Focus Care Link Limited

Focus Care Link - Tower Hamlets

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

We inspected Focus Care Link on 21 and 23 March 2017, the inspection was announced. We gave the provider 72 hours' notice to ensure the key people we needed to speak with were available. Our last inspection took place on 26 January 2016 where we found breaches of regulations in relation to consent, safe care and treatment, person centred care and the provider did not notify us of significant incidents that had occurred in the service.

Focus Care Link provides personal care and support for people living in their own homes. At the time of the inspection there were 159 people using the service in the borough of Tower Hamlets.

There had not been a registered manager in post since June 2016. The branch manager operated the day to day running of the service and was present on the second day of our inspection and told us they had applied for the registered managers post A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risk assessments were in place and updated to show how risks could be managed and reduced, however risks related to people's home environment were not always fully assessed to reduce the likelihood of harm. People were encouraged to remain independent and care plans showed staff how this should be done. Reviews of people's care needs had been carried out in collaboration with relatives and the professionals involved in their care where appropriate.

Allegations of abuse had been investigated and safeguards put in place to protect people from harm but the Care Quality Commission (CQC) had not been notified of these incidents. Care visits were monitored to provide people with their calls on time.

Some people were supported to take their medicines, however some records did not fully include the guidance that staff required to make certain medicines were managed safely. Medicines training had been completed by the staff and their competency was regularly checked.

Thorough background checks were carried out on staff before they were employed by the provider. Staff were equipped with the skills and knowledge they required to ensure people received safe care. Staff spoke positively about the provider and told us the service was well led.

The provider followed the legal requirements in relation to the Mental Capacity Act (MCA) 2005.

People's dietary requirements were met but did not include their food preferences. Communication between the provider and health professionals was frequent to make sure people had access to healthcare services when they needed this.

Care was carried out in a dignified and respectful manner. Staff took the time to speak with people about their preferred pastimes and they told us staff were attentive, helpful and caring.

Quality assurance systems were in place to assess the quality of care; however these did not always identify the shortfalls we found. Surveys were carried out to capture people's feedback and action was taken to improve how the provider delivered their service.

Systems were in place to monitor and respond to complaints and people had information that contained guidance for them about how to report concerns, however information was not provided in an accessible format.

We have made two recommendations about the safe management of medicines and the accessibility of information. We found one continuous breach of regulations about the notification of safeguarding incidents. You can see what action we asked the provider to take at the back of the full version of this report.

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 consistently safe.

Risks had been assessed to reduce the likelihood of harm, however the risk to people's home environments were not always fully assessed.

Staff had received training on the safe management of medicines; but some of the records did not reflect best practice on how medicines should be managed.

People told us they felt safe. Staff had a good understanding of how to recognise and report abuse.

Recruitment procedures were adhered to and staff were thoroughly vetted before they were employed.

Is the service effective?

Good

The service was effective.

Staff received training and support to ensure they were effectively meeting people's needs.

People's capacity was assessed in accordance with the Mental Capacity Act (2005)

People were supported with their nutritional requirements, however their food preferences were not always recorded in their care plans.

People's healthcare needs were met. Staff liaised with health professionals to make certain they accessed healthcare services when this was needed.

Is the service caring?

Good

The service was caring.

People and their relatives told us they were supported by helpful, caring and attentive staff.

People were supported with the choices and decisions they made about their care.

Staff told us they respected people's dignity and privacy and people confirmed this happened.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and focused on people's individual needs, and supported people to maintain their independence.

Staff took the time to speak with people about the things they enjoyed.

Complaints were responded to when people had concerns about their care, however the information provided did not always meet people's diverse needs.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider did not keep the Care Quality Commission informed of safeguarding incidents as required by law.

The provider did not have a registered manager in post, but the branch manager had recently submitted an application for the registered manager's post. Audits had been carried out by the provider; however more scrutiny of certain areas were required.

