Focused Healthcare Limited

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 8 November 2018 and was announced. Focused Healthcare Limited provides nursing and personal care for children and young people living in their own homes. This service is a domiciliary care agency. At the time of the inspection there were 80 people using the service.

There was a registered manager in post at the time of the inspection. The registered manager was not present during the inspection because they were on long term sickness leave. An interim manager was managing operational aspects of the service with support from the provider. 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 the Health and Social Care Act 2008 and associated Regulations about how the service is run. Since our last inspection the service had changed to a new registered provider.

At our last inspection on 31 March 2016 we rated the service Good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns.

Risks for people were identified by staff. Risk management plans contained sufficient information for staff to manage and mitigate those risks. However, people's daily records were not always completed as recommended. Staff followed the provider's infection control policy to reduce the risk of infection.

Medicines were managed and administered safely. There were established systems in place for the administration, storage and disposal of medicines. We found the quality of the medicine administration records were not robust because staff did not always indicate when medicines were given to people. Staff completed training in medicines management and had their competency assessed.

There were established safeguarding systems and procedures in place. Staff understood how to protect people from harm and abuse. Safeguarding training was completed by all staff which helped them to take appropriate action to manage any allegations of abuse. These concerns were reported to a manager and to the local authority for investigation.

Enough staff were available and deployed to provide safe care to people. Safer recruitment processes were used to ensure suitable office based staff, nurses and care workers were employed at the service. Pre-employment checks were returned before staff were approved as suitable to work with people.

Relatives said staff were caring. Staff delivered care, support and treatment in a compassionate manner to ensure people received dignified care while maintaining their privacy.

Staff continued to receive an induction, training, supervision and appraisal. Staff were encouraged to explore and reflect on their jobs.

People were supported to have maximum choice and control of their lives and staff provided care in the least restrictive way possible for people. The provider's policies and systems in the service supported this practice.

Staff asked people for their consent before providing care and treatment. People's choices and wishes were recorded in health and care needs assessments. Care records were completed with and signed by people and their relatives. People were provided with copies of their assessments and care plan so they were aware of the support provided to them.

People had the care and support they needed that valued their levels of independence. This helped people continue their education and to take part in activities they enjoyed. Staff met people's end of life needs when they required this specialist care and support.

Staff completed shopping for people when this was needed. Staff supported people with maintaining their nutritional needs which supported their health care condition and met their preferences.

The provider had a complaints procedure in place. Complaints were managed well and investigated with a written outcome send to the complainant.

The quality of the service was monitored and reviewed. An action plan was put in place to address any concerns found. The manager had developed working relationships with health and social care organisations.

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.

Medicines were managed safely so people received them as prescribed. However, medicine administration records were not always accurate.

Staff assessed and identified risks for people and management plans guided staff to manage risks. However, people's daily checklists and charts were not always completed to confirm essential checks of equipment had taken place.

There were safeguarding processes that guided staff to protect people from the risk of harm and abuse.

Safe recruitment practices were used to employ suitable staff to work with people. Enough staff were available to support people safely.

Staff understood how to protect people from and reduce the risk of infection.

Is the service effective?

Good

The service was effective.

Staff received support through induction, training, supervision and appraisal.

The manager and staff understood the principles of the Mental Capacity Act 2005 (MCA).

People were supported to meet their nutritional needs.

People had access to health care services when their needs changed.

Is the service caring?

Good

The service was caring.

People and their relatives said staff were caring and kind.

Staff respected people and care and support was delivered in a dignified way.

People made decisions about their care and support that was coordinated in an effective way.

Is the service responsive?

Good

The service was responsive.

Care and support was person-centred and staff supported people in the way they chose.

People were encouraged to attend activities they enjoyed.

Complaints were managed well and the complainant was responded to in a timely way.

People's end of life plans contained their wishes and opinions and these were respected and carried out accordingly.

Is the service well-led?

Good

The service was well-led.

The registered manager was absent from the service at the time of the inspection. An interim manager was supporting the operation of the service with support from the provider.

Staff clearly understood their role within the service. Staff said they felt supported by the manager.

The service had quality assurance systems in place. Staff assessed, monitored, reviewed and improved the quality of service.

Staff developed working relationships with organisations which helped to co-ordinate care and support effectively.

Focused Healthcare Limited

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 8 November 2018 and was announced. We gave the service 24 hours' notice of the inspection visit to be sure that they would be in.

The membership of the inspection team included one inspector, one specialist professional advisor who was a registered nurse and two 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.

