Focus Care Link Limited

# Focus Care Link

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

| | |
|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

This inspection took place on 7 and 8 July 2016. The first day of the inspection was unannounced as we had received information of concern regarding the service from an anonymous source. We had been informed that care plans were not reviewed, staff did not have a Disclosure and Barring Service (DBS) check prior to commencing employment, staff were not trained and people did not always receive visits. When we last inspected this service on 6 August 2014 we found the service met all the regulations we looked at.

Focus Care Link is registered to provide personal care to people living in their own homes primarily in the North London boroughs of Camden, Islington and Barnet. At the time of the inspection, there were 169 people using the service. The service employs 106 care staff.

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

Risks were not always adequately assessed for people using the service. During the inspection we identified risks to people which had not been identified by the provider. General risk assessments were in place and were reviewed regularly.

Medicines were not always safely managed. There were inconsistencies between what care plans and medicines risk assessments stated as to what medicines support people received. Daily records completed by staff in relation to medicines support people received differed from what instructions were given as part of the care plan.

People and relatives told us they felt safe. Procedures and policies relating to safeguarding people from harm were in place and accessible to staff. All staff had completed training in safeguarding adults and demonstrated an understanding of the types of abuse to look out for and how to raise safeguarding concerns.

The service maintained sufficient staffing levels and people told us that carers generally arrived on time. The service monitored late and missed calls and took action when necessary.

The provider obtained consent for care in accordance with the Mental Capacity Act 2005. Staff had received training in MCA.

Complaints were logged and monitored for trends and learning points identified were actioned.

Person centred care plans were recently implemented which were comprehensive and reflected what was

important to the person. Care needs were regularly reviewed and updated to meet the changing needs of people who used the service.

We saw evidence of a comprehensive staff induction and on-going training programme. Staff were also safely recruited with necessary pre-employment checks carried out. Staff received regular supervisions and annual appraisals.

The management team enabled an open culture that encouraged staff and people to discuss issues and ideas. People were given the opportunity to provide feedback at service user forums and through an annual survey.

The provider had a quality monitoring system in place to ensure standards of service were maintained and improved.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe. Individual risks to people were not always assessed

Medicines were not always managed in accordance with the person's care plan.

There were sufficient staff to ensure that people's needs were met. There was a robust recruitment procedure in place.

Staff were aware of different types of abuse and what steps they would take if they had safeguarding concerns.

### Is the service effective?

**Good**

The service was effective. Staff had access to regular training, supervisions and appraisals which supported them to carry out their role.

People were given the assistance they required to access healthcare services and maintain good health.

Consent was obtained from people in accordance with the Mental Capacity Act 2005.

### Is the service caring?

**Good**

The service was caring. People and relatives spoke positively about staff. People were treated with dignity and respect.

Care plans were detailed and provided information about people's needs, likes and dislikes.

### Is the service responsive?

**Good**

The service was responsive. Care plans were person centred and regularly reviewed.

People's needs and wishes from the service were assessed and

support was planned in line with their needs.

The service regularly requested feedback from people who used the service and service user forums took place on a regular basis.

## Is the service well-led?

Good

The service was well led. The quality of the service was monitored.

People, relatives and staff spoke positively of the registered manager.

# Focus Care Link

**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 7 and 8 July 2016 and the first day of our inspection was unannounced. We let the registered manager know that we would be returning the following day to complete our inspection.

Before the inspection we reviewed the information we held about the service. We considered information which had been shared with us by the local authority and reviewed safeguarding alerts which had been made.

The inspection was carried out by two inspectors on the first day of the inspection and one inspector on the second day of the inspection. The inspection team was supported by an expert by experience who made telephone calls to people who used the service to obtain their feedback. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspection was carried out due to recent concerns that had been brought to the attention of the Care Quality Commission in relation to inconsistencies in care plan reviews, staff not having a DBS check prior to commencing employment, staff not receiving training and missed visits.

