Link Community Care Limited

Link Community Care (Tottenham)

Inspection report

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Date of inspection visit:
10 November 2017
11 November 2017

Date of publication:
23 January 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 10 and 11 November 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service. At the time of the inspection Link Community Care provided domiciliary care and support for 25 people in their own home. The service worked primarily with older people all of whom were living in the same London borough.

This was the first inspection of the service since registration in August 2016.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults.
Not everyone using Link Community Care 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.

There was a registered manager in post. 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. The registered manager was present during the inspection.

Procedures relating to safeguarding people from harm were in place. Staff we spoke with understood what to do and who to report it to if people were at risk of harm. Staff had an understanding of the systems in place to protect people who could not make decisions and were aware of the legal requirements outlined in the Mental Capacity Act 2005.

The service operated safe staff recruitment procedures and ensured that all staff were suitable for the role before beginning any care work.

Medicines were managed safely and the service was expanding on the number of people that they thought may benefit from staff prompting people to remind them to take medicines.

Risk assessments provided staff with guidance on how to mitigate people's individual personal risks. Risks had been clearly identified and risk reduction measures were identified and acted upon.

Staff were provided with a suitable induction as well as on-going regular training and supervision to support them in their role.

People were involved in planning their care and had regular reviews to gain their opinion on how things were. Staff knew people well and people and relatives felt that they were treated with dignity and respect. Care plans were person centred and included information on how people wanted their care to be delivered as well as their likes and dislikes.

People and relatives were provided with information on how to make a complaint and their views were obtained and acted upon. People were treated with dignity and respect and trusted the staff that supported them.

People who used the service, relatives and stakeholders had a range of opportunities to provide their views about the quality of the service and the provider monitored the performance of the service.

Further information is in the detailed findings below.

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 provided with training and guidance to enable them to recognise abuse and how to report it.

Risk assessments provided staff with appropriate guidance on how to keep people safe and this included medicines management. Medicines were managed safely.

The provider followed safe staff recruitment practices and people received a continuity of care and on most occasions had the same staff visiting them.

The provider had taken steps to understand and learn from any incidents that occurred for future reference.

Is the service effective?

Good

The service was effective. People's needs were assessed in consultation with them and their family if appropriate.

Staff received regular training and an induction before commencing their work.

The service worked in line with the Mental Capacity Act 2005 (MCA) and recognised how this influenced the care that they provided.

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 treated with respect and staff maintained privacy and dignity.

People were encouraged to have input into their care and their views were respected. We were informed that care staff usually responded with kindness and respect for people and paid attention to them when providing care.

Is the service responsive?

Good

The service was responsive. People's care was person centred and planned in collaboration with them, which people and relatives confirmed.

The provider monitored the care provided to people using spot check visits and regular phone calls to people to ask them about the quality of their care.

People knew how to make a complaint. There was an appropriate complaints procedure in place and the provider responded to any complaints that were made.

Is the service well-led?

Good

The service was well led. People were asked about their views on the support they received from the service.

The registered manager had a monitoring system in place to ensure care was assessed, audited and that people's needs were met.

People's views were obtained and were acted upon.

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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 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 10 and 11 November 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the registered manager would be present. The inspection was carried out by one inspector and an expert by experience that carried out telephone interviews with people using the service and relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at information that we had received about the service and any formal notifications that the service had sent to the CQC. We looked at five care plan records and risk assessments, five staff files personnel records and other documented information related to the management of the service.

During our inspection we tried to make contact with 18 people using the service and were able to speak with five service users and three relatives of other people who could give views on their behalf. We spoke with one care co-ordinator and the manager of the service. We sent emails to fourteen of the fifteen staff employed to provide care but did not receive feedback from any of them. We followed this up with the registered manager who said they would encourage staff to respond. Prior to this inspection we contacted the local authority that commissioned all of the care packages that the service provided but did not receive any feedback from them.

Good

Is the service safe?

Our findings

People using the service told us, "Oh yeah, I feel safe most of the time. Most of the time I know who's coming, it's spasmodic, they're not always on time but I'm getting used to it. Yes they do (stay the time)" and "We're in a routine and they just get on with it; I don't feel rushed". Another person did feel that staff were rushed although all of the tasks that staff were required to do were done.