Staff felt the service operated effectively and told us the management team were quick to respond to any concerns they had.

The provider had obtained feedback from people to obtain their opinions and views, and they had acted on this feedback to improve the delivery of service.

Focus Care Link - Tower Hamlets

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 21 and 23 March 2017. The inspection was announced and was carried out by one inspector. We gave the provider 72 hours' notice to ensure the key people we needed to speak with were available. Two experts by experience made telephone calls and spoke with 10 people using the service and nine relatives to obtain their views about the care they received from the provider. 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 checked information that the Care Quality Commission (CQC) held about the service including their previous inspection report, their action plan following our last inspection and notifications sent to CQC by the provider. The notifications provide us with information about key changes to the service and any significant concerns reported by the provider.

During the inspection, we spoke with the administrator, two care coordinators, the branch manager and the director. We looked at the records in relation to 15 people's care including their medicines records. We also viewed eight staff recruitment and training records, minutes of meetings, surveys, quality assurance audits, complaints, staff rotas and some of the records relating to the management of the service.

After the inspection we contacted 29 care workers and spoke with 10 of them.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found that risk assessments were incomplete and did not state what actions would be taken to minimise and manage risks. During this inspection risks to people's safety had been assessed and were specific to each person's needs. These covered areas of support that people required such as moving and positioning, malnutrition, medicines management and behaviours. Risk management plans included guidance to demonstrate how the risks could be reduced, for example, in relation to the prevention of falls with the use of aids and adaptions, the number of staff required for moving and positioning and what to do in the in the event of an emergency.

We found the assessments demonstrated that action had been taken to mitigate risks in relation to people's home environment covering areas such as access and entry, lighting and security in the home, if the person smoked or had pets on the premises. One person commented, "Nothing has ever gone missing and they lockup afterwards so I guess I am safe with them." Risks were considered before organising people's care visits by having guidance in place that staff could follow to ensure people were supported with safe care. Records advised staff to 'adhere to fire safety as the outcome is to remain safe in the home'. The importance of infection control, such as how to dispose of clinical waste and wearing personal protective equipment (PPE) when this was needed was highlighted in people's care records. During our inspection we observed on several occasions that staff arrived at the office to pick up gloves to use during their care visits. However, three out of the 15 files we looked at required further information to ensure risks in relation people's environments were more thoroughly assessed. For example, one person was at the risk of scalding themselves whilst cooking. We found that the risks associated with the person's home environment had not been assessed as this section was incomplete. For a second person who used an electric wheel chair, there was no further information recorded in relation to the servicing of the equipment and a third person had a history of falls, but there was no information recorded about their mobility around the home to ensure that any risks were managed. This meant that staff did not always have the full information to mitigate risks to make certain that people were safely supported in their homes.

We asked people if they felt safe when staff were providing their care. They commented, "Yes definitely, they know how to help me", "Yes I do, nothing bad has happened and I trust them", "I do feel safe, someone comes around and checks on me" and "Yes very safe." When we asked people's relatives the same question they also said, "I think [my family member] is in good hands, the carers know what they are doing and they know how to look after [them]", "Yes, I think so, I don't know how, they just do", "I would like to think so, we have had [staff name] coming, because after a while you get used to it they become part of the routine and they know what they're doing and they're quite trustworthy."

Systems were in place to ensure safeguarding procedures were followed by the provider to protect people from abuse. Staff had a good understanding of their responsibilities in relation to keeping people safe from harm, and were confident that the provider would act appropriately on people's behalf. Staff commented, "Sometimes families can have concerns with the clients and feel they cannot speak up, but it's up to me to report it and take the matter further" and "I would report abuse straight away to the office, this could be when I have observed unusual bruising, or the person is not usually talking or appears frightened."

People's care records advised staff that if they witnessed or suspected any incidents of abuse or self-neglect, they must report this immediately to the provider. There was a safeguarding log book in place that held the outcomes of previous safeguarding incidents and we found that preventative actions had been put in place in collaboration with the local authority in all these cases. However, the provider had not notified the Care Quality Commission of five safeguarding allegations of abuse as required.