We did not receive a Provider Information Return (PIR) for 2018. 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.

As a part of the inspection we spoke with 11 parents who gave us the views of their children and young people who were using the service. We were unable to speak with children directly. We also spoke with the manager, the clinical educator and clinical lead, two nurses, two care workers and a representative from the new registered provider.

We looked at records at the service related to the delivery of care, the administration and management of the service. We looked at 15 care records, five recruitment files, four staff duty rosters, quality audits and medicine administration records for six people.

We asked four health and social care professionals for their views of the service after the visit. We did not receive any responses from them.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe using the service. Relatives shared with us comments about how safe they felt when staff supported them. They included, "Yes, because they do such a good job and keep up with my child. If [my family member] is having a bad day with seizures I can feel assured that I can leave them alone with my child", "Yes with regular carers. We've had others where we have raised issues and happy with how they have dealt with it" and "Yes [we feel safe], I am more than happy to leave them in the house while I go shopping."

The provider had a medicines policy in place. The medicines policy gave staff clear guidance to administer medicines for people in a safe way. The medicines policy gave staff guidance in the different methods of administration of medicines whether this was oral, through an enteral tube (an enteral tube is a method of supporting people's nutritional needs through a tube placed down through the nose into the stomach or bowel) or a percutaneous endoscopic gastrostomy (PEG) tube. This involved the administration of prescribed medicines through a PEG tube attached directly into the stomach.

People told us that they received their medicines as prescribed. Relatives commented, "I do [my family member's] daily medicines before the care workers come", "One of the care workers has known us for a long time and can do it, if a new one comes I show them what to do and if I am happy she can do it" and "The carer does it and there are no problems, last week [family member] had a chest infection and got new medicines, the carers will only give medicines that are on his/her chart, that's fine because I do the other medicines."

At the last inspection we found the medicine audits did not identify the gaps in the medicine administration records (MARs) we looked at. The registered manager told us they had taken action to redesign the MARs so they contained accurate and up to date information. At this inspection we found five people's MARs contained gaps with no explanations for them or had missing information on them such as role of transcriber, doses of medicines not signed for so It looked like the person did not have their medicines as prescribed, and missing staff initials for administration of medicines. The current design of the MAR gave staff limited space to record when medicines were not given and specific codes were not always used to explain those gaps in the records. For example, some medicines were prescribed to be given twice a day but three MARs showed that they had only been given once a day. Care workers and nurses told us that parents sometimes gave people medicines, but this was not reflected on the MARs. There was a system for reviewing people's MARs but it did not identify the issues we found with the inconsistencies of recording. We also saw information about an incident where a person was given their prescribed medicines but staff had not taken their MAR with them.

We recommend the provider seeks guidance from the Royal Pharmaceutical Society in relation to the safe completion of MAR charts.

Staff assessed risks to people's health and well-being. Risk assessments looked at people's needs which included their mobility, health care, eating and drinking and support required with medicines management.

A risk management plan was developed and put in place for staff to follow to manage risks. The care logs we looked at demonstrated that staff followed guidance to keep people safe by managing those risks. For example, when a person required support to manage their swallowing and meeting their nutritional needs, this was clearly recorded and made available to staff. However, we found that there were inconsistencies in how staff recorded this on the charts. Checklists for tracheostomy, ventilator, weekly equipment changes, hourly ventilator observation charts and ventilator temperature checks were not always recorded as required. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe to assist breathing. When checks had to be recorded, either daily, twice daily or weekly these were not always completed. We showed the manager of the service our findings and they told us there were plans for reviewing these charts.

There was an infection control policy in place at the service. Staff had access to personal protective equipment (PPE) such as gloves and aprons. PPE stocks were available to staff at people's homes or in the office. Staff followed the infection control guidance in the policy to manage risks relating to infection control and hygiene.

The provider had a safeguarding process in place that protected people from abuse. Staff understood what safeguarding was and how they would apply their knowledge to protect the children they supported. Staff had completed safeguarding training relevant to their roles. Nurses completed level four and care workers completed level three training in safeguarding. All staff completed refresher training to ensure they were updated with the requirements of safeguarding processes. Staff said they would contact their manager if they had a concern about the safety of a person they were supporting. Staff comments included, "If I was concerned about the safety of a child, I would escalate this up to the clinical manager", "If I was worried about a child's safety, I would phone the social worker, fill in an incident report and report to my line manager straight away" and "I would alert the safeguarding officer, document and raise any concerns." The manager had followed their safeguarding policy and referred an allegation of abuse to the local authority safeguarding team for investigation.

