Focus Care Link Limited

Focus Care Link Ltd- Waltham Forest Branch

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We last inspected this service in September 2017 where it was rated 'requires improvement' overall, with an inadequate rating in 'well led.' This was because we found three breaches of our regulations. These breaches were in relation to risk assessments not being detailed or robust and people's medicine records were not fully completed and were not always accurate. People who used the service and their relatives told us they were unhappy with the service, particularly in relation to the unreliability of care workers and missed calls. An insufficient number of staff were deployed and staff were not receiving regular supervision. There was a complaints procedure in place however complaints were not analysed in order for repeat complaints to be avoided and audits and quality checks were not taking place. Management systems were failing to prevent staffing issues and monitor consistency in care.

At this inspection, we found that although some improvements had been made, there were still issues around risk assessments, medicines, staff punctuality and staff supervision. We found continuing breaches of regulations relating to safe care and treatment and staff supervision and asked the provider to submit an action plan to tell us how they were going to make the necessary improvements. We also asked the provider to send us specific documents on a monthly basis about people's care to show us what improvements they had made since the inspection was completed.

The service is registered to provide personal care to people in their own homes. At the time of our inspection the service was providing care to 88 people. There was a registered manager at the service at the time of our 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 service is run.

Risk assessments were not robust and lacked detail. People's medicines were not managed safely and medicine records were not up to date and contained gaps whereby it was unclear as to whether medicines for some people had been administered or not.

People who used the service and their relatives gave mixed feedback on the punctuality of care workers, and showed that people were not always happy with the care provided by the service.

Care workers were not receiving regular or consistent supervision to support them in their role and to address any training or development needs.

Management lacked oversight of the issues raised during the inspection but have been proactive in sending CQC updates on improvements they are going to make with supporting documentation.

People were protected from infection control and care workers had access to protective equipment such as aprons and disposable gloves.

Accidents and incidents were recorded and care workers told us they knew what to do in an emergency situation.

People were supported to have a balanced diet in line with their preferences and the service worked in conjunction with other organisations and teams to ensure people were receiving the care they needed. This included making referrals to health care professionals.

People who used the service told us they were treated in a caring way by their care workers and that they felt respected.

Care plans contained personalised information about people but we have made a recommendation that the provider seek best practice guidance to expand on the level of detail contained in care plans. We have also made a recommendation in relation to recording end of life preferences within care plans and pre-assessments.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Risk assessments were not robust and medicine records were not completed.

People who used the service gave us mixed feedback about care worker punctuality.

Infection control practices were in place.

Accidents and incidents were recorded.

Is the service effective?

Requires Improvement

The service was not always effective. Staff supervision was inconsistent and sporadic.

People were supported to eat and drink in line with their preferences.

The service liaised health professionals when needed.

Consent was recorded in care plans.

Is the service caring?

Good

The service was caring. People and their relatives provided positive feedback about care workers.

Kind and caring relationships were formed between people and care workers.

People's dignity was respected.

Is the service responsive?

Requires Improvement

The service wasn't always responsive. Care plans lacked specific detail about preferences and end of life care.

Complaints were recorded and responded to accordingly.

People and relatives were involved in their care planning.

Is the service well-led?

Requires Improvement

The service was not always well led. Management did not always have oversight of aspects of care relating to people's safety.

Quality assurance practices were taking place.

Team meetings were taking place.

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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 meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 11 July 2018 and was announced. We informed the provider 48 hours in advance of our visit that we would be inspecting. This was to ensure there was somebody at the location to facilitate our inspection.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Before the inspection we reviewed the information we already held about this service. This included details of previous inspection reports, details of registration and any notifications the service had sent us.

During our inspection we spoke to two care coordinators, a field care supervisor, administrative assistant, two care workers and training manager. After the inspection we spoke with nine people who used the service and four relatives. We looked at seven care plans and eight staff records. We also examined medicine records, policies, procedures and risk assessments.

Requires Improvement

Is the service safe?

Our findings

At our last inspection risk assessments were not thorough or robust and medicine records were not completed adequately. At this inspection, we found that both of these issues had not been rectified.