People and their relatives told us they were supported to take their medicines safely and others explained they required no support with this. One person told us, "I take them myself.", Their relatives commented, "[Our family member] takes a lot medications, the pharmacist puts them in a box for us and [he/she] takes them", "They make sure [my family member] has taken [their] medication, generally [he/she] does take them if not the carer will just make sure that [he/she] has", "[Care worker] gives [them] the medication, [care worker] is very good at sorting all that out, [they] make sure that we've got all the prescriptions"," I give them the medication and I advise them [my family member] is supposed to take the medication after breakfast."

Despite this positive feedback, we found in that in two files the management of medicines was not always clearly recorded or updated when people's needs had changed. For example, one person used a nebuliser, but the support they required with their medicines was left blank, and another person was prompted with their medicines but the medicines were not listed in the care plan or updated when their needs had been reviewed. We recommend that the provider seek advice from a reputable source about appropriate and accurate medicines recording.

Care plans noted where people collected their own medicines from the pharmacists, how people would like to be reminded to take their medicines by the staff and if their relatives were involved with the management of their medicines. Records were kept in people's files about their medicines and any allergies they may experience, how they should be taken and how often. For one person who took Warfarin we found there was a questionnaire signed and dated by the pharmacist, to show their understanding of the risks associated with this. We found that action had been taken when a person had refused their medicines, and disposed of them and in this case staff had contacted the person's GP about their concerns. Staff told us they had received appropriate medicines training and sought advice from the provider if this was needed. Where medicines errors had occurred, staff had been given additional medicines training to update their practice and knowledge. Staff had completed medicines training workbooks and we saw that these questions assessed staff competency about the safe administration of 'as required' medicines.

Suitable arrangements were in place to ensure that the right staff were employed by the provider. Recruitment records for staff were held at the head office and the provider obtained these for us during our inspection. The records we looked at demonstrated that the provider had followed a thorough recruitment procedure in line with their policy. Before staff were employed by the provider their competency was assessed by the use of multiple choice questionnaires and we found that potential employees were scored on these accordingly. Checklists were in place and had been signed by the human resources (HR) department to show all the required background checks had been completed and staff were ready to start shadowing other care workers as part of the induction process. We found that the provider had taken disciplinary action when it was identified that staff had not followed the organisation's procedures to make certain people were kept safe.

People using the service and their relatives had mixed experiences in relation to staff arriving on time to their care visits, "I've never been let down. Generally on time, but living in town it depends on public transport. But they arrive within a general latitude, and I've never felt that no one was going to come depending on traffic, they have a time sheet with them that we sign at the end", "Almost always on time give or take five or 10 minutes due to traffic", "I don't remember them ever being really late" and "It is fine, no issues."

People's relatives said, "I'm lucky to have it I think, there are times where I like to go out in the afternoon so I do rely on [care worker] quite a lot, [they] are my life line. [Care worker] may be 10 minutes late some times, but does have other patients, [they] write something down in [my family member's] book every day" and "They're supposed to be there in the morning I think [they] had to be ready for pick up at half past nine. I am aware that they have arrived later. Evening is supposed to be five to six. I've been aware that they have not arrived until six."

The provider used electronic call monitoring (ECM) to monitor staff time keeping. We observed that staff in the office contacted people to inform them when staff were running late for their care calls. 'Interruptions to the service forms' were completed where care workers had attended, but the person was unavailable or had to attend an appointment and this was classified as a late cancellation. The provider told us they obtained people's consent for staff to log into people's phones to inform the provider that they had arrived on time, where people had not consented this was followed up during their review meetings. The majority of staff told us they had enough travel time between their care calls, but two members of staff explained they did not. We saw minutes of the staff meeting to show this was addressed with staff to ensure they were scheduled care visits within their locality. Records showed there was enough staff to cover their care visits and the people we spoke with confirmed this.

