Focus Care Link Limited

Focus Care Link Ltd- Waltham Forest Branch

Inspection report

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Date of inspection visit:
27 September 2017

Date of publication:
12 December 2017

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

The inspection took place on the 27 September 2017and was announced. This was the first inspection of the service since it was registered with the Care Quality Commission in February 2016. The service is registered to provide care to people in their own homes.

There was a registered manager at the service at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was not consistently safe. Risk assessments were not detailed or robust and did not explore ways to mitigate risks that had been highlighted. In addition, people's medicine records were not fully completed and records were not always accurate.

People who used the service and their relatives told us they were unhappy with the service, particularly in relation to the unreliability of care workers and consistently late and missed calls. People and their relatives told us about occasions where care workers had failed to attend and the consequences of this on their care and the rest of their family.

An insufficient number of staff were deployed and a number of staff had recently resigned from the service as a result of issues relating to pay and management. A group of staff had gone on 'strike' as a result of these issues and there were currently eight care workers employed to support 35 people.

Staff were not receiving regular supervision. Supervision that had taken place had not been recorded. In addition, staff appraisals had not taken place meaning that management were not monitoring the needs of staff.

There was a complaints procedure in place however complaints were not analysed in order for repeat complaints to be avoided. We have made a recommendation about the management of complaints.

Regular audits and quality checks were not taking place. Management systems were failing to prevent staffing issues and monitor consistency in care.

There was an on call system for care workers and people to call out-of-hours and records were kept of all calls received and actions taken.

Staff were knowledgeable about safeguarding adults and whistleblowing. The service had up to date policies and procedures in place regarding safeguarding adults and whistleblowing for staff.

The service had robust staff recruitment procedures in place.

Newly recruited staff took part in an induction and shadowing programme. There were certificates confirming that staff had passed their introductory training modules.

Care plans contained information about people's medical needs and involvement with health professionals.

People who used the service and their relatives told us that although care workers were unreliable, when they did arrive they were caring.

Care plans were personalised and contained person centred information about people's needs and backgrounds.

We found the provider was in breach of three regulations relating to safe care and treatment, good governance and staffing. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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. Risk assessments were not detailed or robust and did not demonstrate clear risk minimisation plans.

Medicine records were not always up to date and correct.

People and their relatives were extremely unhappy about the unreliability of care workers and reported that their care workers were consistently late and often did not turn up.

Policies and procedures were in place for safeguarding and whistleblowing.

Staff told us they knew what to do in an emergency.

Is the service effective?

Requires Improvement

The service was not always effective. Care workers did not receive regular supervision or appraisals.

Training provided to care workers was relevant to their role. An induction programme was provided to care workers who were newly recruited to the service.

People's rights were protected as staff understood their responsibilities under the Mental Capacity Act 2005 (MCA).

Care plans contained information about people's medical needs and involvement with health professionals.

People were supported with meal preparation where this was part of their care plan.

Is the service caring?

Requires Improvement

The service was caring. People and their relatives told us about kind and caring relationships that had been formed.

Care workers knew how to treat people with respect and dignity.

Despite care workers displaying care and compassion, the

inconsistent service affected the strength of relationships.

Is the service responsive?

Requires Improvement

The service was not always responsive. People and their relatives reported that care workers were consistently and regularly late.

Care plans were personalised and contained people's life histories.

Care plans were reviewed every six months.

There was a complaints procedure in place however complaints were not analysed in order for repeat complaints to be avoided .

Is the service well-led?

Inadequate

The service was not well led. The registered manager lacked oversight of the quality of care being provided. They had failed to carry out regular quality checks and audits. They had failed to minimise the impact of the care workers' strike action on people using the service.

Staff meetings took place every three months.

Policies and procedures were updated annually and available for staff to access.

Staff meetings took place every three months.

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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.

The inspection took place on 27 September 2017 and was announced. We informed the provider 48 hours in advance of our visit that we would be inspecting because the location provides a domiciliary care service. This was to ensure there was somebody at the location to facilitate our inspection.

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

During our inspection we spoke to the registered manager, care coordinator, two care workers, one senior care worker, the operations manager, training manager and human resources manager. After the inspection we spoke with nine people who used the service and four relatives. We looked at six care plans and eight staff records. We also looked at various other documents relevant to the management of the service including, medicine records, policies, procedures and risk assessments.

Requires Improvement

Is the service safe?

Our findings

People were not protected from the risk of harm because risk assessments were not robust and lacked detail. For example, one person who used the service was described in their care plan as having, "Balance difficulties" and a, "History of falls." However their risk assessment did not explain these difficulties stating, "No risk when carer provides personal care tasks and breakfast preparation". Another person who was identified as being at "high risk of falls" didn't have a risk assessment in place to mitigate against the risk. This meant that staff did not have the information to tell them how to mitigate risk and protect people from harm.