During the inspection we spoke with eight people who used the service and three relatives. With permission, we also visited the home of one person who used the service. We spoke with the registered provider, four care coordinators and eight care staff. We contacted three local authorities who placed people and obtained their feedback.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe. One person told us, "I have never felt concerned about the carer who has been here with me. You do hear such horror stories these days but I trust my carers and I have got to know them very well now. If I did have a problem I would pick up the phone and speak to a manager." Another person told us, "I've never had any real concerns about the level of support I have. To help me with my shower it only really needs one carer and as long as she is there I feel safe."

Care files contained risk assessments which addressed generic areas of risk such as environmental risks, risks associated with moving and handling, medicines and Control of Substances Hazardous to Health (COSHH). Risk assessments were reviewed on a yearly basis and records confirmed this. However, we found risk assessments had not been carried out specific to the individual needs of people using the service. We identified risks to such as poor nutrition and hydration, epilepsy, choking, psychosis, SALT requirements, dysphagia and the risks associated with the use of cot rails. Risk assessments were not completed to demonstrate the appropriate management of these risks in order to minimise them leading to serious health complications. This placed people at risk of harm as risk assessments failed to provide enough information for staff to adequately understand or mitigate risks posed to people they cared for. We discussed this with the registered provider who confirmed that they would complete individual risk assessments for all people using the service which would be reviewed.

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

We looked at the arrangements in place to ensure people would receive their medicines safely when needed. One person told us, "I have help with my medication. My carer gets the tablets out of my dossette box and gives me a drink to take them with. When I have taken them, she completes the Medicine Administration Record (MAR) chart so that everyone can subsequently see that I've had my daily dose."

Staff told us and we saw evidence that care staff received medicine training on a yearly basis and as part of their training they were required to complete a competency assessment to confirm their learning. There was additional evidence where field supervisors carried out observations of medicine administration when care staff were on a care shift. Prior permission of the person was sought where the observation was to be carried out. Staff knew what to do if they discovered a missed dose or medicines error.

Despite the training staff received, not all MAR were consistently completed. Support plans were not always clear on whether staff were prompting or administering medicines. For example, one person's medicines risk assessment stated that medicine was self-administered. The person's care plan stated that staff were prompting medicines and staff were signing the person's MAR chart to state that they had administered medicines. We saw on one occasion the carer signed the person's MAR chart to say they had administered medicines, the carer on the same date recorded that the person had not yet taken their medication.

We saw another instance of where a person's care plan stated that carers were to ensure medication was

taken by the person using the service, however, on two occasions the carer recorded in the daily notes that the person had taken their medicines before the carer had arrived but had recorded on the MAR chart that they had administered medicines to the person.

Where medicines were administered from a blister pack or dossette box, the individual name of the medicine, dose and frequency prescribed was not detailed on the MAR chart. MAR charts are the formal record of administration of medicine within the care setting. We discussed our findings with the registered provider who, following the inspection, provided an action plan outlining how they would ensure medicines would be more effectively managed moving forward.

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

People were supported with sufficient staff with the right skills and knowledge to meet their individual needs and promote person centred care. One person told us, "Because I have a small group of regular carers who I have got to know and who know me, it means I don't worry every day as to whether somebody is going to turn up or who it might be. They are all lovely and it gives me peace of mind." Another person told us, "For the type of things I need help with, my one carer is fine and is very good at doing things the way I like them to be done." The registered provider told us that they were continually recruiting new staff to ensure that they had sufficient staff and that they were trying to recruit staff who were able to speak specific languages such as Greek and Bengali to support people who did not speak English.

We looked at 13 staff records in order to ensure that the service had undertaken safe recruitment checks for each person that it employed. The service obtained two to three written references and also checked various different types of documents to verify a person's identification. The service also completed criminal records checks for all staff that they recruited. Original DBS checks were not held at the location but were held at the HR department which was at the provider's different location. The location only held records of the DBS number and the date the check was completed.

The provider as good practice re-checked DBS checks for each staff member every three years. Each staff file had a recruitment checklist as well as a file audit check which was carried out every six months. The service carried out company checks as part of the reference request whereby companies completing the references were checked to confirm that they did exist and were not fraudulent companies providing fake references.

