Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

MiHomecare Carmarthen

Unit 1 Mihomecare
Llwyn-yr-eos Parc Menter
Llanelli
SA14 6RA

Date Inspection Completed

21/11/2023

About MiHomecare Carmarthen

Type of care provided	Domiciliary Support Service
Registered Provider	MiHomecare Limited
Registered places	0
Language of the service	English
Previous Care Inspectorate Wales inspection	26th October, 2022
Does this service promote Welsh language and culture?	This service is working towards providing an 'Active Offer' of the Welsh language and demonstrates a significant effort to promoting the use of the Welsh language and culture.

Summary

MiHomecare Carmarthen are a domiciliary support service providing care and support to people in their own homes across Carmarthenshire. People we spoke with were generally happy with the service they received from care staff, are treated with dignity and respect, though noted how recent staffing difficulties had impacted on their care provision.

We found greater oversight of the management, quality, safety, and effectiveness of the service is required to ensure people are safe and receive quality care and support. Areas of priority action have been identified regarding the supervision of management of the service and standards of care and support. The provider must take immediate action to address these issues. A returning, acting responsible individual (RI), is currently re-registering with Care Inspectorate Wales (CIW). Assurances have been given that the issues raised will be addressed. These issues will be considered at the next inspection.

An area for improvement has also been highlighted regarding the review of personal plans. While no immediate action is required, this is an area for improvement, and we expect the provider to take action.

Well-being

People spoke positively about their relationships with care staff. People are treated with dignity and respect and feel able to discuss issues with the manager of the service. A person who uses the service told us, "'*The carers are very good. They are caring. I can't fault them anyway."* Another person who uses the service told us, "*The carers are really kind… they listen to me. They know me… I feel safe."* People can also communicate in Welsh, to Welsh speaking care staff.

People's individual circumstances are not always considered. The care and support provision does not consistently meet the unique needs of all people who receive a service. People cannot be assured that they will receive their care and support call at a time which consistently meets their nutritional and medication administration needs. A person using the service told us, *"They can be late, and they can be early. It depends on if they are short staffed. Sometimes it affects me." A family representative told us, "I have had to…raise issues, like inconsistency of call times."* The service has experienced staff recruitment issues, which are being experienced across the health and social care sector. This has resulted in disruptions to call times. However, the service has ineffective oversight of the quality and safety of the service and does not always identify where people's care is compromised. This is crucial to ensuring the best possible outcomes for people.

People are not consistently protected from harm. Whilst the provider does ensure all staff undertake Disclosure & Barring Service (DBS) checks, some staff are in employment without robust recruitment and vetting procedures. Documentation also does not evidence that potential or identified issues in practice are consistently followed up with all care staff when necessary. This is crucial to ensuring that quality care and support is consistently provided by care staff who work unsupervised in people's homes.

Care and Support

People speak well of the care and support they receive from care staff who treat them with dignity and respect. A family representative told us, "*They treat [my relative] well. They are very caring…needs something extra doing they will do it."* Personal plans are clearly written, mostly contain the required information and support care staff to provide support as required. People and their representatives are consulted on the care received. A person using the service told us, "*A supervisor comes out and we have a chat about my care."* However, personal plans are not reviewed in a timely manner when an individual begins receiving care and support from the service. Not all personal plans are reviewed in a timely manner or when necessary. Identified changes do not consistently result in personal plans and risk assessments being updated. Reviews do not consider whether people's personal outcomes are being met. While no immediate action is required, this is an area for improvement, and we expect the provider to take action.

People receive care from care staff who are motivated in their role and want to provide a good standard of care. They are knowledgeable about the people in their care and are empathic and patient in their approach. People and their representatives told us the care staff will almost always ring to say they will be late. However, people do not consistently receive the care and support they require at the time they require it. A person using the service told us, *"They aren't always on time."* Care staff told us that staffing issues can result in call time changes which do not always take peoples' time-critical care into consideration. Inconsistent care and support call times unreliably meet the nutritional and medication administration needs of people. A representative of a person using the service told us, "*We had to drop a call…didn't have breakfast and had…meds really late.*" A member of care staff told us, *"This may impact on people's meds…. I am aware of incidences where this may be happening."* This is having an impact on people's health and well-being and placing them at risk, and we have therefore issued a priority action notice. The provider must take immediate action to address this issue.

The service has inconsistent processes in place to safeguard people. Care staff receive safeguarding training and know the safeguarding and whistleblowing procedures to keep people safe. However, documentation did not evidence that arrangements for sharing safeguarding concerns with local safeguarding services are sufficiently robust. The service does not always follow-up with care staff when opportunities to improve the safe delivery of care and support arise. This information is key to ensuring that safeguarding issues are correctly reported at a local level and appropriately managed to keep people safe.