At this inspection, we found that where people were supported with their medicines, medicine administration record [MAR] charts were in place. These had space to record the name of the person receiving the medicine, the names of the medicine and the date each medicine was given. They also had a space for staff to sign to indicate they had administered each medicine so there was a clear audit trail. However, MAR charts we checked were not completed fully. They contained many unexplained gaps where staff had not signed to indicate a medicine had been administered. For example, the MAR chart for one person in May 2018 contained 56 unexplained gaps. The MAR chart for another person contained 62 unexplained gaps in June 2018. For another person, the MAR charts did not have their name or the date entered on them. The care coordinator told us no one had responsibility for checking that MAR charts were completed correctly and told us they planned to introduce medicines audits but that this had not yet been implemented. This meant we could not be certain that people received their medicines as prescribed. This put people at risk of becoming unwell.

We found most people had risk assessments in place. These covered areas including mobility, the physical environment, hazardous substances and medicines. However, these risk assessments were basic, and largely consisted of a tick box exercise to indicate if there was a risk or not. For example, one person's care plan stated, "[Person] is blind but due to the familiar surroundings [person] is able to negotiate within [their] own environment with ease. [Person] needs support when accessing the shower and the support of one other is needed to remain safe." This person did not have a risk assessment in place in relation to their visual impairment and there was no detail in relation to how they could be supported in order to keep them safe.

Another person's care plan said, "Poor mobility (zimmer frame) manual handling support for transfers." This person's care plan was reviewed in October 2017 and stated, "High risk of falls. [Person] had a fall in the past and broke [their] knee. [Person] have [sic] to be mobilised from one place to another with wheelchair or walking frame. Two carers need to support [person] with such task." This person's subsequent risk assessment for their mobility was rated as "low", however, there was no mitigation plan in place on how to reduce the risk of falls and what the specific risk factors were.

A third person's care plan stated, "[Person] has episodes of agitation which results in [person] becoming short of breath when things are not done [their] way. This normally happens about three times a week. [Person] finds it difficult to breathe over very little exertion and fatigue due to [their] cardiac diagnosis." This person did not have a risk assessment in place to support care worker's in mitigating the risks highlighted or what emergency action needed to be taken if the person became breathless.

After the inspection, the provider sent us documentation to show that they were reviewing all of the people who used the service to make amendments to care plans and risk assessments. In addition, they sent us information stating that people who were supported with medicines were having their MAR charts reviewed

and audited.

At our last inspection, people we spoke with consistently told us care workers were late. In addition, at our last inspection, a sufficient number of care workers had not been deployed to meet the needs of people who used the service. At this inspection, we found that more care workers had been recruited, however the number of people using the service had also increased substantially and the issues around punctuality had not been fully resolved. The care coordinator told us that staff were "usually good" with their time keeping but we received mixed feedback about care worker punctuality. People and relatives told us if their care worker was running late, they would be informed and others told us punctuality was "Not too bad", however, one person told us, "They give me my medicines and of course if they are late so are the medicines," another person said, "Timing can be a bit variable," a third person explained, "Timing is terrible, 10 or 15 minutes is one thing but an hour or hour and a half is unacceptable." A relative told us, "Our previous regular was always on time but the others vary, often an hour and a half late, and they don't let us know."

During our inspection, we saw that the service used a system called 'CM2000' for monitoring care worker attendance and punctuality at their visits to people. Staff logged in and out of each shift by telephone. This system alerted office staff if a staff member did not arrive on time for a visit. One of the care coordinators told us if there was any lateness recorded, they in turn telephoned the care worker and then telephoned the person to advise them of the situation. Although people told us they were often informed of any lateness, some people stated that communication was poor.

A care coordinator showed us their CM2000 system that showed various occasions where care workers were not logging in upon arriving and leaving a person's home. This care coordinator explained, "Our log in rates at the moment are not the best. There are a few reasons for that [care worker's not logging in]. Some service users get annoyed if we use their phone and that their phone bill will increase. We tell them it's a free number. We are doing our best to address this. The admin' assistant is keeping a log of everyone who hasn't been logging in and the messages we send to care workers." They also explained, "We've set the system up to alert us of the high risk service users if there is no log in at the time of the visit." The care coordinator told us what action they took if a care worker did not attend a visit and stated, "If we do have a missed visit, then we remove the care worker from the visit straight away and put in a replacement." Despite this, people still reported that their care workers were not always punctual.