People had the support from enough staff to meet their needs safely. We reviewed staff rotas for nurses and care workers. We found that sufficient time was provided for staff to travel between care visits. This ensured people received their care and support as expected. Each person was allocated one and often two members of staff based on their individual needs to support them. We received mixed feedback on whether there were enough staff available. Comments included, "No. They have staffing problem. They cancel shifts at very short notice. I should get support five days a week. I can only trust one carer, who I recruited, for three days. The other two days are always cancelled because they struggle to find carers", "Yes, because me or my partner stay in the home. We should have two carers but often they send one carer so we have to stay at home", "There don't seem to have enough trained available staff. Current carer is on time. In the past we have had some seriously ropey individuals [care workers] always late" and "At the moment we have regular slots and carers. We've not had carers to fill in when regular cares on leave." There were enough staff employed at the service however, people did not always receive a continuous and reliable service.

There were safe recruitment practices used in the service. This ensured that suitably, qualified, skilled and knowledgeable staff were employed at the service. Each of the staff recruitment records we looked at contained documents relating to the application and recruitment process. Staff showed proof of their UK nurse registration with the Nursing and Midwifery Council (NMC). The NMC is the regulator for nursing and midwifery professions in the UK. Newly employed staff provided two references including an explanation for any gaps in their employment history and proof of the right to work in the UK. A criminal records check was completed with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working in care services.

Good

Is the service effective?

Our findings

People were cared for by staff who were effective in their roles. People and their relatives were involved in the assessment process and their opinions and choices were identified and recorded so these met people's requirements. Following the assessment people were provided with a copy so they were aware of the care and support to expect from staff.

People had specialist equipment at home to meet their individual needs. Staff told us and records showed that training was completed in the use of equipment so people were cared for in a safe way. We received mixed views on staff's ability to use equipment. Relatives told us, "Yes staff are trained to use the equipment by the hospital staff and I do one month's training and induction because I think it's important that they know what they should be doing and I can trust them so I train them", "The agency briefs the carers before the first shift. They try to arrange a meet and greet. Training manager visits to check the care workers training on site as well as their training in the office", "Sometimes they take care workers who don't know how to use the hoist or do things. They should be giving us a break but they are giving us more stress because the care workers don't know how to do anything, change nappies, wash, or use a hoist. Some care workers, if they come regularly, they do" and "Sometimes the staff complain because they don't have training about the feeding tubes through the nose. I normally do it with carers because I'm scared they may do it wrong such as check the PH level. They train for PEG feeding not for the tube through the nose." We checked the training records for nurses and care workers. Records showed and staff told us that they had completed training in the use of specialist equipment. However, from the comments we received individual staff competencies were not met following training in the safe use of equipment.

We recommend the register provider seek guidance about suitable educational resources so staff are effective in their roles.

The manager of the service supported staff. Each member of staff was supported through an induction when they began working at the service. All staff said they had undergone induction training. The induction programme supported newly employed staff to shadow experienced staff and become familiar with the service, policies, procedures and to understand the needs of children who received care, support and treatment. Staff commented, "They have introduced online e-learning, which has increased the completion of training and the in-house training has had improved attendance due to the service now paying staff to come for training", "All my training is up to date and if it isn't then they email me or phone me if it needs updating" and "I work with children with tracheostomies and to get experience the carers sometimes swap around." "Every six months all carers get tracheostomy training all together which is good for peer support. The in-house training also includes oxygen therapy and measurement, oral suctioning training, management of autism, learning disabilities, behaviour training." The clinical lead said, "The compliance team get alerts when mandatory training is due."

Staff also had training, supervision and an appraisal to support them in their roles. Mandatory training included safeguarding children, health and safety, moving and handling, ventilator and tracheostomy care. Nurses were supported to maintain their professional development and registration with the Nursing and

Midwifery Council (NMC).

Staff had regular supervisions and an appraisal with their line manager. These meetings were used to identify staffs' professional development needs. Meetings were conducted in a flexible way. Staff who were unable to visit the office had supervision either at home or through telephone calls. Supervisions and appraisal meetings gave staff the opportunity to reflect on their job performance over the past year and for their manager to discuss any performance, training or development issues or needs. Staff confirmed that they had regular supervision and appraisals which they valued.