People told us that they did not experience late or missed calls on a regular basis. Comments from people included, "My carers are very good at arriving on time. Even when the traffic is bad they are not usually any later than 10 minutes after the time. I did experience a missed call; this was probably a good three to four months ago, when messages got confused between the office and a relief carer. The office was very apologetic and it has not happened again. I have never experienced any totally missed calls other than that" and "My carers are really good and arrive very well on time. If they are running very late it has only been once or twice, and then someone from the office usually calls to let me know what is happening and to find out if there is anywhere I am supposed to be going. I have never experienced any missed calls."

The registered manager told us that they used an electronic call monitoring system to monitor call times and lengths. When a carer had not logged into the persons home telephone, a text message was sent to a mobile phone which was monitored by a designated person in the office. The registered manager told us that the system they were using was currently not fit for purpose as it was not effectively monitoring call times. Therefore, additional checks were carried out which included weekly visits by the field supervisor to the most vulnerable clients to ensure that they were receiving their allocated care as well as regular

telephone checks.

We looked at the rota management system in place and checked rotas for the week of the inspection. Care staff were provided with a weekly rota which consisted of a brief care plan of the person they were supporting along with details of each call they had for the week. 15 minutes travel time was factored into the rota between calls. The rota system had a link to a map application which gave the service estimated travel times so anything more than 15 minutes was also factored into the rota. Where staff spent in excess of 15 minutes travelling they were paid for their travel time.

Accidents and incidents were recorded and actions and learning identified as a result of the incident were implemented.

Staff had undertaken appropriate safeguarding training and certificates confirming this were seen in staff training records. Staff understood how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. One member of staff told us, "There are many types of abuse and how they impact on clients. I forward concerns to the local authority immediately." Staff were able to describe the types of abuse to look out for and the steps they would take if they had concerns. Staff identified that they could report abuse concerns outside of the organisation to the local safeguarding authority and the CQC.

The provider had a whistleblowing policy and staff had a good awareness of whistleblowing. One staff member told us, "When someone has a concern or when care is not according to the care plan, they can anonymously report it to the CQC or the local authority."

Good

# Is the service effective?

## Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One person told us, "I would say that I've never had a carer come to me who wasn't able to do all the jobs I need help with." Another person told us, "I really can't think of anything that they don't know how to do, certainly in relation to the jobs that I ask them to help me with."

Staff had the knowledge and skills which enabled them to support people effectively. New staff received an induction based on the Skills for Care guidelines and training in mandatory areas including moving and handling, safeguarding, first aid and health and safety. One member of staff told us, "I had two weeks training when I first started and it has been updated." Each staff member prior to commencing work were required to complete a 10 hour minimum shadow period of working so that the provider could assess competency. If more hours shadowing was required this was provided.

Each care staff member had an individual training record on file which stated the training courses undertaken and the dates of completion. We looked at the training records for a sample of 14 members of staff. The records confirmed that staff had received training in a variety of areas including safeguarding, continence, diversity and equality, moving and handling, managing challenging behaviour, medicines, food hygiene, pressure care and first aid. There was evidence that these had been refreshed on an annual basis.

Each staff were also required to complete knowledge based competency assessments after completing a course. These were then marked and where a gap in knowledge was found, care staff were required to attend the training again. We saw evidence of care staff booked on refresh training where gaps had been found as part of their competency assessment.

As part of their training, each care staff also had a policies record form on file whereby each care staff member would attend the office to read policies and procedures and then write about the specific policy or procedure confirming their understanding.

The provider had a supervision policy which stated that care staff would receive supervisions on a quarterly basis. Supervision records and comments from staff confirmed this. We also saw appraisal records for people who had been working with the service for more than one year. As part of supervision a development plan was produced and supervisions included sessions held when care staff were out providing care. Supervisions covered communication, knowledge assessments in different areas such as communication, supporting people and relationships. Appraisals covered current performance, development and training.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do 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 the best interests and legally authorised under the MCA. We checked whether the service was working within the

principles of the MCA.

Records showed that staff had received MCA/DoLS training, however staff knowledge was mixed. One member of staff told us, "Mental Capacity – people who have illness mentally.  I haven't worked with them yet." Whereas another member of staff told us, "If the person is able to make informed decisions." This was discussed with the registered provider.