One person had a medication risk assessment in place that stated they were at "high" risk and that they, "self- administer but high risk of neglect". There was no further information to inform staff what they needed to do to support the person and prevent them from any neglect. In addition, records showed this person's medicine administration records (MAR) had not been adequately completed. There were gaps in their MAR sheet, which the registered manager told us was where the person had self-administered. The person's daily record did not show the person had self-administered their medicines on these dates. This meant that it was unclear whether the person had self-administered their medicine or whether they had missed it completely.

Care and treatment was not provided in a safe way for people. The provider failed to assess the risks to the health and safety of people. The provider also failed to implement proper and safe management of medicines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback from people who used the service was negative, especially in relation to the reliability of care workers. People told us their care workers were regularly late and sometimes did not turn up at all. One person told us "They are meant to come at 8am but it's often not until 10am, that's 2hrs! Weekends are the worst for missed calls or they come very late." Another person told us, "Call due 8am no show when I rang at 10:09am." A third person said, "Sunday is often bad – they should be on time to help me get ready so I can go to church but they often come just a few minutes before I have to go – I can't miss church." A fourth person said, "Last night nobody came and my husband had to help me. They don't always come – I'm so grateful that my husband is here. They are meant to come at 9am and when they come at 10am or after they tell us that the office told them the later time. Sundays are always bad and my husband wants to get off to church." A relative told us, "Three times since June [2017] they haven't shown up at all." Another relative said, "They totally miss calls sometimes and they never phone or explain." A third relative told us, "Last Sunday nobody came at all – my Mum rang me and I went over. It's the 8th time that this has happened. I keep detailed records."

Only one person told us they did not have any issues with the timing of care workers and said, "On time and no missed calls – they are alright."

The service employed eight care workers and had 35 people who used the service. A person who used the service told us, "I think that they are short staffed – people from the office have to come out. An office person came this morning." Since the inspection, the provider has told us they have 18 care workers.

One care worker told us about their shifts and the rota, "All the shifts are near to each other." They also told us about cover arrangements for any unexpected absences, "If I call in sick they cover, always." When asked if there were enough staff they told us, "Sometimes they struggle." Another care worker told us, "The shifts are ok for me." The care coordinator told us, "I do the rota. The care workers that live in the local area are attached to those care plans, we have a few care workers that drive too." However, in light of the fact that there were an overwhelming amount of missed and late visits recorded, the ratio of staff to people who used the service was insufficient. The care coordinator told us, "We are speaking to the HR manager now to recruit some more care workers."

The provider failed to ensure that care visits were completed and to ensure there were sufficient staff to complete people's care.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The senior care worker told us about the on call system that was used at the service and stated, "We always have a mobile with us and normally on call is 5:30pm to 9am the next day. We recently put a voicemail message on our on call system so that we could call carers back but we have gone back to the original set up where we pick up the phone immediately because of feedback we received from staff." Records showed that an on call log book was kept to record all phone calls received out of hours and on weekends. We saw a recent record where a care worker had called to report an incident and the actions that were taken had been documented.

Care workers told us they knew what to do in an emergency situation. One care worker said, "I'd call an ambulance." Another care worker told us, "If I make a medicines mistake, I'd call the office and rapid response."

Policies and procedures were in place for safeguarding and whistleblowing. The safeguarding policy stated how to raise a safeguarding alert and who to contact. Care workers demonstrated a good understanding of safeguarding and whistleblowing. One care worker told us, "I did [safeguarding] training. There are different types of abuse. You have to report it straight away to the manager." They also told us, "With whistleblowing I'd straight away tell the office." Another care worker told us, "If I had any concerns I'd call the office and I'll write it in the book and call the manager. There's a lady above her, I could go to her too or come to you [CQC]."

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

Requires Improvement

Is the service effective?

Our findings

The provider had not maintained records to show staff were receiving adequate supervision. One care worker told us they had received supervision in 2017 but was not sure this was recorded. Another care worker told us, "[Care coordinator] supervises me once or twice a month about general care." There were no supervision sessions recorded for 2017, only for 2016. The care coordinator said that staff came into the office for one to one chats, however nothing was recorded. The care coordinator also told us that no appraisals were carried out. This meant that the provider was not effectively monitoring or recording staff competence. Since the inspection the provider has sent us a spread sheet with supervision and appraisals planned to take place.