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 were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. From the discussions we had with staff they understood how to care for a person who needed care within the framework of the MCA. However, for some children and young people using the service they would not be cared for within MCA. The MCA protects people over the age of 16. Staff were aware of The Children's Act 1989 and 2004 which specifically protects the needs of children and young people. Staff understood the concept of mental capacity and how to care for people when they lacked capacity to make decisions themselves.

People gave their consent before receiving care and support. People and relatives said staff asked them for consent before providing care and treatment. Records showed relatives signed care records and assessments and gave their written consent to care and treatment.

People were supported with meals, which they enjoyed and their food choices met their needs. People and relatives said, "They need to support my [family member] to eat, they have to be in the proper position and must be monitored as she/he has a swallowing problem and can get juices in her/his lungs [staff follow this guidance]" and "They give my [family member] breakfast with no issues and they are always watching out for choking." Staff understood people's nutritional needs. When people required a specialist diet, nutritional guidelines were followed by staff. For example, when a person required their meals via a percutaneous endoscopic gastrostomy (PEG) this support was provided by staff.

People's health care needs were monitored and reviewed by healthcare professionals. When people's needs changed staff referred them for specialist support, advice and an assessment. Staff knew people well and would alert clinical managers if people's health deteriorated. Staff knew how to refer people for treatment in an emergency if they became acutely unwell. Records showed that people received support, advice and equipment from occupational therapists, hospital teams and people's GPs.

Good

Is the service caring?

Our findings

Relatives said staff understood their family member's needs and showed kindness and compassion. Comments included, "Yes, my [family member] has a relationship with individual staff. They give hand massages at night. Talk to him/her and stroke their face" "My [family member] is severely disabled and they treat her/him like a person. They treat her/him like a child. They are very respectful", "Some carers are so nurturing kind and caring, one of them is a mother and grandmother and you can tell, she is great", "They are always caring and compassionate" and "They are very flexible and whenever my [family member] had to go into hospital or comes home they accommodate. We have a good relationship with our two carers."

Care and support was delivered by staff to promote people's dignity and privacy. People told us staff were respectful of how they carried out personal care for them. A relative said, "They always shut her/his door when she/he is being cared for."

Staff completed records of their care visits to ensure the support delivered reflected people's needs. We reviewed the care logs which showed staff had provided care in line with the care plan, because staff documented the care they had provided. Each care log was returned to the service and these were reviewed to ensure they were of a good standard.

People were encouraged to maintain their independence. Staff supported people with their care and support needs. However, staff motivated people to be involved in the management of their care and support as much as they were able. For example, one person was supported to decide which care workers that wanted to manage their care. The person met the care workers and provided them with training in managing their specific needs before staff could provide care for them This approach meant people could manage their own care and support which helped people maintain some control over their lives.

Good

Is the service responsive?

Our findings

People received care and support that was personalised and met their needs. Before people received care and support an assessment of needs was completed with them and their relatives. Assessments were completed by the clinical nurse managers who looked at the specific needs of people to make sure they received appropriate care. Nurses and care workers were introduced to the child and their family so they become familiar with each other. Assessments gathered information about people's individual likes, dislikes, health care needs and communication needs. The outcome of the assessment was used to develop the care plan which staff followed to ensure the care provided was appropriate. Staff told us that they discussed every aspect of care and support with people and their families. Staff recognised that each family was different, and the involvement was different for each family. A member of staff said, "Each person is assessed on an individual basis."

People's private information was documented in line with the Accessible Information Standard (AIS), for example; providing documents using large print books to ensure these were accessible. The AIS makes sure that people with a disability or sensory loss are given information in a way they can understand. We saw records were written so people and their relatives could understand the information presented to them. One member of staff told us they used flashcards to communicate with some people with communication difficulties. Flashcards are often used with people who have communication needs and contained symbols and signs which were used by people to aid positive communication. Another member of staff told us they communicated with a person using sign language and it worked well. They said that the person was able to talk with them and respond to questions asked. The use of sign language helped the person to communicate their thoughts, wishes and choices. Care records documented people's communication needs and the support they required to communicate with staff and others.

People's care and support was reviewed. Care plan reviews looked at people's individual needs and recorded them to ensure the care and support was appropriate. Following care reviews care records were updated so the most accurate information was available and the care continued to meet people's needs. Relatives said that the staff did what was expected of them in a way they agreed. One relative said "They're okay with me and explaining things. I equally listen to them because they have experience and may suggest I try things. They give [my family member] time to respond.''

