MiHomecare Limited

MiHomecare - Finchley

Inspection report

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Date of inspection visit:
25 June 2018
26 June 2018
27 June 2018

Date of publication:
12 October 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 25, 26 and 27 June 2018. The provider was given 48 hours' notice because the location provides a domiciliary care service. It provides personal care to people living in their own houses and flats. It provides a service primarily to older adults and people with physical disabilities.

Not everyone using MiHomecare – Finchley receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection MiHomecare - Finchley provided domiciliary care and support for 456 people in their own home. Following the inspection, the deputy manager informed us that 381 people received a regulated activity.

At our last inspection on 4 and 11 May 2017 the service was rated 'Requires Improvement'. We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 which related to the safe management of medicines and providing sufficient information on people's personal risks to ensure that staff were able to minimise the risk and Regulation 17 which related to monitoring and auditing people's medicines and daily care records. At this inspection we found that the provider had addressed these breaches.

We also made a recommendation around capturing and documenting information on the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) in relation to people using the service. At this inspection we found that the service had addressed this and MCA/DoLS was well documented and managed.

The service is now rated 'Good'.

There was a manager in post. However, at the time of the inspection the manager was on planned leave. The manager was in the process of applying to CQC to become the registered manager and was registered on 17 July 2018. The inspection was supported by the deputy manager. A registered manger is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of law; as does the provider.

People and relatives were positive and felt that they were safe with the staff that visited to provide care.

People had person centred risk assessments based on their individual needs. Risk assessments were detailed and provided staff with guidance on how to minimise known risks.

Staff had received training in safeguarding and understood how to recognise and report any concerns. The company had a dedicated whistleblowing phone number for staff, relatives and people. Staff understood how to whistleblow if they had any concerns.

Medicines were safely managed. Staff had received training in medicines and were competency assessed each year. Medicines auditing was effective and had improved since the last inspection.

Staff were recruited safely. The service completed necessary checks to ensure that staff were safe to work with vulnerable adults.

Staff were aware of infection control and how to keep people safe from the spread of infection. The service provided gloves and aprons for staff when delivering personal care.

People received continuity of care and often had the same care staff visiting them. People and relatives told us that staff were on-time and stayed the correct amount of time.

Accidents and incidents were well managed and any actions or learning documented.

Staff received an induction when starting work. Part of the induction included shadowing more experienced staff. However, whilst staff told us they did shadow during their induction this was not well documented.

Staff received regular supervision, appraisal and training to support them in their role.

People were supported to express their views and were actively involved in making decisions about their care. Where appropriate, relatives had been involved in planning people's care.

People were supported with their nutrition and hydration where this was an identified need. People were positive about the support they received with meals.

Staff were aware of how to report concerns if they noticed a change in people's health or well-being. People were referred to healthcare professionals where appropriate.

There was a complaints process in place and people and their relatives knew how to make a complaint. Complaints were investigated and followed up.

People and relatives told us that they felt that staff were kind, caring and treated people with compassion and empathy. Staff understood the importance of communication and building rapport with people and their relatives.

People were encouraged to be as independent as possible.

Staff knew people well and people told us that they were treated with dignity and respect.

People and where appropriate, their relatives were involved in planning their care. This was well-documented in people's care plans.

Care plans were detailed and provided enough information for staff to support people. Care plans were regularly reviewed and updated immediately if changes occurred.

Audits were carried out across the service on a regular basis that looked at things like, medicines management, health and safety and the quality of care. Surveys were completed with people who used the service and their relatives. Where issues or concerns were identified, the manager used this as an opportunity for change to improve care for people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were able to tell us how they could recognise abuse and knew how to report it appropriately.

There were sufficient staff to ensure people's needs were met. People experienced a continuity of care.

Risks for people who used the service were identified and comprehensive risk assessments were in place to ensure known risks were mitigated against.

Staff were safely recruited.

People were protected against the risk of infection.