The provider operated an out of hours number people could call if they had any concerns and people and their relatives told us they had this number if they needed to speak with them about their care. One person said, "I would just ring the office I have the number here I don't know anyone in particular I would talk to." Relatives commented, "I have several numbers, I don't have a name in particular for who to speak to", "I have the nine to five number and I have an out of hours number as well, those two would be the numbers I go to", "[Person's name] has been doing all that", "I would probably contact the number that's in the book" and "Sometimes they don't answer the phone, but they do get back."

The out of hour records demonstrated the actions staff had taken when they were providing care outside of the normal office hours, for example, where a member of staff had recognised a person was in poor health we saw notes to show they had contacted emergency services. Staff had followed the provider's policy on the 'no entry' procedure to ensure people were safe and we saw that staff had acted on this when necessary. We found that one person did not answer the door when the staff arrived for their care visit and records showed they had contacted the appropriate people involved in the person's care to make certain the person was safe.

Precautions were taken to ensure personal records held in people's home were kept safe. Records called 'keeping information safe in the home' had been signed by people to make certain they had received their personal records safely, and to place them in a safe place so documents were not mislaid. People's personal records were stored in lockable filling cabinets in the provider's office.

Good

Is the service effective?

Our findings

People's rights were protected as staff understood their responsibilities under the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

At our last inspection we found that the provider's policy did not inform staff about what actions to take where people lacked capacity to make specific decisions and who they should consult regarding routine decisions about their care. There was no evidence that relatives had legal authority to act for and consent to the care and treatment of the people who used the service. During this inspection we found that people's capacity had been assessed in consultation with health professionals and their relatives. Records showed for one person that the provider had held a best interests meeting with health professionals to review the person's environment and assess their capacity to receive care. One person commented, "Most of the big decisions my [relative] will help me with them." For another person it was noted that staff must inform the provider if they have concerns about the person capacity, and their reasons for this. One relative told us, "It's made between me and the social worker, [my family member] doesn't have the capacity to do it. I'm sure [they] would make it plain what [they] want and what [they] don't."

Consent forms had been signed by people to agree to have their care records reviewed when their needs changed and people had signed agreements in relation to accepting the terms and conditions of the service. Where people were able to make their own decisions this was recorded, one person said, "I make all my choices; they have to ask me otherwise I would give them an earful," and a relative commented, "[My family member] can make most of the day to day decisions, [he/she] knows what [he/she] likes and they will try and help [them] with that."

We found that people had consented to share their information with the professionals involved in their care when this was considered necessary. Where relatives had the legal authority to consent to people's care and treatment, discussions had been held with their families and documented in their care records. One relative explained, "It's between the two of us, I do have power of attorney. At [age of person] [my family member] is still very focused but generally we have a conversation between us and we have a debate between the two of us, it's a partnership, as it's [their] care, the final decision is [theirs]." The provider's policy had been reviewed and updated to include guidance for staff to adhere to where people lacked the capacity to make decisions for themselves and documented the training that was required. Staff explained they had received training and were aware of how to apply the principles of the MCA and the records we viewed confirmed this.

Staff were trained and supported effectively, which enabled them to deliver quality care to people. A staff member told us," When we start we do a lot of training and a lot of exams we submit before they take us on,

we do shadowing for five days, they would not allow you to start without it." The service had an induction workbook that comprised of a 12 week programme that included a practical guide regarding the orientation of the office, the providers' facilities and their procedures. Records showed how often and how long staff had shadowed other experienced members of staff to observe how care should be carried out specifically to meet people's individual needs.Staff records evidenced they received a wide range of training using different approaches to learning, such as DVD, face to face and online learning. Training records show that staff had completed training in a range of topics including moving and handling, with demonstrations on how to use sliding sheets, continence promotion, fire safety, dementia, equality and diversity, introduction to financial and material abuse, safeguarding, effective communication, pressure care, visually impairment awareness and emergency first aid.

