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Focus Learning

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Focus Learning is a domiciliary care service providing personal care to one person at the time of the inspection.

People's experience of using this service and what we found
We identified concerns in relation to risk assessments, understanding of the Mental Capacity Act 2005 (MCA), person centred care, duty of candour and good governance. Risks related to people's health condition were not fully assessed to help reduce risk of pain when providing personal care. Care plans lacked detail and were not written in a person-centred manner. The initial assessment of need did not provide information on how and what care should be provided. Records of care were not accurate or up to date and did not clearly identify how and when care should be provided. The provider did not understand their duties in relation to duty of candour and did not show an understanding of when to notify CQC. The provider was not transparent about when they began providing care.

The provider had introduced systems for monitoring and auditing the service, however, these were not effective in identifying the concerns found during our inspection.

The provider had completed training relevant to their role, such as, moving and handling, health and safety and infection control. The provider had not attended MCA training and required prompting when we checked their understanding. They understood the importance of offering people choices and asking permission before providing care, however they were not clear about what happens when people cannot consent to care. People told us the provider asked their consent before providing care. We made a recommendation in relation to MCA and refresher training.

The provider did not always follow good practice guidance in relation to visitors to the office preventing and spreading infection. We have made a recommendation in relation to good practice in infection prevention and control (IPC).

The disclosure and barring service (DBS) checks for the provider had been updated. No new care staff had been recruited since our last inspection.

Systems were in place for recording incidents and accidents. Further improvements were required to ensure learning from incidents and CQC notifications were included in the process. There had been no incidents since our last inspection in July 2020.

People felt safe with the provider who provided care. Medicine policies and procedures were in place to support the management of medicine administration. Staff had completed training in medicine administration.

The provider understood their safeguarding responsibilities and had worked with the local authority in relation to a safeguarding concern.

The risk of infection was reduced as there was sufficient personal protective equipment which was being used appropriately.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; however, the policies and systems in the service did not always support this practice. We have recommended the provider considers current guidance in relation to the principles of the MCA where people lack capacity.

Feedback about the care provided by the provider was positive.

The provider told us they did not discriminate against people and people's privacy and dignity was respected.

People's care plans were personalised but lacked detail about preferences and likes and dislikes.
The provider told us they had not received any complaints.

People were asked for their feedback about the service, however, this was not was not formalised. We have made a recommendation in relation to obtaining formal feedback.

The provider told us they attended manager forums to gain further knowledge.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (24 June 2020) and there were multiple breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the service was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold managers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, need for consent, assessing people's needs, person-centred care and good governance. Please see the action we have told the provider to take at the end of this report.

Follow up
The overall rating for this service is 'Requires improvement'. However, the service remains in 'special

measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Focus Learning

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. The service did not have a registered manager, they had a manager who was also the provider. This means they are legally responsible for how the service is run and for the quality and safety of the care provided with the Care Quality Commission.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with the provider and assistant director. We reviewed one care record, including care plan and records of daily care. We looked at training records for the provider and assistant director. We also viewed a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed further documentation related to care provided by the service. We spoke to one person who used the service and the local authority commissioning team.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● At our last inspection risks assessments lacked detail related to risk of falls. During this inspection we found risk assessments had slightly improved. Risk assessments now included information on how to mitigate the risk of falls.
● Risks related to health conditions had not been fully assessed, such as triggers and the signs to look for when the person was in pain or discomfort during personal care. This included the side effects of any medicines on the persons health. The impact of harm was reduced as the provider was able to tell us about these risks, however, should a new staff member provide care instead of the provider this could put the person at risk of harm as this information was not documented.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The person using the service told us they felt safe with the provider who provided care.
●. Risks to the environment had been assessed.

Staffing and recruitment
● At our last inspection we recommended that the provider consider current guidance in relation to updating their criminal record check. At this inspection we found the provider had made improvements. The Disclosure and Barring Service (DBS) certificate for the provider had been updated. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● The provider told us they had not recruited any new staff since our last inspection in July 2020. They had a

recruitment policy and procedure in place to support the recruitment of staff.

Learning lessons when things go wrong
● Systems were now in place for logging incidents and accidents. We found the provider had made some improvements to the way incidents and accidents were recorded. Records showed there had not been any accidents or incidents involving people using the service since our last inspection, but the provider had created an incident form to record any future incidents, and told us they would adapt the current form to include a record of learning from incidents and notifications sent to CQC.

Systems and processes to safeguard people from the risk of abuse
● Systems were in place to safeguard people from abuse.
● A person using the service told us they felt safe with their carer, "I haven't got no problem with [carer]."
● Safeguarding procedures were in place and provided guidance on how to report and act on possible abuse.
● The provider had appropriately reported a safeguarding concern to CQC and the local authority
● Records showed the provider and an office staff member had completed training in safeguarding people from abuse.

Using medicines safely
● Systems were in place to safely manage medicines. Medicines policies and procedures were in place to support the management of medicine administration. The provider and an office staff member had completed training in medicine administration.
● The provider told us they were not currently providing any medicine administration support. They had completed medicine training in July 2020.