The above issues meant that people's medicines continued to be managed unsafely and risk mitigation was not thorough or robust. In addition, staff punctuality and reliability continued to be inconsistent, having a negative impact of people's safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a safeguarding adult's procedure in place which made clear their responsibility to refer any allegations of abuse to the local authority and the Care Quality Commission. The care coordinator told us there had only been one safeguarding allegation since our last inspection and this had been referred to the local authority and CQC. There were also policies in place about whistleblowing and protecting people from financial abuse which helped to keep people safe. People who used the service told us they felt safe with their care workers. One person said, "Yes, they are very good." Another person said, "I have three different bits of equipment in use so they have to be ultra-careful and they are." A relative explained, "[Relative] has care four times a day and [relative] does feel safe with them."

Care plans included contact details of people's relatives and GP, which meant staff could contact them in an emergency. Staff were aware of what to do in an emergency and one member of staff told us they had called

an ambulance for someone.

Infection control practices were reflected in people's care plans and care workers told us they had access to protective clothing and gloves. One person's care plan said, "Always use gloves when in contact with body waste, never re-use gloves, take off gloves inside out and dispose of in a plastic bag."

Accidents and incidents were recorded. For example, one person had missed their medicines and their report stated, "Medication error. Care worker noticed that medicine was missing from blister pack. [Relative] said [they] had accidentally given [person] the medicine. Carer contacted out of hours doctor who advised it shouldn't be a problem." In addition, we saw email correspondence showing that the service had contacted the person's health professionals to inform them.

The service had staff recruitment procedures in place. Records confirmed that checks were carried out on prospective staff before they commenced working at the service. These included employment references, criminal records checks (DBS), proof of identification and a record of the staff's previous employment. This meant the service had taken steps to ensure suitable staff were employed.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, there were no records to show that staff were receiving adequate supervision. At this inspection, we continued to find gaps in supervision. The provider's supervision policy stated, "Focus Care Link is committed to providing its care staff with formal supervision at least six times a year [the minimum would be four]," however we found that this was not the case. For example, one care worker who had been employed since April 2017 did not have any supervision records on file, another care worker who had been employed since November 2017 also did not have any supervision records on file. A third care worker did not have supervision on record since 2016. Of the seven care worker files we looked at, we did however find that two care workers who were employed in March 2018 had received supervision in July 2018 and another two had received supervision in April 2018. A care coordinator told us they were working with the two newly recruited care coordinators to implement supervision as per their policy.

The service employed a training manager who showed us records of training that had been provided to care workers. This included health and safety, continence, hygiene, managing challenging behaviour, safeguarding adults, equality and diversity, medicines, fire safety, dementia and mental capacity. Training records showed that training for care workers was up to date. Newly recruited care workers took part in a week-long induction, shadowing and competency testing by way of written tests.

A care worker told us about the training they had received and said, "We had training here first, one week." In addition, they told us they had medicines training which included a test, but were never told if they had passed the test or not. Records showed that this member of staff had taken a test and scored below 50%, but that no additional training was offered or provided. In addition, this person had taken a first aid test and scored below 50% but again, no additional training was provided. Another care worker told us, "We got a week's training." They also explained after their medicines training they carried out a role play in the class pretending to administer medicines to a person, but couldn't remember if there been any written assessment of capability to administer medicines.

After the inspection, the provider informed us that all care workers would be receiving refresher training, specifically in relation to medicines. The provider also sent us supervision records that had been completed after the inspection, and also supervision records that we were not shown during the inspection.

The lack of consistent supervision, coupled with the absence of communication in relation to the low marks in competency tests meant that staff were not being supported to maximise their skills to ensure that safe practice was being adhered to. This was a breach of Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Care plans recorded whether or not people had the capacity to make decisions. People had signed an 'Agreement to the care plan' document which indicated they consented to staff providing support in line with their care plan. People had also signed consent forms to agree to the service sharing personal information about them with the regulator of health and social care in England. People we spoke to told us their consent was obtained before receiving care and support from care workers.