People were supported to have their medicines safely. Staff had been trained in medicines and how to administer them safely.

Staff arrived on time and stayed the correct amount of time for care visits.

Accidents and incidents were investigated and actions taken where necessary.

Is the service effective?

Good

The service was effective. Staff had on-going training to effectively carry out their role.

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and how this impacted on the care they provided.

Staff received supervision and appraisals. People were supported by staff who regularly reviewed their working practices.

People's healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

Where identified, people were supported to have enough to eat and drink so that their dietary needs were met.

Is the service caring?

Good

The service was caring. People were supported and staff understood individual's needs.

People were treated with respect and staff maintained privacy and dignity.

People were encouraged to have input into their care.

People and their relatives told us that staff were patient and kind in their interactions.

People were encouraged to be as independent as possible.

Is the service responsive?

Good

The service was responsive. People's care was person centred and care plans were detailed.

Staff were knowledgeable about individual support needs, their interests and preferences.

Complaints were responded to in an effective and timely manner. People and relatives knew how to complain.

Is the service well-led?

Good

The service was well led. There was good staff morale and guidance from the provider.

There were regular staff meetings.

People and relatives were actively encouraged to provide feedback on the quality of care.

Systems were in place to ensure the quality of the service people received was assessed and monitored.

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.

This inspection took place on 25, 26 and 27 June 2018. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the someone would be present to support the inspection. The inspection was carried out by three adult social care inspectors, a pharmacist inspector who reviewed people's medicines records and four 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. The experts by experience supported this inspection by carrying out telephone calls to people and their relatives.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe and well-led to at least good. This included information around safe medicines management, personal risk assessments for people using the service and overall quality and monitoring of the service.

We used information the provider sent to us on 11 May 2018 in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we looked at 17 people's care records and risk assessments, 14 staff files, 17 medicines records and other documentation related to the management of the service. We spoke with the deputy manager, the operations director, the head of quality, the quality manager, the director of the company and 17 care staff. We also spoke with 15 people that used the service and 15 relatives. Following the inspection, we spoke with the registered manager.

Good

Is the service safe?

Our findings

We asked people if they felt safe when care staff visited them. People told us, "Oh yes I can definitely trust the carers they are all very good. They don't touch anything they shouldn't. For example, they don't just open my underwear drawer", "Yes, I do trust and feel safe with the carers because I get on well with all of them", "Yes [I feel safe]. The carer is always keeping an eye on me and if she sees there's something that might be dangerous to me, so tells me to be careful" and "They are marvellous. Yes, I do trust them and feel that I can trust them. For example, [staff] goes to the shops for me and the money always has to be right." Relatives' comments included, "Yes I do [feel relative is safe]. I think they are just kind to my aunt, and talk to her. I haven't seen anything that would worry me" and "The care she has is excellent. The carer is very applicable, very good and very prompt, like one of the family. I have no concerns whatsoever."

At our last inspection we found that risk assessments did not always provide sufficient information on the management of risks to people with on-going health concerns. For example, diabetes and how staff could recognise if a person's blood sugar levels dropped or increased. At this inspection we found that the provider had addressed this issue.

Risk assessments covered a broad range of relevant hazards, both generically for things like the care environment and specifically for people's identified personal risks. For example, diabetes, falls, behaviour that may challenge, moving and handling and choking. Risk assessments provided staff with guidance on how to minimise the risk and what actions to take if the risk occurred. Risk assessments were person centred and detailed how the risk affected the person. For example, one person had a risk of falls and their risk assessment stated, 'Fear of falls. Due to muscle weakness, legs lock up, ankles and knees are weak.'

Risk assessments were reviewed on an annual basis and the deputy manager told us, "Risk assessment plans are reviewed on an annual basis. However, if there are changes to a person's condition or support needs this will trigger a review, as will, medicines changes, changes in hours, whether requested by social services or the client themselves." The team leader told us that people with complex needs such as dementia, risk of falls and diabetes, were reviewed every six months.