Preventing and controlling infection
● We were not always assured that the provider was preventing visitors to the office from catching and spreading infections. During our inspection we noted the office staff did not wear masks and inspectors were not asked to provide evidence of testing for COVID-19, but noted there was adequate space to allow for social distancing during our visit, reducing the risks of spreading infection. The provider told us they were exempt from wearing a mask and carried out COVID-19 lateral flow testing two to three times a week.

We recommend the provider seek good practice guidance in relation to infection prevention and control.

● A person using the service told us, "When [carer] comes in puts on gloves, and wears apron, exempt from wearing masks."
●The provider had sufficient supply of personal protective equipment, including masks, gloves and hand sanitiser. Hand washing facilities were available for visitors to the building and the provider provided a hand sanitiser for use during our visit.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At our last inspection we found people's initial assessment had not been updated to explain their level of need. This was a continued breach of Regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

- At this inspection we found initial assessments had slightly improved. For example, areas of need were now identified, however, the assessment lacked detail about how needs should be met. For example, the assessment did not document what the person could do or how the service would assist them with when providing care. The assessment stated, "Service user can do something." There were no details about what the person was able to do.
- There was also a discrepancy between the date the provider told us the person receiving care had been assessed and the date on their assessment document. The provider amended the document when we raised this during inspection.
- After our inspection visit, we requested a copy of the initial assessment of need. We noted this document was different to the document seen during our inspection. This meant we could not be assured records related to care were accurate and up to date.

We found no evidence that people had been harmed however, people were not assessed in line with national guidance. This was a continued breach of regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
At our last inspection the provider had not completed any recent training despite providing care. This put people at risk of receiving unsafe care. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● At this inspection we found the provider and a director had completed on-line training covering various topics, including health and safety, moving and handling, fire safety, food hygiene and infection control. However, the majority of this training had taken place in 2020 and the provider had yet to complete training on the Mental Capacity Act 2005 (MCA) and equality and diversity.

We recommend the provider seeks advice from a reputable source in relation to refresher training and training in MCA.

● Since our last inspection in June 2020, the provider had completed training in the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

Supporting people to eat and drink enough to maintain a balanced diet
● At the time of our inspection the service was not supporting anyone with eating and drinking.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
●At our last inspection we recommended the provider seeks advice and guidance from a reputable source in relation to documenting communications with health professionals.
● During this inspection, the provider told us they had not worked with a healthcare professional since our last inspection in June 2020.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.
At our last inspection the provider failed to demonstrate they were working in accordance with the MCA. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

● At this inspection we found, whilst the provider was able to explain their understanding to offer choices and ask permission before providing care there was still a lack of understanding of the principles of the MCA around assessing a person's capacity and best interest decisions.
When asked to explain their understanding of people's mental capacity they told us, "I would contact the

local authority, if [person] cannot make a decision on their own I wouldn't be able to get that person to make a decision. People who can't make decision for themselves, we do regular training and development…. If person cannot make decision for themselves, we can't go in."
● Following our inspection, during the feedback meeting the provider told us, 'It's about choice."

We recommend the provider consider current guidance in relation to the principles of the MCA where people lack capacity.

● The service was not currently supporting anyone who lacked capacity to consent to care.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Although we received positive feedback about the care provided, the lack of robust systems and processes failed to support consistently good care delivery.
- People were treated with dignity and respect. A person using the service told us the care provider was good and treated them well, they were happy with the care, "If not [happy with the care], I would call adult social care and say I don't want [care worker]."
- The provider had not completed training in equality and diversity but told us they would not discriminate against anyone who wished to join the service, including in relation to protected characteristics under the Equality Act, such as people who identified as lesbian, gay, bisexual or transgender (LGBT) would be welcomed. The provider said, "I don't discriminate whether you are [LGBT], I provide care to everyone who wants to join me."

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- People were involved in decisions about their care and their privacy was respected.
- A person gave us an example of how they were involved in their care and supported to do tasks they were able to do themselves.
- The provider gave us an example of how they involved the person in their care, they said, "When providing care I greet [the person] with good morning, I always involve [person] in their care and they make the decision if they want it."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People received care personalised to them and their individual needs, but this was not always well documented. Care plans included some personal history, such as where the person grew up, family members and hobbies. Care plans also provided a visiting summary with duration of visits. However, care plans lacked detail about people's preferences for care and were not written in a person-centred manner.
- We found care records were inconsistent. Daily care records provided some information about the care provided to the person receiving care, including evidence where choice of care had been offered. However, these were not always consistent or written in a legible manner. For example, daily notes provided for 18 to 21 March 2022 were not dated and did not provide a time when care was provided, therefore we could not be assured that care was provided during this period.