Training was scheduled to be renewed when staff's previous training had expired. Some staff had completed the Care Certificate and others were in the process of completing this. The branch manager explained they were a Care Certificate assessor, so was able to sign off the workbooks when they were satisfied that staff had completed the training to the required standard. Supervision and appraisals were planned and organised and care workers were invited to the office to have a two way discussion with the provider. Records showed that open questions were used during this meeting to allow staff to think and reflect on their work performance and discuss their development needs. The branch manager told us they worked with a nurse to deliver training to staff for people who required specialist care, such as stoma and catheter care, diabetes, peg feeding and the use of nebulisers, and the records we looked at confirmed this.

People told us they were supported with sufficient food and drink when they required this. Some people were supported by staff to prepare their meals and others explained they did not require support with their meal preparation. People commented, "I usually get ready meals and just ask them to heat it up for me", "I can still cook for myself" and "If I want something they will get it for me like some tea."

Staff had a good understanding of people's nutritional needs and how these were to be met. For example, one person had meals delivered to them to maintain their nutrition, and records showed that the person should have regular fluids to maintain their hydration, and noted the amount of fluids to be left open for the person and within easy reach, as they liked to drink fluids at regular intervals. Dietary monitoring sheets assessed people's nutritional intake where they required more specialised support with their meals. One care worker told us, "We feed [person's name] with only soft foods and never hard food, we work in collaboration with the Speech and Language Therapy (SALT) team and we follow their recommendations." Care plans noted that staff should check if there was enough food in people's homes and stated if they relied on their relatives to purchase food. One person's records showed how they liked to have choice and control over what they ate and drank and how meals should be prepared by staff in a healthy way. People's relative's commented, "Some days [family member] is able to make [their] breakfast, [the person] is asked exactly what [they] like, generally [my family member] is asked." However, people's food preferences and the types of meals they enjoyed or disliked were not always documented in their care plans. The branch manager acknowledged this and agreed to update these records.

People were supported to maintain good healthcare and had access to a range of healthcare services. Frequent communication took place with health professionals when people required access and intervention to professionals to meet their healthcare needs. People's diagnosed health conditions were documented in their care records and the health professionals involved in their care, such as the district nurse and the GP. For one person we found that the provider had requested a visit from a physiotherapist when it was reported by staff that their wheelchair required additional adjustments. Assessments were on people's files in relation to their continence and foot care. In another person's file we saw that staff had observed that their continence pads did not fit the person's requirements and would have an impact on

their skin integrity and this was reported to the district nurse.

People using the service and relative's told us that staff assisted people to attend their health care appointments, "[Staff] have to go with me to see the doctors and dentist because I can't push the wheelchair" and "I have attempted with the hospitals to send all the appointments to me, and the carer goes with [them] to the appointments and the social worker commissions the time." Conversations were held with families regarding their family member's health needs, for example, we saw notes to show a relative rang the office when they had attended a health appointment with their family member and had informed the provider about the outcome of this.

Good

Is the service caring?

Our findings

All of the people we spoke with commented positively about the care that they received from staff. They told us, "I would say they are very attentive and helpful, we get on really well", "Very caring and nice, most days I see the same ones", "They're alright, they generally live locally, they're generally good people", "Friendly and helpful I think so" and "Amazing I could not ask for better."

Relatives gave us equally positive comments about the staff's ability to provide good care. They commented, "All the carers I have had contact with have been very caring, kind and willing to help. I don't think we have had any problems with any of them, I think they try and get to know [the person] as best they can", "They're friendly, easy going, caring, kind", "Very helpful, very nice, and generally extremely helpful, [care worker] seems to be quite open with [my family member] and generally very good", "We've had about two or three but we have had the same one's all the time, they're quite pleasant and know what [they're] doing."