Safeguarding training was provided as part of staff induction when they started working with the service as well as yearly refresher training. All staff members that we spoke with were able to explain how they would keep people safe and understood how to report any concerns where they felt people were at risk of harm. Staff could explain different types of abuse and how to recognise it. Staff comments about safeguarding included, "We have to report [any concerns]" and "We have had training [on safeguarding] so we know what to do."

Staff were aware of what whistleblowing was and how to report any concerns. People, relatives and staff had also been given a telephone number, provided by the company, that they could report any concerns to. The operations director told us, "The clients have a whistleblowing line that they can call and we do occasionally get a call come through. The operations team pick it up. Staff use it too, if they feel the need to use it and we can address it with individual branches." The operations director told us, and we saw, that

details for the phone line were on people's care plans and in the service user guide that was provided to people when they began using the service.

At our last inspection we found that medicines were not always being managed safely. Medicines dosages were not always accurately recorded on Medicines Administration Record (MAR) charts and omissions in signing the MAR were not always identified. At this inspection we found that the provider had addressed this issue.

At this inspection, we looked at policies, records, training and systems for medicines management and found that medicines were being managed safely. Each person had been assessed before being supported with their medicines and this assessment included how they managed their medicines and any risks associated with this. The results of this assessment were clearly recorded and acted on. We saw that where possible, people were encouraged to manage their own medicines and where they needed support this was tailored to their individual needs. For example, we saw that one person had had support with their medicines but later could manage it on their own with care staff monitoring.

Each person who was supported with medicines or creams had a MAR. We saw that since the last inspection the provider had improved their auditing system of MAR's. We saw that MAR's were audited once a month to ensure the medicines were given as prescribed. Any gaps were noted and followed up with staff. Additional medicines training was given to staff when necessary to prevent future errors.

People's care plans had important information such as the name, photograph and allergies. Each person had a medicines profile in their personal file. This listed all of their current medicines, what they had been prescribed for and any side effects that the person could experience. We saw that the monthly quality assurance assessments were carried out by senior field staff. Staff told us that the assessment included a review of people's medicines to ensure peoples MAR's were a true reflection of the medicines at people's homes. There was a medicines policy in place. Staff received annual medicines training and the provider assessed the competency of staff to ensure they handled medicines safely.

People told us, "The carer helps me with my medication I have it in the morning" and "The carer brings me a glass of water and prompts me to take my tablets." Relatives also told us that they felt the care staff supported people with taking their medicines. Some comments included, "Yes, I am confident they can support her with her medication and they remind her to take the medication in her dosset box", "They do put it in a pot, and offer it to him, and encourage him to take it" and "They help with meds and they make sure she takes it."

The service protected people from the risk of infection. Staff had access to personal protective equipment (PPE) and would collect supplies from the office when needed. During the inspection we observed a large delivery of PPE and staff told us that PPE was always available. A person said, "Yes, they [staff] do wear it when giving personal care. When they arrive, they put on an apron, gloves and blue shoe protectors." A relative said, "They concentrate on hygiene. They always wear gloves and aprons when giving personal care."

We reviewed staffing rotas and found that staff were given travel time in-between each care visit. The service had electronic call monitoring in place for Barnet and Camden. Electronic call monitoring is where staff log in, often using their mobile phones, when they arrive and leave a care visit. This information is relayed to the office so that office staff can ensure that staff are on time and stay the correct amount of time.

People told us that they received continuity of care and often had the same staff visiting them. Where care

workers were running late people said that either the staff member or office would call them to inform them. If a different staff member was attending, people were informed of the change. People's comments included, "I have the same carer although occasionally they have to change because of ill health or holidays", "At the moment it's the same care worker. They let me know if they're running late and somebody always comes", "If they're going to be late they always call me. They always let me know, even if they are only going to be late by a little bit of time because of traffic they will call me" and "Same care workers, they do tell me if there's a change."