Medication administration records (MARs) are available at the service and staff routinely sign when medication is given. Medication audits take place and medication issues identified are documented. However, documentation did not evidence that oversight of medication administration arrangements is sufficiently robust. The service does not always

seek professional advice in response to medication errors and does not always follow this up with care staff to reduce the likelihood of similar events happening again. This is key to ensuring that medication arrangements are consistently safe.

Infection prevention and control procedures are good. Care staff wash their hands regularly and wear appropriate personal protective equipment (PPE).

Leadership and Management

The service has ineffective monitoring and oversight to ensure quality care and support. Whilst the responsible individual (RI) has visited the service to gain the views of people and quality of care reviews have been undertaken, we noted a lack of analysis to identify where the quality and safety of the service is being compromised. There is insufficient monitoring and reviewing of the care and support provided by the service. There is ineffective oversight of actions taken by the service in response to incidents and occurrences which may impact on the care and support received by people. This is key to ensuring the service can identify shortfalls and the best possible outcomes are achieved for individuals. This is having a negative impact on people's health and wellbeing and placing them at risk, and we have therefore issued a Priority Action Notice. The provider must take immediate action to address these issues.

There have been changes to the leadership of the service. A returning, acting responsible individual (RI), has made an application with CIW to be re-registered. The acting RI is taking steps to identify where the quality of care and support is compromised. The manager is suitably qualified for the role and is appropriately registered with the social care workforce regulator, Social Care Wales.

There are ineffective processes to oversee that call times consistently meet the individual needs of people. Arrangements do not always take peoples' time-critical care into consideration. Inconsistencies in length of time between calls can impact on people receiving the care they need when they need it. A member of care staff told us, "*Extra calls can be put onto the runs which can make it challenging for people to keep up with at times… It does impact on people."* The service cannot be assured that people will receive their care and support call at a time which consistently meets their nutritional and medication administration needs. This poses a significant risk to people's health and wellbeing.

The service has experienced difficulties in staff recruitment. This has impacted on the service providers ability to consistently manage the service and provide care and support to people. A member of care staff told us, "*There is no point lying, it impacts on the client."* CIW acknowledge retention and recruitment of staff is a wider issue across the social care sector currently. The service provider is taking steps to recruit more care staff.

Newly appointed care staff complete an induction programme which includes training, shadow shifts and checks to ensure they can perform specific care tasks. Disclosure and Barring Security (DBS) checks are in place and current. However, insufficient recruitment and vetting arrangements in place. We did not see evidence of manager oversight of the recruitment and vetting process. Not all staff personnel records contain all the information required by regulations to ensure they are safe and fit for work. Some files did not have

sufficient references, the person's full employment history or reasons for leaving prior work with vulnerable people. There are ineffective processes in place to ensure that all care staff are registered in a timely manner with Social Care Wales (SCW), the social care workforce regulator. This places people's health and wellbeing at risk.

Staff training records indicate care staff have completed training appropriate to their role. However, potential or identified issues in practice are not always followed up with care staff when necessary. The support and development of care staff is key to ensuring that quality care and support is consistently provided by staff who work unsupervised in people's homes. This is placing people's health and well-being at risk.

Summary of Non-Compliance	
Status	**What each means**
New	This non-compliance was identified at this inspection.
Reviewed	Compliance was reviewed at this inspection and was not achieved. The target date for compliance is in the future and will be tested at next inspection.
Not Achieved	Compliance was tested at this inspection and was not achieved.
Achieved	Compliance was tested at this inspection and was achieved.

We respond to non-compliance with regulations where poor outcomes for people, and / or risk to people's well-being are identified by issuing Priority Action Notice (s).

The provider must take immediate steps to address this and make improvements. Where providers fail to take priority action by the target date we may escalate the matter to an Improvement and Enforcement Panel.

Priority Action Notice(s)		
Regulation	Summary	Status
21	The service provider has not ensured that care and support is provided in a way which protects, promotes and maintains the safety and well-being of individuals.	New
66	The responsible individual has not ensured supervision of the management of the service, to confirm proper oversight of the management, quality, safety, and effectiveness of the service.	New

Where we find non-compliance with regulations but no immediate or significant risk for people using the service is identified we highlight these as Areas for Improvement.

We expect the provider to take action to rectify this and we will follow this up at the next inspection. Where the provider has failed to make the necessary improvements we will escalate the matter by issuing a Priority Action Notice.

Area(s) for Improvement		
Regulation	Summary	Status
16	Service providers cannot be assured that people are receiving care and support based on their current needs. Service providers cannot be assured that the service is supporting people to achieve their personal outcomes.	New

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