People were supported with the choices and decisions they made about the care they received. For example, one person stated they would like their care worker to be reliable and flexible with their call times. We saw people were allocated staff based on their choices and a replacement care worker was allocated if the original staff member was unavailable. One person said, "I have no problem recently. I set the time for them because nine am is too early so I advised to come around nine thirty so it's a time that suits me, there's a book here so they record in there."

Care plans were written to advise staff to respect people's personal space and privacy, to keep their homes secure and take into account their personal possessions. For example, records noted to 'ensure the person does not need anything before they left the home', 'make the person comfortable before leaving' and 'to ensure the safe keeping of people's keys'. In another person's file it was noted they would like the staff to 'respect their home and not to move objects without their permission and the staff should have good communication skills as I need to feel comfortable in my home'. A relative commented, "Just the way they help [my family member] and take care of all [their] needs. They always seem to listen and are very caring and understanding."

Records of the staff meetings showed discussions had been held with staff about people's rights, such as the right to live their life, to be respected, to remain independent, be treated as individuals and to uphold their dignity at all times. A relative commented, "There is a key safe, which they let themselves in and when the [staff member] comes in she/he announces this just in case [my family member] doesn't know or is asleep." Staff we spoke with told us they respected people's dignity by closing the doors and curtains before assisting people with their personal care.

Several written compliments documented the impact the quality of good care had on people and one relative had written "Pleased with the care worker, brightens up [my family member's] day and would like [staff name] to become the permanent care worker'. As a result of this the provider had informed the staff member of the feedback they had received and agreed to place them on the person's rota more frequently.

Good

Is the service responsive?

Our findings

At our previous inspection we found that the provider's assessments and care plans did not demonstrate how people received care that was person centred. They lacked detail about how staff should support people to meet their individual needs and did not include information about their personal preferences. During this inspection, we found that assessments included information to show assessments of their needs had taken place, such as how people liked to spend their day, what was important to them and details about other providers that were involved in the person's care, such as outreach workers. A care plan analysis was mapped of people's needs that were matched with the duties staff were able to provide. Care tasks were detailed which gave more specific information on how people should be supported with their personal care. For example, people's personal care information was detailed and gave clear guidance about their routines, noting that people might already be dressed on arrival but not bathed and advised staff that people will need to be encouraged and reminded with this routine. Specific guidelines were in place to show how this should be done, such as to make sure their skin gets moisturised and ensure consistency with their personal care needs.

People were supported to be as independent as possible. One person had noted 'I feel safe when living in my home, I mobilise independently , ask me questions I appreciate this, it's important I'm listened to' and ' It's important I remain independent with eating and drinking.' Care plans and assessments showed how people were able to manage their care independently. For example one person had mobility needs and records noted that conversations with the person documented they could take part in the task of providing their own personal care and a health professional had agreed to make a referral to the wheelchair service after they had asked for additional aids to remain independent. A relative commented, "As time has gone on he/she has become very inactive, it is not due to the carers, they always try and encourage [the person] to do things. But [my family member] just wants to sit in [their] favourite chair and watch TV."

Reviews of people's needs were regularly carried out by the provider and in partnership with health professionals to check on their circumstances, needs and their current situation. People were included in the development of their care plan and we found they had signed their records to show they were satisfied with their plans. The provider told us they always invited health professionals to attend these reviews and we found in some cases professionals had attended when this was requested. We saw that when reviews of people's needs had taken place the placing authority had been informed.

People told us that staff took the time to have conversations about their preferred pastimes, hobbies and the things that mattered to them. They commented, " I like reading and watching television, we have a chat about what is on TV tonight", "I do simple things throughout the day like watch TV or do crossword puzzles, I also like doing jigsaws, things like that. When I complete a jigsaw I will show them and we have a chat about that, they always listen to me about everything", "I knit whenever I can and watch TV, there is not a lot they can do to help me, I just get on with it", and "Oh yeah I have a chit chat, see how they're getting on, how their families are, after a while you get to be quite social with them." Relatives commented, "Yeah they sit and chat" and "My experience of that is when [my family member] hasn't been able to mobilise, the carer will sit there and be interactive while [he/she] is eating. Generally a way of working out whether [their] wellbeing is

good."