All people and relatives that we spoke with told us that staff were on-time and stayed the correct amount of time. People also told us that the service was flexible with timing. For example, if a person had an appointment. One person told us, "Sometimes they are late, sometimes a little early. Yesterday I had a hospital appointment so they came early to make sure that I was ready in time." Another person's care plan documented days that the person attended a day centre and their visits had been adjusted accordingly to ensure that they were ready on time.

Since December 2017 we saw that there had been 13 missed visits recorded. The details of the missed visits were documented with actions taken and apology letters sent to people along with any actions taken.

There was an out of hours phone number that people and staff could contact if necessary. We looked at the out of hours records for the preceding three weekends and saw that on average there were 26 calls taken per day over the weekends. The person covering made detailed notes and mainly arranged for back up carers. Many of the calls logged were from people and relatives cancelling visits. People and staff told us that they were always able to get through and receive assistance. One person said, "Any time I've rang out of hours I've always got 100% response."

The service followed safe recruitment practices. Staff files showed pre-employment checks such as two satisfactory references from their previous employers, photographic identification, their application form, a recent criminal records check and proof of eligibility to work in the UK. Records showed that all staff employed longer than three years had received a criminal records re-check. This is in line with best practice and ensures that staff are safe to work with vulnerable adults.

The service recorded where people experienced accidents or injuries, such as when staff visited someone and found they had had a fall. A member of the management team then promptly reviewed any such reports and set actions needed to minimise the risk of reoccurrence. These included advising the person or family of suggested changes, making referrals to community professionals such as occupational therapists for additional support, requiring statements from involved staff, or asking senior staff to undertake a further needs or risk assessment of the person's circumstances.

Good

Is the service effective?

Our findings

We asked people and relatives if they felt staff were well trained and provided a good quality of care. We received positive feedback and people told us, "I think they are well trained. Every so often they have a little refresher course", "Oh yes, they are all well trained and good at their jobs. I have a nice lot. They help me have a shower and to get dressed" and "Yes, I think the carers are well trained and good at their jobs. I definitely I have confidence in them." Relatives said, "Well obviously some are better than others. Some are very professional and good. The new ones take time to get used to what the [person] requires. It takes time to break new carers in but I don't have any problems" and "The carer does the same thing every day. As far I know she is good at her job. She does write things down if there is something wrong she will write it down and then find out what can be done about it."

Staff received an induction when they started working at the service. Induction consisted of office based training including, moving and handling, medicines, mental capacity, safeguarding, fire awareness, health and safety and basic food hygiene and ensuring that staff understood the policies and procedures of the company.

As part of staff induction, new care staff shadowed more experienced staff for up to 16-20 hours depending on experience. Shadowing was done by established care staff called 'Star Pupils' and were spread across the three boroughs that the service covered. Shadowing was not a well-documented process and it was difficult to check how long staff had spent shadowing. We checked pay-roll records to see how many hours shadowing new staff had completed. For one staff member we found that they had only completed four hours shadowing. The deputy manager told us that this was because the staff member had been very experienced and did not require any further shadowing. The deputy manager said that they would look at how shadowing was documented in staff induction.

Staff received supervision. However, this was not always regular for all staff that we looked at. The service was not up to establishment with field care supervisors having only two in post as opposed to four. Field care supervisors completed staff supervisions. Supervision records that we saw were person centred to the staff member and some seen were responsive to concerns raised or a complaint. They included personal reflection, work and rotas, concerns about people and staff conduct. Staff had received an annual appraisal. Staff that we spoke with said that they did receive supervision and were positive saying that they felt supported by their line managers and were always able to access help if necessary.