Staff were not receiving appropriate supervision or appraisal in order for the provider to ensure competence is maintained. This was a breach of Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One member of staff told us, "I started working here in February this year. When I started here I had no care experience. They gave me full five days training and induction, there was so much information, I learnt a lot. They showed us videos, they make sure everyone knows what they are doing and told me to call if I have any problems." They also said, "I did shadowing for a week, it was helpful." Another member of staff told us, "I've worked here almost a year now, I did care work before. I did training with the lady here, she was very good and gave us lots of information, for example health and safety, moving and handling and safeguarding. Afterwards we did an assessment, I passed. I also did shadowing for a few weeks, it was good."

There were certificates confirming that staff had passed training modules and the service had a dedicated training manager and training room to enable staff to receive the training they needed to perform their roles. There was equipment such as hoists and beds in the training room to aid people with practical moving and handling training. As well as theory training, staff received practical training in moving and handling, medication and basic life support. One care worker told us, "There's more mandatory training coming up, they send us an email or text to remind us." This meant that training practices at the service were thorough and up to date.

All staff were asked to sign a code of practice for social care workers to ensure that they understood the expectations of the role. All of the files viewed contained signed copies.

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

People's rights were protected as staff understood their responsibilities under the Mental Capacity Act 2005

(MCA). Care workers told us about their understanding of the MCA and how they implemented it into daily practice. One care worker said, "Never force them to do something."

Care plans were signed by people who used the service which showed they were consenting to their care in line with legislation and guidance.

Care plans contained information about people's medical needs and involvement with health professionals. One person's care plan contained information about their recent hospital stay and details about their hospital discharge assessment with email communication between the provider and local authority. Another person who had recently gone into hospital had been reassessed by the provider and records confirmed this. As a result of the reassessment, the provider made a referral for the person to be assessed for a pendant alarm. This meant the provider was proactive in engaging with other professionals to support the needs of people who used the service.

Care workers told us about the people they supported with meal preparation. One care worker said, "They tell me what they want to eat. For example one person wanted jacket potato and bacon so I made it for her. I have all different service users and try to adapt to them and their needs, I'll cook anything, I don't have any boundaries." Care plans contained information about people's dietary needs, for example one person had guidelines in place from their speech and language therapist relating to suitable foods and textures. This meant staff could refer to this information for guidance and to support people accordingly.

Requires Improvement

Is the service caring?

Our findings

People who used the service were not always supported in a caring way in order to meet their religious and cultural needs. This was because of consistently late visits. For example, two people we spoke with told us the late visits had a negative impact on them and their families getting to church on a Sunday. This meant people were not being supported on time to enable them to practice their faith.

One person who used the service told us, "When they do come the people are kind, never rough even though they must be pushed for time. They treat me with dignity and I like that they chat to my husband too."

A relative of a person who used the service told us, "They are kind and caring when they are here – the actual people are not a problem." This meant that although care workers were regularly late, when they did attend to people, they were kind and caring.

One care worker told us about how they formed caring relationships with the people they cared for, "I listen to them. I have experience; my mum had dementia. It's hard working with people with dementia but dignity means a lot to me for example if someone has lost their memory they lose their ability and become angry and they take it out on you. As a carer you think, they're like your mum or grand mum. I do it for kindness."

A care worker told us about how they supported people during personal care in a dignified manner stating, "Some people don't like to remove their underwear during personal care and I respect that." Another care worker said, "I close the door and cover person during their personal care. I talk to them, they talk to me, they tell you what they want and I respect that." This meant that people were treated in line with their preferences and needs.

Staff recognised the importance of treating people as individuals. One care worker told us, "I don't mind [if someone identifies as LGBT (lesbian, gay, bisexual or transgender)]. It's not my business; I'm not here to judge. I treat them and listen to them, it's their home, I respect what's going on in there."

Requires Improvement

Is the service responsive?

Our findings

Care plans contained background information about people who used the service such as medical conditions, their GP details and the level of support they required. For example for one person this stated, "I need support with personal care and breakfast preparation. I need my carer to support me with personal care tasks (strip full body wash, dressing, skin care and toileting needs)." Another person's care plan stated, "Support with personal care, making breakfast, empty commode, prompt medication, provide hot or cold drink as required." Care plans also contained information about people's life histories, for example the job they had held.

Care plans contained a document that care workers signed prior to working with people which stated, "Please read and analyse the care plan before you start any job. Should you feel that your health or welfare is put at risk by the shift working schedule report to supervisor." One care worker told us, "You don't know how to look after them if you don't look in the care plan. The care plan is good, got lots of things." Another care worker told us, "Yesterday I got a new service user and I read everything [in the care plan]. It was really good. I also met with the social worker, the care plan is going to tell you everything." This meant that staff had to read care plans prior to starting a shift so that they were aware of all care needs and any potential changes.