We found no evidence that people had been harmed however, care plans were not person-centred and did not document people's preferences, likes and dislikes. This was a continued breach of regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns

- Systems for reporting and responding to complaints were not accessible. Information about complaints made in relation to people using the service were not available on the day of our visit. The provider directed us to where complaints were logged, however, no records were available despite a complaint made by a relative to the service in 2020. This was not in line with the provider's complaints policy and procedure. Therefore, were not assured operating systems for recording, handling and responding to complaints were effective.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- At the time of our inspection no one using the service required support with their communication.
- We asked the provider about how they would support someone who could not verbalise or had sensory needs, they said, "I would talk to them and ask them how they want things."
- People's communication needs were documented in their plan of care.

End of life care and support

● At the time of our inspection no one was receiving end of life care, however, the service had an end of life policy outlining how care should be provided should end of life care be required.

● The provider told us about their experience of providing end of life care and told us they would talk to the person and encourage and comfort them.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider failed to ensure effective systems were in place to properly monitor the quality of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Whilst we found provider had made some improvements during this inspection, we found repeated concerns with the overall management of the service.

- The provider failed to demonstrate good leadership qualities and oversight of the service. Provider did not have an awareness of the number of breaches from the last inspection and appeared confused when asked how they had met these since our last visit.
- Systems put in place to monitor the service were ineffective. The provider had not ensured records of care and audits were accurate and up to date. For example, daily records were conflicting and did not reflect dates provider told us care had initially started. There was also a discrepancy between the date the Local Authority told us care had started and the date reported to us by provider.
- The provider failed to ensure audits were relevant and up to date. Audits were last completed in March 2021 and failed to identify concerns found during this inspection, such as inconsistent care records.
- The provider had not ensured risks to people had been fully assessed. They had failed to ensure risks related to people's health conditions had been clearly documented.
- The provider failed to demonstrate evidence of continuous learning from previous concerns, despite having an action plan in place.
- The date the provider told us the person receiving care was assessed was different to the date stated throughout their assessment document. The provider amended the dates during our inspection. This meant we could not be assured records related to care were accurate and up to date.
- The provider was unable to provide all daily notes relating to the person's care as requested during inspection. This meant it was unclear how and when care was provided.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the service was effectively managed. This placed people at risk of harm. This was a

continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider told us about some of the challenges they faced following their last CQC rating. They told us they were struggling and were keen to prove themselves and demonstrate how they were going to make improvements.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last inspection the provider was not aware of their duty of candour responsibilities and had failed to notify CQC without delay of a death of a person who used the service. This amounted to a breach of regulation 16 (Notification of death of a service user) Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 16. Further improvements are required to ensure systems for managing notifications are in place and guidance is followed.

● At this inspection we found the provider had reported a notifiable safeguarding incident since our last inspection. However, the provider required a lot of prompting when asked about the types of incidents they would report to CQC. They could not answer questions on when and what notifications were to be submitted.
● We asked the provider what they understood about their responsibilities under duty of candour, and they told us the other director dealt with this most of the time stating, "I can't answer that one." However, the other director also struggled to explain duty of candour. They told us, "It's about the criminal justice or court, the care act, equality, health and social care act, MCA code of practice."
● The provider failed to ensure systems were in place for dealing with notifications should this be required.
● The provider was not transparent about the date when the current package of care started with the service. We have asked the provider for more clarity about this and have not yet received a response. We also found there were discrepancies with daily care records reviewed during our inspection visit. The provider failed to establish appropriate procedures to support a culture of openness and transparency.

We found no evidence that people had been harmed however, the provider failed to establish systems to support a culture of openness and transparency. This amounted to a breach (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There was no formal process in place for obtaining feedback about the service.
● The provider told us they obtained verbal feedback from one person using the service who was happy with the care provided by the provider. This was confirmed by the person using the service who said, "Yes she's good."

We recommend the service seeks a reputable source in relation to formal feedback.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● A person using the service told us the provider was good at providing care and they felt able to talk to them about anything.
● The provider knew the person they cared for well and always encouraged them in a positive way, they told us, "When providing care, I greet the person with, good morning, I involve them [in their care]."

Working in partnership with others
● The provider told us they attended provider forums where they were able to network with other providers. They had not worked with healthcare professionals since our last inspection as this was not required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment of service users must be appropriate and meet their needs. People's initial assessment lacked detail to show how their needs should be met. Regulation 9

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. The provider failed to understand their duty of candour responsibilities in relation to CQC reporting requirements and the law. Regulation 20

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. Risks related to people's health condition were not clearly identified in the risk assessment to mitigate the risk of possible harm. Regulation 12

The enforcement action we took:

Care and treatment must be provided in a safe way for service users. Risks related to people's health condition were not clearly identified in the risk assessment to mitigate the risk of possible harm.

Regulation 12

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service were not robust. The provider did not have effective systems in place to monitor or improve the service. The provider failed to maintain accurate, complete and contemporaneous record in respect of care and treatment provided to people using the service. This placed people at risk of harm Regulation 17

The enforcement action we took:

Systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service were not robust. The provider did not have effective systems in place to monitor or improve the service. The provider failed to maintain accurate, complete and contemporaneous record in respect of care and treatment provided to people using the service. This placed people at risk of harm

Regulation 17