Staff received regular on-going training to support them in their role. During the inspection we observed that there were two days of refresher training being delivered in the office training room. Training was monitored at branch level and provider level and all staff who were due for an annual refresher training were booked onto courses in June and July. The training audit showed that the service was 98% compliant with staff having up to date training. Where staff had not received refresher training, this was due to staff sickness or holidays. We saw that there were yearly medicines and manual handling competency assessments completed with staff to ensure that their practice was of a good standard. We saw that staff were being supported to achieve the care certificate. The care certificate is a set of standards and principles that care

staff should adhere to, to underpin good care delivery.

Staff that we spoke with said that they had received training in working with people living with dementia. However, they said that they would like further training on working with dementia and behaviour that challenged. Staff felt that dementia was becoming one of the largest demographics that they were working with and said that they wanted to understand it better in order to provide better care. We fed this back to the management team at the end of the inspection.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Services providing domiciliary care are exempt from the Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the courts with the support of the person's local authority care team. Nobody currently using the service was subject to a judicial DoLS.

At our last inspection we made a recommendation that the service sought advice and guidance regarding appropriately capturing and recording information on MCA and DoLS, based on current practice. At this inspection we found that this had been addressed.

The service had introduced new MCA documentation and we saw that mental capacity was part of people's care records. The service had clear protocols where needed by which to assess people's capacity to consent to care-related decisions. People that had capacity had signed their care plan. Where people had capacity, but were unable to sign their care plan due to a physical disability, the service had gone through their care plan and people consented verbally, which was documented. Where people did not have capacity, the service had completed best interest meetings with relatives and healthcare professionals. The service understood that relatives could not consent to care unless they had legal authority to do so. Where relatives did not have legal authority, they signed to say that they had been involved in planning the person's care. Where relatives did have legal authority to consent to care such as Lasting Power of Attorney (LPA), this was well documented.

Where appropriate, the service completed a MCA assessment for various aspects of people's care. For example, we saw MCA assessments in place for personal care, food and nutrition, toilet and continence, dressing and medicines.

Staff received training on the MCA at the point of induction and this training was refreshed yearly. Staff understood the importance of asking for consent before carrying out any care. People told us that staff always asked if they were ready and comments included, "Yes of course they ask my permission before they help me" and "They always ask first."

Where identified as a need, the service provided light meal preparation for people. This was often heating food up for people, making a snack such as sandwiches or preparing a hot meal. People told us, "I enjoy mealtimes. They are coming at 12.30pm to do my lunch. They only have half an hour but she will cook me

fishfingers, mashed potatoes and peas. I choose what I want and normally tell her when she comes in the morning so that if she needs to get something out then she can", "They make very nice lunches. The food is very good and I am happy with it" and "They give me my breakfast and dinner. They ask me what kind of sandwich I would like them to make."

People and relatives told us that before starting to receive care from the service a pre-assessment was carried out. During the assessment, people were asked if they had a preference of male or female staff member. One person said, "I have all female carers and that was my preference." A relative told us, "Oh yes, he always has a male carer which is what he prefers." Pre-assessments were conducted following a referral to the service and looked at people's care needs, their well-being and tasks that needed to be completed for the person.

The service expectation was that pre-assessments and care plans were to be completed within 48 hours of the person being referred to the service and service delivery starting. We found that in the majority of cases this was being done. However, we saw two examples of people not receiving a pre-assessment or care plan within 48 hours. For one person we were told that the service was waiting for the person's representatives to be present. We discussed this with the deputy manager at the time of the inspection who told us that people should not be waiting more than 48 hours and this would be raised with the management team. This was also in part due to the service not having a full complement of field care supervisors.

The service did not generally support people with routine appointments and the majority of people were supported by relatives. Where staff noticed a change in people's health or well-being, this was reported to the office. We saw examples of where the service had referred people to other healthcare professionals such as GP's and occupational therapy. Where this had been done, we saw that this was documented in people's daily care records. Relatives were positive about staff recognising any changes in people's health and said that staff always informed them and sought advice from the office. One relative said, "The other day my dad's leg was swollen up and the carer pointed this out. The carers when they washed him noticed his swollen leg told us straight away, and we called the doctor and were able to get it treated straight away."