Care plans contained information about people's involvement with health professionals. Records showed that as a result of one person's care plan review, the service made a referral to a healthcare professional due to the person's risk of falls. Their care plan stated, "The client is at high risk of falls. OT [occupational therapist] is required." Email correspondence between the service and relevant health team showed that a referral had been made.

Where people required support with meal preparation this was set out in care plans. Some were more detailed then others. For example, one care plan stated, "Make cereal and a cup of tea or coffee [for breakfast]." Others simply said to prepare breakfast. However, staff told us they supported people to make choices about what they ate and drank. One member of staff said, "I always ask what would you like for breakfast. Those who can't say, point." The majority of people we spoke with told us they prepared their own meals or that they were supported by family. One person who was supported by their care worker said, "[Care worker] does my meals and makes me whatever I want, sausage and mash is my favourite."

People and their relatives told us they were involved in a pre-assessment prior to receiving care. One person said, "Yes, we had a home visit and some paperwork." Another person told us, "Yes, we got a visit and lots of paper." A relative told us, "Yes we did and a visit." However, during our inspection, we found that care plans did not contain pre-assessment information and one of the care coordinators told us the pre-assessment documentation was the risk assessments within people's care plans. We recommend the service seeks advice from a reputable source in relation to pre-assessment documentation.

Good

Is the service caring?

Our findings

People and relatives provided positive feedback on their care workers and told us they were treated kindly. Feedback included, "[Care worker] is really lovely, she makes me feel very much cared for," "I have two regulars and they are great, always willing to do extra," "The one we have got now is very very good and she chats with my [relative] even when she can't chat back."

People we spoke to also told us how care workers treated them with dignity and respect. Feedback included, "They are very respectful, and they always call me by my name," "They are always respectful and treat me as a person," "They are really nice and we chat while they help me," "Well she is like a friend, and always listens to what I have got to say." Relatives also told us how their family members were treated by care workers. Comments included, "They talk and listen to [relative] all the time they are with her and she says they are wonderful," "Our previous regular was such a treasure, but they all treat [relative] with respect."

Care workers told us how they supported people in a dignified way, in particular when carrying out personal care. One care worker told us, "You have to involve them in what you want to do, you have to ask their permission. If there are curtains you close them to make sure they are not exposed. What they can do for themselves leave them to do that." People who used the service reiterated how they were supported in a dignified manner. One person explained, "They make sure that all the curtains are closed and I am covered up when I am not dressed." Another person said, "They are really careful not to expose me at all." A third person told us, "My two are very good and make sure that all doors and curtains are closed and I am covered up when they are doing shower and dressing." A relative said, "They always have doors shut while [relative] is having her wash and being dressed."

People told us they were actively involved in decisions about their care and told us care workers were flexible in meeting their needs. For example, one person said, "My carer is as flexible as she can be." Another person said, "They do as I ask, so that means changes to routine as well." A relative told us, "Yes, changes are made all the time, if [relative] doesn't want his bath they play cards or chat with him."

Staff recognised the importance of treating people as individuals. A care coordinator told us, "We can't discriminate anyone. We are mindful of matching people with their needs, for example culture, religion, gender."

Requires Improvement

Is the service responsive?

Our findings

One of the care coordinators explained how they devised the rota and decided which staff worked with which people. They said they took into consideration what the person wanted, for example in relation to the gender of their care staff. In addition, they sought to match staff with people where they had relevant experience. For example, one member of staff had a lot of experience working with people with mental health needs and they worked with people at the service who had those needs. The care coordinator told us, "I always try to have at least three care staff who are familiar with a service user." This meant if one member of staff was not available they were usually able to provide a member of staff who had worked with the person previously and knew their support needs. One care worker who spoke a specific language told us they had been paired with a person who spoke the same language in order to support them in a personalised way.

At our last inspection, we made a recommendation about complaints. At this inspection, we saw where complaints had been made, they had been dealt with in line with the service's procedure and where possible to the satisfaction of the complainant. For example, records showed one person had complained that they were not happy with their care worker who was subsequently removed from providing care to that person. Another person complained about staff punctuality and we saw this was addressed with the relevant staff members. One person told us, "I have raised concerns and they were acted on." Another person said, "I can and do raise concerns and they get dealt with."