A relative told us, ""Yes she's safe [their relative]. She's built up a tremendous link with people from the agency. I know because she's all smiley and happy. [in terms of any late visits they told us] Yes on time, give or take a few minutes and the office informs me if it's longer." Another relative told us ""Yes. He likes the carers. A man comes, and he comes on time. Sometimes he is a little bit delayed but he lets me know. I think [relative] wants him to stay, he cries when he goes. "Yes he [staff member] does everything 100%."

The service had a safeguarding policy that described the definition of safeguarding and the ways in which the service would respond to any concerns. The policy and procedure commented upon people's right to be protected from abuse regardless of their heritage or other diverse needs and that people had the right to be treated with dignity and respect. Types of abuse and the action that must be taken if abuse was suspected was also outlined. Staff were trained in safeguarding during their induction and had received this training prior to being able to begin to deliver care. A care co-ordinator told us about a concern that had arisen just before this inspection and the action that was taken. We looked at this and found that the action was suitable in response to the concern.

We viewed five people's risk assessment and care assessment records. We found in each case that people had risk assessment and risk reduction measures included in their care plan files. These were tailored to environmental common risks and any personally identified risk that the service needed to consider when providing care. Most people had only begun using the service in the last six months. The provider's risk assessment policy stated that risk assessments should be reviewed regularly but not how frequently the review should take place. We suggested to the provider that they should consider adding a frequency to the policy. However, the care planning policy did refer to risk assessments being included during at least annual reviews of care.

The service followed safe recruitment practices. Recruitment files showed pre-employment checks, such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. Where staff members required home office permission to work in the UK, this was documented. This minimised the risk of people being cared for by staff who were inappropriate or unsuitable for their role.

We looked at the arrangements in place to cover the care needs and call times that had been agreed with people. Although some people said there could be delays, most said they were informed about staff running late and that no calls were being missed. The service required staff to make a call to let the agency know they had arrived for their visit. This system worked well although the registered manager told us they were looking into another system for monitoring visits. Along with the on call out of hours contact number

this meant that any risk of missed or late calls were quickly responded to and it was reported by people that missed calls was not usually an issue.

Training records showed that all staff had undertaken medicines training since starting to work for the service. We were told by the registered manager that one person required assistance to take medicines. We looked at copies of medicines records for three previous months and these were completed correctly. The registered manager stated that staff thought other people may need reminding and this was being reviewed. We advised the provider that if that is found to be the case then that would need to be recorded. The one person who was being assisted to take medicines had fully completed records of administration including the medicine, the strength, and time to be taken and initial of the staff member that provided assistance each time. We asked the registered manager to ensure that both of the member of staff's initials be put into the chart not just the initial of their first name, which they agreed to do.

All staff were provided with personal protective equipment such as gloves and aprons that were supplied by the provider. We were informed that no-one using the service had any communicable illnesses or other conditions and that staff were required to use the equipment provided when carrying out intimate physical care. We were unable to verify this with staff although no-one using the service or relatives we contacted raised any concern that physical care was not being carried out appropriately.

The service recorded any incidents that had occurred and it was reported by people and relatives, as well as staff, that very few, if any, had taken place. The service responded appropriately to incidents or other events that had been reported. The registered manager was able to show us information that had been taken in response to a complaint made early in 2017. The service had used this experience as an education and discussion point for future reference. The registered manager had liaised with the local authority and discussed the complaint with staff in order to look at what could be learnt from the difficulties that the person had with accepting support.

Good

Is the service effective?

Our findings

People using the service told us ""I get the same ones, it's comforting to have them and we have friendly banter together. They say I'm rude and cheeky and we laugh." Others told us "Yes, I think so [when asked about whether staff respected their choices]. I'm able to do? some things [when talking about their physical care needs]. I'm independent and want to do things myself" and [about help with meals] ""I put it in the microwave sometimes."

Relatives we contacted told us "They are very, very flexible for my [relative's] need. They advise us on things. She has a hospital bed and a hoist. They know exactly how to use the equipment in respect of Health and Safety yes." Another relative told us "My [relative] doesn't eat sometimes and he helps him with eating some bread, (my relative) trusts him. He [staff member] does massage and exercises with him. He can walk with him and it's good for him 100%."