Good

Is the service caring?

Our findings

We asked people if they could give examples of how staff showed a caring attitude. People were positive about the staff and felt that staff were compassionate, kind and took time to listen to them and understand them. Comments included, "They make me tea and sit with me and see how I am. We have a chat. I go to pottery classes; if I'm having a bad day and don't go, they encourage me to go", My carer gives me a lovely bath which I enjoy. My carer makes me feel special and every so often she bursts into song and does a lovely dance. My carer cares about me." A relative said, "The carer sits with her and tries to think of little things, such as giving her different types of food and talking to her."

People were encouraged to be as independent as possible. The service worked with a lot of care packages for reablement. This is where people have a care package usually between two and six weeks to help them regain skills following things like hospital admissions. However, staff were also aware of encouraging independence where people required long term care and staff told us that they felt that it was important for people to be encouraged to do things for themselves where possible. People told us, "I like to be as independent as possible so I do what I can do and ask them to do the rest", They support me to go shopping and encourage me to do what I can for myself" and "They [staff] always encourage me to be active, and I always do 'cos if you don't use it you lose it, I firmly believe that."□

People told us that they felt that staff treated them with dignity and respect. People commented, "[Staff member] has a wonderful attitude and she respects my privacy and dignity. She is wonderful at her job", "They do respect my privacy and dignity. For example, when my son comes in they do not let him past the bathroom door [when receiving personal care]" and "They absolutely 100% treat me with respect and dignity." Relatives said, "[Staff] do treat [person] respectfully. They have a good relationship with him and they are always talking with him" and "They [staff] do respect her privacy and dignity for example they would not leave her undressed. They talk kindly to her they have a kind attitude." A staff member told us about respecting a person's wishes around their culture and faith and said, "I used to do a man that was [specific culture] and Muslim and he wanted to be bathed in a specific way. I always did it how he wanted to show respect."

Staff that we spoke with knew the people that they cared for well and spoke positively about building rapport with people to enhance the quality of care that they provided. People and relatives felt that because they usually had the same carer, they were able to build good working relationships.

Staff understood the impact that providing care to people could have on people's well-being. Staff commented, "Make them feel important. You are the only one they may see that day", "I have had a client for 14 years. I make her day" and "It's important to listen to your client and communicate with them. Never ignore anything that they say. If there's two carers working together talk to the client and not each other and make them feel comfortable. Communication is as good as fresh air to them."

People told us that staff offered choice and listened to what they wanted. People said, "Oh yes they give me choices about what to wear and they help cream me", I'm always consulted and they respect my wishes"

and "They listen to what I want."

Assessments helped form the basis of people's care plans. People and relatives told us that they had received pre-assessments and had been able to have input into this process. People and their relatives were also involved in care reviews by the service. People told us, "I do have a say; they consult me on everything" and "Yes, I have seen my care plan, it's in the folder [in the person's home] and I've been involved in it. When I moved from a house to a flat they did a new assessment. Relatives commented," Yes, I've been very involved with the care plan for him" and "I tend to sort everything out, as he's not able now. He tends not to remember. I'm very much involved in the care plan."

Good

Is the service responsive?

Our findings

Care plans were detailed and person centred and people told us that they were involved in creating their care plans. Care plans contained practical information on tasks that needed to be completed as well as information on people's personal preferences. One person told us, "My preferences are considered and used to make the care plan." There was information on people's backgrounds, medical and personal histories which staff were aware of when we talked to them. Care plans had a section called 'culture'. In all the care plans that we looked at this section contained information on people's communication needs. However, there was no information on whether people had any specific cultural needs. We raised this with the deputy manager as well as during feedback at the end of the inspection. The operations director told us that this would be reviewed.