People told us that their diverse needs were met however, one relative disagreed. They commented, "Some people are not fully indigenous, so there is a language problem. [Family member] has complex problems. I have raised this several times but they can only provide what's available. I am aware that [family member's] medication was left on top of a unit that is easily seen and when the carer arrived [they] spend 20 minutes looking for the medication. I can't communicate effectively with the carer to rectify and I also have problems with the language issue." We spoke with the provider regarding people's diverse needs and they told us they were in the process of recruiting more staff to meet people's needs. We checked to see information was accessible to meet people's specific needs; however we found that the information was not provided in an accessible format to meet people's communication needs. We recommend that the provider seek advice from a reputable source about providing information that meets people's diverse needs.

People told us they knew how to report concerns but their views differed about the name of designated staff member who would deal with their complaint, but were confident any concerns would be resolved. They commented, "I would just ring the office I have the number here, I don't know anyone in particular I would talk to", I would talk to my [relative] and [they] will deal with it for me but I have never had to do it", "I do not know" and" I guess I would phone the manager if I had something big to complain about, if it was a little thing I guess I would just talk to someone in the office or my carers." Their relatives commented, "What I would do is speak to someone in the agency and then discuss the matter. I would email or phone the social worker, I copy in the manager, and when they feedback to me, I get back what was done It's written in the notes I can't corroborate that because I'm not there", "I would talk to the manager, very helpful" and "There is a Focus Care Link help diary and inside it contains the contact numbers and there is no names but there are phone numbers there, and when I have phoned before a lady was on the switch board."

There was an essential service user guide in place and people were given the organisation welcome pack, which included relevant polices related to their care, such as the complaints procedure. A relative commented, "They provided information about everything they do and the carer records exactly what they are doing on each call." There was a system in place that recorded complaints to show action was taken when people were dissatisfied with the service. We found that these were acknowledged and responded to by the provider within appropriate timescales.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found there had been one incident involving an allegation of abuse of a person that had been investigated and not reported to the Care Quality Commission (CQC). During this inspection we found that the provider failed to notify us of five safeguarding incidents of alleged financial, psychological and emotional abuse and neglect. We saw these cases had been thoroughly investigated by the provider and steps had been taken to mitigate any further risk to people. The provider told us they were not aware these incidents had to be reported to us as they had been reported to the provider by the local authority when these incidents had occurred. However at our previous inspection we had highlighted that the registered provider is required by law to notify the CQC of important events which occur within the service to protect the safety of people who use the service. The branch manager agreed to send us these notifications, which have now been received.

This was a continuous breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People and their relatives spoke positively about the provider but were not clear who managed the day to day running of the service. People told us, "I do not know his name but I think he is the manager. I have only spoken to him once or twice he seems alright I am really happy with them", "I don't know, that is something [my relative] would know but carers are brilliant I couldn't ask for better", "I am not sure but pretty much everything they do is impressive", "I am not sure who is the manager, I have had someone come around from the office to do checks but I don't know if they are the manager, when he came around he was always asking me what I like and he seemed really friendly." Relatives said, "I can call him if I need anything and he's always willing to listen. He might have to call me back but usually I get a call back pretty quickly", "I know the supervisor but I don't know the name of the manager" and "Yes the person is called [branch managers name]."

There had not been a registered manager in post since June 2016. The branch manager had also been employed by the agency during this period of time, and the director explained they had recently applied for the registered manager's position and the branch manager confirmed this. The branch manager later emailed us the information to evidence they had submitted further information that was required for their registration.

Audits were carried out by the provider of staff files, scheduled calls, the out of hours' service, and people's care records. However they were not thorough enough to identify some of the inaccuracies we had picked up regarding people's medicine records and risk assessments and more thorough scrutiny was needed in relation to this.