All people's care plans that we looked at had been compiled in recent months as they begun to use the service, all starting with a comprehensive assessment of need. None of these care plans yet needed review under the provider's care plan policy. The registered manager informed us that reviews would be carried out should anyone's care and support needs change and their circumstances required this to happen. This too was referred to in the care plan policy. The involvement of people, and their relatives if also involved, was included in care plans and consent to care had been obtained.

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. We checked whether the service was working within the principles of the MCA.

The provider was aware of, and understood, their responsibilities in relation to meeting the requirements of the MCA and the service assessed people's capacity. People's capacity had been documented on a specific assessment form which was included in their care plan records. Where people were unable to be involved in planning their care, relatives had been consulted and this was referred to on people's care records and the details of who had been involved and their relationship to the person were also included.

The service was clear about obtaining consent to care and had done so in all of the care plans that we viewed. These people had all consented themselves to their care and had not required anyone else to do so for them. People, and where relevant, relatives were consulted about care assessments and care plans. This involvement was recorded on assessments and care plans as often relatives might be present when these discussions were held.

Care staff received regular supervisions. Many of the care staff were new and had only recently begun to have supervision. Records of staff supervision confirmed the three month frequency for longer term staff in line with the provider's supervision policy.

The 15 care staff who were currently working with the agency to provide care were appointed within the last twelve months. Most of these staff were part time employees. An annual appraisal would not have yet been required for any of the care staff. The manager had recently reviewed the appraisal policy and this stated that a six monthly review of job performance was being introduced. This new system had yet to be implemented. We discussed with the provider the fact that when staff had passed their induction this had not resulted in any record of them having formally passed their probationary employment period. The registered manager said that their full contract of employment was not confirmed until after this although they would consider recording successful completion of a probationary period more clearly.

Induction included training in line with the Care Certificate, which is training for care workers which provides the fundamental knowledge and skills for people working in care services. Staff induction covered necessary core skills, for example, medicines, moving and handling and keeping people safe from harm. Induction commenced with a five day classroom based introduction followed by shadowing a mentor [an experienced care worker]. The length of shadowing depending on the experience of the person and the mentor reported how ready the staff were to begin working with people.

Care staff usually only provided light meal preparation for people where this was required. This was heating food up for people or making a snack such as sandwiches. All staff had been trained in food hygiene and nutrition. Where people required support with meal preparation or encouragement to eat, care plans documented people's likes and dislikes regarding food. Dietary needs were known about and these needs were met.

The registered manager informed us that care staff did not routinely attend healthcare appointments with people as this was usually managed by people themselves with assistance from their family or friends. However, the manager stated that this would be considered carefully if there was a need to provide assistance to do so if someone was unable to be assisted by a relative or friend.

Good

Is the service caring?

Our findings

People and relatives were invariably, with one exception, positive about the attitude of the staff. People said, ""They let me do what I can do; I can wash my face and they know that" and "They are caring. There's no argument about their manner." A third person told us about their care worker and said "He's been very nice and kind."

Relatives told us "Yes they do offer her choices. This morning they did her personal care and while one was tidying the bed and changing the sheets, the other moved her around. They show curiosity about her, asking her things like 'who's in the photo? They're angels!" Another relative said ""I'm happy. He's good [care worker], he's flexible. He is a good man. I love the job he does." With minor exceptions we gained an impression that people trusted the way that care staff supported them and their attention to what they did.

From the views that people did share with us it was evident that care staff respected people's privacy when providing personal care. Most people did not tell us in detail about whether they believed their dignity and privacy were respected, however, from the overall comments that were made these areas did not seem to be anything of any concern to people.

Staff supported people in making day to day decisions about their care. People and their family members told us that staff talked to them and discussed how people liked things to be done. A person told us "They let me do what I can do; I can wash my face and they know that." Relatives told us "They don't stop 'doing' for her. They greet her very nicely; they know her moods and always say 'shall we do this or that?'" and "Yes, these two [care staff], they understand her and put up with [relative] telling them what to do all the time."

The provider had clear policies in relation to the right of people to have their diverse characteristics respected. No one made any specific comments about whether the agency or care staff showed consideration for their personal, cultural or religious beliefs or heritage. One relative did say that they would like care staff who could speak there relative's first language which we include in this report for the agency to follow up with the person directly. However, from other comments made it was evident that people felt that they were treated with respect.