Despite care workers having access to care plans prior to supporting people and demonstrating and understanding about the people they supported and their needs, the consistent unreliability of care workers meant that the service was not responsive to people's needs. Care was scheduled to be at specific times in order to meet people's needs and preferences. People told us they did not receive care when they needed it.

Records showed that care plans were reviewed on a six monthly basis. Reviews included looking at objectives, whether the person's needs were being met, issues with equipment, risks and emotional wellbeing,

There was a complaints procedure in place. This included timescales for responding to any complaints received and details of who people could complain to if they were not satisfied with the response from the service. We looked at complaints records and saw that they had been responded to and actioned in accordance with the procedure. Despite this, complaints were not analysed in order for repeat complaints to be avoided.

We recommend that the service seek advice and guidance from a reputable source, about the management of and learning from complaints.

Inadequate

Is the service well-led?

Our findings

Records within some people's care files showed that spot checks had taken place in May and June 2017. However they were not consistently completed for all service users. The care coordinator advised that that there was "Not enough time" to carry out regular audits.

Since the inspection the provider has sent us examples of spot checks they have carried out.

The care coordinator said that they hadn't carried out any analyses of complaints, incidents or missed calls to identify any trends. Records showed that the service had sent out a staff and service user survey in June 2017. Four client surveys and three staff surveys had been returned. However we were told that they had not been analysed when we inspected in September 2017. We were told that this was due to making allowance for people's holidays and that it was planned that they would analyse the results the following week. Staff responses were generally positive. Client responses were generally anonymous however one person had ticked that they strongly disagreed with the statement "The agency listen to my concerns, complaints and comments, act upon them and provide me with feedback within an appropriate timeframe". The provider had not taken action to address this person's concerns.

Since the inspection the provider has sent us a spread sheet with dates setting out when they plan to carry out audits and reviews.

One care worker told us about their relationship with management stating, "I feel supported [by care coordinators] but I don't know [registered manager]. I saw her one day but I don't know nothing about her." When asked if they liked working for the agency they told us, "We are doing too much work and not getting enough money. There was a delay two times in getting paid. The carers got upset and refused to work because of pay delay and some carers tried to get us all to strike because of pay delays." We asked them how the provider managed the situation and they said, "They told us to come into the office to collect our money in the meantime. We all got together and came down here and shouted at management, I don't know how it happened twice, we have to carry on the work but since then there's been no more problems." Another care worker told us, "I don't have contact with [registered manager]. But I know who she is. I feel supported [by care coordinators]." A third care worker told us, "Before, we didn't get paid on time and now they've sorted it. There was a petition and I signed it."

The registered manager told us about the carers that went on 'strike' as a result of pay issues and said, "Some of them have come back and some are still angry. Four of the care workers that went on strike have now left. We want continuity with care workers. We dealt with the situation well, we even offered them a permanent contract." Despite the assurances of the registered manager it was clear adequate actions were not taken in order to prevent late and missed calls. Records showed one person stopped using the service due to the unreliability of care. Management systems were not robust in preventing a negative impact on people who used the service or in supporting care workers in resolving the issues surrounding the 'strike'. Since the inspection, the provider has advised us that they have contacted people affected by the 'strike' to apologise.

The company's policy for staff meetings was that they were held every three months and we saw that one had been held on the 13 June 2017 and we were told that there was one scheduled for the day of the inspection, however, it had been cancelled due to the inspection. The manager said that meetings were held more frequently if there were additional issues that needed to be discussed. The minutes of the meeting held on the 13 June 2017 showed that the issue with staff pay had been discussed however there were no other topics covered. As indicated by continued dissatisfaction of staff and people receiving the service, the staff meetings had not been an effective forum for discussing and resolving issues with the staff team. As the discussion had been limited to staff pay and conditions, the provider was not able to demonstrate staff meetings were used to develop staff, or discuss the needs of people receiving a service.

The registered manager lacked oversight of the quality of care being provided. They had failed to carry out regular quality checks and audits and had failed to minimise the effects on people who used the service as a result of a 'strike'.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The operations manager at the service told us about their policies and procedures and how these were distributed to care workers, "We send policies and procedures to each branch and these are annually updated. Branch managers print them out for staff to read." This meant staff had access to updated policies and procedures to enable them to keep up to date with any changes.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for people. The provider failed to assess the risks to the health and safety of people and had failed to implement systems for monitoring staff attendance and reliability whilst on duty. The provider also failed to implement proper and safe management of medicines. Regulation 12 (1) (2) (a), (b), (c), (g)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not receiving appropriate supervision or appraisal in order for the provider to ensure competence is maintained. Regulation 18 (1) (2) (a)