Staff told us they were appropriately supported by the provider and said that the service was well led. They commented, "They are the best, they are fair with everybody, and give us work equally", "The support is very good, if I have any concerns I would inform the manager and they rectify the situation"," When I call them they take action, or if we are unsure they show us what to do. I am very pleased with Focus Care Link" and

"When I send emails they respond very quickly the [branch manager] will also talk with the social worker, I have even recommended them to my friend."

The care coordinators carried out service assessments in people's homes, to observe staff practice and audit people's care records. Monitoring of staff included punctuality, communication, and medicines management and if they wore their identification badges. Where improvements for their work practices were identified the provider then worked with staff to address this with further training and development.

Quarterly meetings were held with staff and the records showed that a good number of care workers had attended. The meetings commenced with a word of appreciation. Minutes of these meetings showed reflective discussions were held during these events, for example, the most important things they had learned, how to apply any training they had attended to their work, suggestions on how the meetings could be improved and the 'best' care worker qualities. We also noted that the meetings highlighted the importance of staff completing records held in people's homes accurately.

Annual surveys had been sent to people to obtain their feedback, benchmark how the provider was delivering care, learn new ideas and guide future business decisions. The most recent had been sent in July 2016 to 84 people of which 45 responded. The survey was made up of 43 questions based on the CQC five key questions and showed a high level of satisfaction of the care workers. Where people were not satisfied with aspects of their care their answers to the survey questions had been evaluated and assessed to make improvements to the service, such as a review of the recruitment procedures, staff retention, more appropriate training for care workers to reflect the needs of the people they were supporting and more scrutiny of late visits. We saw during this inspection that people's feedback had been acted on. For example, the provider used a quality assurance system that showed the overall score staff had achieved in relation to logging into electronic call monitoring (ECM) when they arrived and left their care visits.

The provider told us about the current challenges they faced in their local borough and in relation to staff retention, and to show their appreciation of the care provided to people in the community they held 'Care Worker of the Year' events. Staff were given gifts and a certificate of recognition for their work which was based on staff votes and the feedback they received from people about the quality of care they had received.

Staff surveys had been sent to staff about equality and diversity, training, reporting abuse and responding to people's cultural needs and travel time and identified that staff felt valued and motivated to provide good care. Care workers identified travel time as an ongoing issue and the provider had agreed to allocate staff that lived within close proximity to people to reduce their travel time, and ensure office staff phoned the care workers when their rotas were being created to confirm that the travel time was suitable. Coordinators were advised to match people's requirements with care workers' skills and competencies.

Office staff were observed to be professional, courteous, and discreet when speaking with people over the phone and with staff when they visited the office. The local authority had conducted a recent visit to the service and the provider told us they were working towards addressing the shortfalls they had identified.

We asked people and relatives their views about the service and how the provider could make improvements. Comments included, "I can't think of anything, "Nothing, everything is as good as it can be", "I don't think so. I am trying really hard to think of something bad to say but so far we have had a very good experience here", "They generally clean up, and look after anything that needs to be doing and they cook quite well and they clean away anything that is necessary" and "It might be good if they could become a bit more aware of what English food is. I often say I want this or that like a Danish pastry and they have no clue

what that is. It's just generally an unawareness of what English people eat. Some of them, their English might not be as good like what various bits and bobs are around the house. But nothing outrageous, just something that's a bit of a surprise." , "I've not had any problems, the lady who comes in is extremely well and very caring and intuitive with [the person]","Communication, they could also do better to try get someone that would fit [family member's] ability more", "I'm pleased with the carer [the person's] got" and "Because we have only experienced two different [staff] so they know what they're doing and they're quite professional and we're very happy with them."

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 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met: The provider did not notify the Commission of incidents of abuse or allegations of abuse in relation to service users were they are required to do so. Regulation 18 (1)(2)(b)(e)