People and their relatives told us they were involved in contributing to their care plan. One person said, "I have a plan and my [relative] and I both contributed to it." Another person said, "I have a care plan and I helped them write it." A third person explained, "I have a care plan and I was in the discussion about it." A relative told us, "Yes, they just reviewed it and I was fully involved."

The care plans we reviewed gave a brief overall outline of what people required support with. For example, the care plan for one person stated, "Support me with bathing, strip wash, dressing, skin care and toileting needs." There was no further explanation of what these tasks involved for the person. For another person the care plan stated, "I need assistance washing and dressing, changing pad, meal preparation, medication and keeping the environment clean and tidy." The care plan for a third person stated, "Assist me to have a wash, get dressed and prepare breakfast with a drink." The care plan for a fourth person stated, "Assist me to have a wash, get dressed."

Care plans contained information about people's interests and hobbies, for example, one person's care plan stated, "Attending the mosque on Friday, accessing the local community and shops, listening to the television". However, care plans lacked detail about whether people needed support from care workers to attend community activities and how they would be supported in their own homes.

Care workers we spoke to demonstrated that they knew the people they cared for well and relatives we liaised with expressed that care workers were flexible to people's needs and that they were involved in the care planning, however the specifics of people's preferences were not always reflected in people's care

plans. We recommend the provider refers to best practice guidelines on care planning and recording.

Care plans failed to address people's end of life wishes and preferences and people we spoke to told us they had not been asked about this. We recommend the service seeks best practice guidance on how to support people in relation to end of life and how to record this in care plans.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection the registered manager lacked oversight of the quality of care being provided. They had failed to carry out regular quality checks and audits and had failed to minimise the effects on people who used the service as a result of consistently late visits. At this inspection, although we found audits were taking place and that people who used the service and staff spoke more positively about the management of the service in comparison to our last inspection, management oversight of medicines, risk assessments and supervision continued to be prevalent. Since our inspection, the provider has sent us additional information in relation to the improvements they aim to make, along with supporting documentation.

A care worker told us about the manager of the service and said, "They are good. When I call them, they help me." Another care worker told us, "They listen and take on board what you say." People and their relatives we spoke to gave us positive feedback about the management. Comments included, "Very approachable" and "Yes, I have spoken to management many times."

The care coordinator told us after the previous inspection they had realised that there was not enough office based staff employed to manage to service effectively. They told us the service had recently recruited a second care coordinator, two field supervisors and an administrative officer to help with the running of the service.

Various quality assurance and monitoring systems had been introduced since our last inspection. Senior staff carried out spot checks at people's homes which included talking with people. This involved asking people if there had been any instances of staff not turning up for visits, if staff were punctual and whether they stayed for the full amount of time and if people were happy with the staff that supported them. One person told us, "We have had several phone calls and questionnaires." Another person stated, "Yes, they come and tick the boxes." The spot checks also involved some monitoring of the staff that were present at the time of the check.

One of the care coordinators told us they were introducing a system of phone monitoring. They said this would involve phoning each person monthly to see if they were happy with the service or had any concerns. This had only just been introduced and not all people had received monitoring calls at the time of our inspection. Records of phone monitoring that had taken place showed it looked at staff punctuality, if staff always turned up and if people were informed of staff running late, if staff wore protective clothing and whether office staff were responsive.

The service carried out surveys of people and relatives, the most recent of which was in January 2018 and we saw this contained mostly positive feedback. For example, one person stated, "I am very happy with the service" and "I like my carers, they are very supportive." Another person wrote, "The care workers are very nice and caring. They do what I ask them to do for me and that give me confidence. I would really love to keep the same carers all the time. The care workers listen to me and respect me."

Team meetings were taking place on a quarterly basis and records confirmed this. A recent team meeting

discussed topics such as missed calls, annual leave, recruitment, telephone audits and care plan audits.

A care coordinator told us they had attended local authority provider forums. Feedback from one of the local authorities we spoke with prior to our inspection had highlighted issues around poor timekeeping of care workers, risk assessments not being robust and a lack of staff supervision.