The service conducted annual reviews of care which was documented in people's care plans. Where people had more complex needs reviews were completed every six months. Where there was a change of needs we saw that care plans were updated to reflect this. One person told us, "They do come and check the book with me and go through certain questions and ask if there are any changes." Relatives commented, "I was involved in a review a couple of weeks ago that took place at her house" and "Yes they come round once every six months to conduct service reviews."

The service kept a 'centralised tracker' that documented all complaints that the service had received. Since the last inspection, six formal complaints were documented. Themes included miscommunication between the office and people and missed or late visits. Complaints were seen to be investigated and responded to and actions identified such as increasing spot-checks on staff. Some complaints contained a post complaint feedback form which asked the complainant how the complaint was handled and if they were satisfied with the response. Feedback forms we saw were positive on how the complaint had been dealt with. People and relatives told us that they knew how to make a complaint and that information on how to complain had been given to them when they started using the service. Information was also located in people's home and one person said, "There's a leaflet in the book explaining about complaints."

Feedback from people included, "Oh yes, I definitely have the confidence to complain but I don't have any qualms about the service", "I ring and I have a very good relationship with all the staff. They are very accommodating they always listen, and they let me know the outcome" and "I've had a couple of complaints, but they were sorted out." Relatives commented, "No I don't have any complaints. The quality of the service is very good" and "I've never had to complain and I would speak to the office if I did." We found that the service's quality monitoring phone calls and visits included questions on complaints and whether people and relatives knew how to complain. It was documented that people were reminded how, where they said they did not know.

Where people required help to access the community, we saw that this had been documented in their care plan. For example, one person attended a day centre twice a week and needed to leave earlier in the morning. We saw that the care plan reflected that the person required an earlier care visit to ensure that they were ready on time to attend the day centre and the person confirmed that this happened. Where

appropriate, people told us that they were encouraged to maintain contact with family and friends. One person told us, "Yes, they do support me to stay in touch with family and friends."

At the time of the inspection the service was not providing end of life care to anyone using the service. The deputy manager told us that where a person had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) this was located in the person's file within their home and documented on their care plan. Where a person had a DNACPR, staff were aware.

Good

Is the service well-led?

Our findings

At the time of the inspection, the manager was in the process of applying to CQC to become the registered manager and was registered on 17 July 2018. We received mixed feedback about how well staff and people knew who the registered manager was. Staff said, "They sent out a letter to inform us of the new manager with the contact number" and "'I've been fortunate to meet the new manager in a meeting." However, other staff said that they were not aware of who the new manager was. Staff felt that this was in part because MiHomecare – Finchley was a large service and staff had more contact with their line managers. We raised this with the head of quality who said that this would be looked at. Staff were positive about their line managers and said that they felt well supported and were always able to access help if needed.

There was a clear staff structure in place and staff we spoke with were aware of how to report concerns and understood the branch management structure.

People said, "No I don't know who the manager is but the service is well run. The quality of the service is very good in my opinion", "Yes I think the service is well run it is good the quality of the service is really good" and "I don't know who the manager, but I know a lovely lady co-ordinator who sometimes comes to see me; she's very nice."

People were overall positive about communication with the office. Comments included, "The communication with the office is very good" and "The people in the office are very respectful." However, some people that we spoke with said that they sometimes found it difficult to get through to the office. One person said, "Sometimes it's really hard to get through to them. I don't call very often."

Staff said that they were overall happy with the allocation of work but felt that communication around new people and rotas could be improved. Staff received their rotas by secure text each week. However, staff commented, "Sometimes come Saturday or Sunday they add more work to it [the rota]. Over the weekend we are not supposed to call at weekends about rotas", "Sometimes they put a non-regular client without telling you", 'You don't get information, there's a care plan at the house. I notice they put someone there without telling me" and "I go to bed and check my rota, I check again and there's another new one. Imagine if I didn't check!"

The service covered the London boroughs of Barnet and Camden. At the time of the inspection, the service had taken on a contract to provide care within a third borough, Islington. We asked how growth of the service was being managed to ensure that care continued to be delivered safely. Following the inspection, the operations director sent us an overview of how the service planned to expand safely.

