plan and asked questions about how it was all going."

Care records confirmed that reviews had not been completed. Although people were happy with their care, the provider had not ensured that people's care needs were reviewed when required. For example, in two people's records it showed a review had not been completed by the service in approximately 14 months. Another record showed that an assessment for a person completed in July 2013 was the most recent assessment completed. The manager told us that these assessments should be completed every six months as a minimum. There was a risk the service may not be aware of any changes in the person's care needs due to the failure to reassess people's needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People or their relatives gave a mixed response about complaint handling at the service. However, most people commented that when they had previously raised a compliant with the service they had not received a response. People were aware of how to complain and the provider had a policy and procedure in place. People had a leaflet within their homes about the complaint procedure. One person said, "I haven't needed to complain but there is a leaflet here with how to if I did want to."

Most of the people we spoke with who told us they had previously complained to the service told us they had never received any feedback or acknowledgement of their complaint. One relative told us, "There have been instances when staff haven't cleaned up properly. I have complained but not sure what they did about it. I never get feedback." One person we spoke with said, "I don't get any feedback when issues have been raised." One person told us they no longer made any comments to the service as, "Nothing ever gets done." This showed the service did not have an effective system to listen to and learn from people's complaints.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt they received personalised care and care records communicated personal about people. A record called "About Me" recorded information about the level of care people received and the level of support they required. It gave information on a person's medical history and their current preferred care routines. For example, one record showed a person preferred to be given the choice of a bath or a shower and how they liked to receive their personal care to maintain their dignity. Another record within care records was a 'History of Life' record which gave an overview of the person's life history such as if they were married, where they worked and where they were born.

Inadequate

Is the service well-led?

Our findings

The provider did not have an effective system to monitor the quality of people's care records and ensure the service held current and accurate records about people. Records did not always contain proper information about people to protect them from inappropriate care. The provider had not identified failings in the lack of recording of information about people we identified during this inspection.

The provider did not have appropriate system to monitor the views of people or their relatives. Only one person we spoke with told us they had ever received a questionnaire or survey from the service but told us they were unable to recall when this was. When asked, nobody we spoke with told us they had ever been contacted by the manager or senior staff at the service to request feedback on the care provided by the service.

The manager told us that a review system was being set up to be launched in the near future which would involve reviews both in people's homes and on the telephone. The service did not currently have an effective system to regularly ensure people's views were obtained.

We were given a copy of the providers annual satisfaction survey however this was dated for the period of 2013 to 2014. These results however were a compilation of all of the provider's locations nationally and did not show individual location results. Some of the positive results shown in the providers national survey did not reflect the views of people we spoke with during this inspection.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records were not always located promptly when required. During the inspection there were several delays when we requested records to be presented to us and on occasions it was evident there was no clear knowledge on where records were located. In addition to this, a specific record requested could not be located.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives had not been informed of key information by the provider. Only two of the 21 people we spoke with were aware there was a new manager in post however they were not aware of the new manager's name. The manager had been in post since December 2014. Some people commented positively and said that recently there had been an improvement in the service since around Christmas. Others told us that although calls were still sometimes late, they were advised of this via the telephone now whereas before this did not happen.

The new manager had implemented systems to assist in monitoring the care appointments for people. At our last inspection there were no effective systems in operation to monitor missed or late appointments. During this inspection we found that the system available to the provider was being used and the results we being collated and monitored by the manager. However, the feedback we received from people indicated this had not always been effective as people were still not always being contacted when appointments were late.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: The provider had not always re-assessed people's needs or planned and delivered care to ensure the welfare and safety of people. Regulation 9(1)(a) and 9(1)(b)(ii). This now corresponds to a breach of regulations 9(3)(a) and 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The provider had not ensured there was sufficient staff to ensure that people who use the service were safe. Regulation 22. This now corresponds to a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: The provider had not ensured people were fully protected from the risks associated with medicines. Regulation 13. This now corresponds to a breach of regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: The provider had failed to maintain accurate records for service users. Regulation 20(1)(a). This now corresponds to a breach of regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints How the regulation was not being met: The service had not ensured all complaints were fully investigated and responded to. Regulation 19(1) and 19(2)(c). This now corresponds to a breach of regulations 16(1) and 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: There were no appropriate systems to identify and assess risks to people who used the service. Regulation 10(1)(a) and 10(2)(b)(iii). This now corresponds to a breach of regulation 17(1), 17(2)(a) and 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014