People took part in activities they enjoyed. Relatives told us that staff supported their family member to access their local community. They told us, "Yes they take her/him to the park", "In the summer they take her/him out in our garden", "To be honest we go out, the carer takes her to school, we can't take a risk with the cold as she is always getting chest infections and can be in ICU for a long time" and "Staff are used as a school escort, or the Saturday care worker will take him/her out for a walk." Staff provided practical support and advice to others involved in people's life. For example, staff completed a project with a local transport service. Staff provided training and developed guidance for the safe use of wheelchairs during school escorts to the transport staff. The guidance referred to the child's specific needs and support required for a journey. A competency assessment and a wheelchair safety check was completed by a school escort to ensure they were safe and had the skills and knowledge to support the young person to school.

Before this training, the young person was unable to use the transport because the transport staff did not have the knowledge to support the person to get onto the transport because they did not know how to manoeuvre the wheelchair and were concerned about this risk. This training enabled staff to gain knowledge and skills to support the young person to access the transport safely so they continued their education because they could now access transport to go to school. Staff also shared other examples of training care workers to support and escort other children to school, supporting children and their families whilst a child is in hospital and support children on family holidays.

Care records included people's end of life care needs. Staff understood how to provide palliative care when people were at the end of their life. Nurses and care workers had received training in how to care for a dying person. Care records detailed information on how care was to be provided and staff told us end of life care for some people was symptom and pain control management. Staff told us that they were well supported after people had passed away. Managers supported staff to attend funeral services and time was set aside for staff to reflect on the person who died.

The registered provider had systems in place to manage complaints. The manager followed the complaints process to investigate complaints and to provide a response following the investigation to the complainant. People said they knew how to make a complaint and some people had raised concerns with the service about the care and support they received. Relatives commented, "A complaint is still in the process of being sorted. I've asked for a meeting with Focussed Healthcare, continuing care, and social care. Focused Healthcare is in the process of doing things. They have removed the care worker. I want to give them the opportunity to put things right", "One lady who works there who I trust completely and she always sorts it out. Yes, issues around training have been resolved" and "Yes in three years we've had three issues [complaints]. One carer I couldn't work with. The issue is being investigated and they explained the steps they were taking and I am happy."

Good

Is the service well-led?

Our findings

People said the service was well-led. There was a registered manager at the service, however at the time of this inspection an interim manager was supporting the service. People all knew the registered manager by name. One relative said "I think [the registered manager] used to be [manager's name] I've heard they are merging with another company but I'm not sure. From the conversations with people and staff they did not always know who was the manager of the service was and were not clear about the merger with the new provider. Staff comments included "She is noticing changes now Voyage has merged, she likes the newsletter as it makes her feel part of a team when lone working a lot" , "[Communication with management is] very good working here, very communicative" and "Most people don't know that [the new provider] has merged but she has noticed improvements such as the paying for training days, the paperwork, regular training, changeover of staff and the communication has improved too."

Staff we spoke with said the overall management of the service was of a good standard. Staff said they were supported and felt listened to. They commented that working at the service was ''brilliant'' ,"They don't force you to be in a package [of care]" , "Feels that I can talk to everyone if I has a problem" and "The new management is good and the new processes for education are good. I feel well supported when there are family difficulties."

Staff attended regular team meetings. Nurses also attended weekly clinical meetings to discuss and review people's care, treatment and support needs so they were familiar with any changes or updates. Team meetings provided staff with the opportunity to contribute to them and share ideas with colleagues. The provider had a newsletter for staff. This contained information about the provider and any changes or developments occurring in the service. The newsletter was accessible to all staff and kept staff updated with what was happening in the service.

The provider had established systems to review the quality of care. Regular reviews took place at the service. Staff audited medicine administration records, care records and clinical records to ensure these were of a good standard. The quality of care provided to people was reviewed. Each member of staff providing care had spot checks. Spot check observations assessed staff's competency in providing person centred care and in line with the provider's standard and requirements.

Each year relatives were provided with an annual questionnaire and regular telephone quality reviews. Clinical managers also completed home visits with families once a month. The questionnaires, quality reviews and home visits enabled people and relatives to give their feedback on their care and support. People rated the service highly and most stated they were satisfied with the level of care they received. While some of the feedback was positive we received some feedback that was not so positive about the service, including the inconsistencies in care workers. The service produced a quarterly newsletter that was used to communicate information about the service with families.

Staff had developed working relationships with health and social care services. Interagency meetings were held with staff from the service and representatives from health, education, social care and voluntary

agencies. These meetings enabled people's holistic needs to be identified, discussion held and decisions made on the appropriate support for people to help them improve of maintain their health and wellbeing.