The operations manager told us that the service operated an on-going recruitment for care staff with two internal recruiters. They start approximately 10 new care staff per month. At the time of the inspection there were 27 potential staff going through recruitment checks. This meant that as the service was expanding, there would be enough staff to cover care calls.

At the time of the inspection we found that there was not a full complement of field care supervisors . The operations director said that they had not been at full capacity since April 2018 and the service had two vacancies out of four. This had impacted on the timeliness of pre-assessments, supervisions and care reviews. The operations manager told us that they were aware of this issue and had a new field care supervisor starting in the coming week and were actively recruiting for a fourth.

The service had a set of values that all staff were expected to abide by and embed in their daily work. These values included, being straight forward, accountability, honesty, respectfulness and reliability. The head of quality told us that staff were trained in these values at the time of induction and refreshed yearly. Staff that we spoke with were aware of the company's values.

The service actively sought feedback from people and relatives regarding the quality of the service and people's satisfaction and there were systems in place to check the quality of care being provided. The service completed regular monitoring visits and telephone calls that looked at the quality of care people received. People told us that the service regularly contacted them to ask about their experience of the care that they received. Comments received included, "I receive regular phone calls from the office for feedback", "I get regular questionnaires through the post, plus phone calls most weeks" and "Yes they come round every few months and they phone me personally to ask if I am satisfied. If I am not satisfied I phone them." We saw records of monitoring and found that feedback was positive. Where any actions were required we saw that actions taken had been documented.

The service completed annual surveys and people told us that they had received questionnaires to gain their views and opinions. We saw the results of the 2017 survey. Feedback was overall good and the service used this to complete an action plan if there was anything that needed to be addressed.

The service conducted spot checks on staff which was documented in individual staff files. People were aware that the service conducted these checks and their purpose had been explained to them. Staff told us that they received regular spot checks and felt that this system meant that if there were any concerns, these could be raised immediately. One person told us, "They also do spot checks of the carers and the logbook. They turn up unannounced arriving just before the time the carer should be here to see if the carers arrive on time. They stay and watch and check what's being done."

The service had introduced an application for mobile phones that staff were able to download. This contained all the company's policies and procedures. Staff were in the process of being trained on how to use the application. This ensured that policies and procedures were available to staff at all times.

There were records of regular staff meetings that allowed staff to discuss care needs and development of the service. Staff said that they felt comfortable raising any issues and felt that staff meetings were useful.

There were systems and processes in place to audit various aspects of the service. Each month the registered manager completed 'Branch Manager Self-Assessment Monthly Audit'. This included auditing of things such as, staff files, people's care records, accidents and incidents, any safeguarding notifications, staffing levels and training. There were also six-monthly provider audits. We saw the most recent audit from 31 January 2018. The quality manager told us that the provider audit was, "A working document with regard to actions." There had been an increase in the quality of medicines auditing since the last inspection. Daily logs were returned to the office and audited for things such as, quality of information recorded, legibility of handwriting and correct entry times. On all audits we saw that where issues were identified, there were actions in place to address them.

There was good senior management oversight from managers above the registered manager. As well as being identified at branch level, any missed visits or late calls were notified each week to MiHomecare's head office so that there was senior manager oversight of any concerns or emerging patterns. The head of quality told us, "We have a quality governance board that meets every month, including clinical leads, CEO as well as our learning and development team. We discuss anything that comes through from individual branches regarding complaints, risks and its very much about continuous improvement and learning."

We asked how appreciation was shown for the work that staff did. The head of quality told us, "In branch terms it would be through the newsletter, they also do carer of the month." We saw pictures on the wall of staff that had received this award in the past several months. Company-wide there was a 'high five award' which was open to people and staff to nominate individual staff or teams. This recognised best practice, teamwork and examples of excellent care.