Good

Is the service responsive?

Our findings

Care plans were person centred and included people's likes and dislikes and the way they wished to be cared for. Information contained within care plans was specific to the type of support they required. For example, if people needed help to wash and dress this was included with details of how staff should do this in the way that people preferred. Some people needed help to have a meal or carry out domestic chores. Staff were given guidance about how this should be done.

Care plans were specific to the agreed care that staff were required to provide in line with the initial assessment of care needs. The service had a daily log recording the care provided to people at each visit. The registered manager told us that four weeks previous log sheets were always held in the person's home and the older log sheets were returned by care staff each month for review and holding on each person's central care records.

A person told us "There was one occasion when I had to go to hospital and came back I was frustrated that no one came to help me to bed in the evening. I wasn't happy with the way (a different agency) handled it but I was satisfied with how it worked out with this one, they sent me someone to put me to bed." Another person told us that people did come to talk but could not remember when that had been. A relative told us ""Only once did I have a concern about a month ago, the carer didn't turn-up on a Sunday. I called the office [the person didn't think the phone was working] but he [the registered manager] did send someone later and apologised. I was satisfied with the way he handled it".

The service monitored the care provided to people and were taking steps to increase the level of spot check monitoring in line with a recent increase in the number of people using the service.

People and relatives were provided with information on how to make a complaint when they began using the service. From the feedback that we received above it was evident that people had felt able to raise concerns when they felt the need to and that they had been responded to in a way they were satisfied with.

Good

Is the service well-led?

Our findings

At the time of our inspection, the service had a registered manager. The registered manager had appropriate training and experience to manage the regulated activity.

The service provided care and support that was of a good standard and people were usually happy with it, but evidently felt able to raise anything they were not happy with.

A person using the service told us when asked about how well the agency was managed that it was "reasonably well" and another said "Yes, I would think so. I would say so. At the moment I'm satisfied."

Relatives told us "They're doing what they say they do. I've got no problems" and "Yes. Once, one of the carers had a sick child and couldn't come so the office called me and that was fine. So far we do communicate for mutual problem-solving." Another relative told us, "They are helping me [with the care of their relative]. They give me letters. They communicate. Everything is good with the care."

There were systems in place to monitor the service. For example, the manager and other members of the management team carried out audits across a range of areas. These included medicines, care plans, spot check visits and monitoring staff training and staff performance. This demonstrated that the provider had good governance procedures in place and acted upon the findings of their monitoring procedures, for example, responding to changes in needs for people and any alterations to the care provided as a result.

The service had systems in place to ensure that care staff abilities in spoken and written English were assessed and support was provided to improve this if required. This demonstrated that the provider acknowledged the importance of both verbal and written communication. Records showed the care staff communicated regularly with the agency as required.

People using the service were asked about their views although it was too early for an annual survey to have been carried out. The registered manager informed us that a survey was soon to be sent to people and their relatives and they were in regular contact with the local authority that commissioned the service. The provider viewed the experience of people as important. In one case, where a disagreement about a person's care had emerged, the registered manager was able to show that they had communicated openly with the client, their family and placing authority to resolve the situation.

The care co-ordinator and newly appointed field care supervisor were responsible for carrying out regular monitoring of care for people at home. There was some organisation still required for this to become fully established and for spot checks to be recorded properly as such. However, it was evident of care and other records that people were in regular contact with the agency and that views about their day to day care were obtained. A small number of people did make suggestions for improvements when we spoke with them although at the same time some stated that agency was far better than previous care agencies that they had used and was meeting their needs. The comments that people made demonstrated that they felt able to contact the agency and they received a response. This demonstrated that the service was open and

encouraged people to freely share their views and responded to people's views.

The service had appropriate, up to date policies and procedures in place which were available to staff to guide on various areas of their work. The policies we viewed included, infection control, safeguarding people from abuse, equal opportunity, medicines management and complaints. These policies had been introduced when the agency was first registered and were not due further review at present. The policies were appropriately detailed for a service of this type and were well written and clear so that staff knew what was expected of them and what they needed to do.