People's care files contained a consent form which was signed by the person using the service. When care reviews took place, the provider also obtained consent from the person using the service to carry out a review.

People told us staff obtained consent. One person told us, "When my carer let's herself in in the morning with the key, she always calls out so that I don't worry about who is coming through the door. She always asks me if I'm ready to get started, and if I'm not she will do some tidying up while I get myself sorted." A relative told us, "I have heard my husband's carer knock on the bedroom door and say who it is before she goes in and I know that she always has a quick chat with him and then I will hear her ask if he's all ready to get started every morning." Staff told us they always obtained consent from people prior to delivering care. One member of staff told us, "Consent – from showering to shopping to food. I have to ask."

People's nutritional needs were assessed as part of their initial assessment and when their needs were reviewed. There was clear information about dietary needs which included likes and dislikes for people who the staff supported with meals. When asked how staff supported them with eating and drinking, comments from people included", "My carer will make me a meal at lunchtime which is usually one of the ready meals. I sometimes get her to make me some soup on days when I don't fancy a full meal. She always make's sure that I've got everything I need and that I have a drink ready for the afternoon before she leaves" and "My carer usually makes me breakfast after I've had a wash and got dressed. I don't always have the same thing every day but she will always ask me what I would like and then she prepares it for me. She always makes me a hot drink before she goes." Where people required specialist input in relation to people's nutrition and hydration needs for example where people require input of the SALT team, we saw evidence that referrals had been made and input recorded where someone had been prescribed thickener and pureed diet. Guidelines had been provided as part of the care plan. There was guidance on how to administer the thickening agent.

Most people and relatives we spoke with did not require assistance from the provider to access healthcare services as domiciliary care agencies do not generally support people with healthcare appointments as they provide care such as washing, dressing, medication and food preparation. However, appropriate and effective referrals were seen on people's care plans to external health care professionals including Occupational Therapist referrals for equipment and social workers where concerns had been noted.

Good

# Is the service caring?

## Our findings

People told us carers were professional, caring and dedicated who were willing to do extra jobs where required. Comments from people included, "I really value the fact that nothing is too much trouble for my carers and when they ask me if there is anything else they can do, they really do mean that rather than just saying it because they think they should" and "The last thing my carer does before she leaves every morning is to ask me if there any other jobs that I need help with because she knows I'm not likely to see anybody for a good few hours. I'm really grateful that she asks this because very often I'll forget to ask for help with something." One member of staff told us, "It is a lovely job. I meet different people; different characters and I try to understand who I am working for."

People told us that they had a small team of carers which they preferred. Staff also commented that they provided care for the same people on a regular basis. The registered manager told us that at present they were trying to establish area based care teams which would reduce the time staff spent travelling between visits. The registered provider told us that some people using the service were resistant to this change, as it meant that their regular carer would be changing. The registered provider told us that they have tried to reassure people who use the service and explain the benefits.

People told us staff respected their privacy and dignity. One person told us, "When my carer first comes in the evening, the very first job she does is to close all the curtains and particularly to make sure that in the bedroom no one can see in before she starts to get me ready for bed. I never have to ask her to do this for me." Another person told us, "My carer will always make sure that the shower is running at a nice temperature before she comes and gets me as I hate getting cold. She also makes sure that I have a nice warm towel to dry me when we are done."

Care plans included background information, medical history about the person and stated people's preferences around whether they wanted a male or female care worker or where they wanted a care worker with specific language skills. A one page summary was developed for carers to have access to a quick reference document about the person. People told us they were consulted about their care and involved in planning. One person told us, "When I started with the agency, I met a manager who sat down with me and asked me all sorts of questions about how I found myself and what help I needed. She went away and put this together into a care plan which she sent me to read. I then signed it, and it's in my folder where the carers sign every day to say what they have done. I was also asked what time of day I would like my carer and the agency were able to arrange these times for me. The other thing I was asked was whether I prefer male or female carers and I said that I really didn't mind." Another person told us, "I remember meeting with the manager who asked me all sorts of questions about what I needed. I think my daughter was there with me at the time. The manager then sent through the care plan which she had written out and my daughter and I looked at it and then signed it. We also discussed whether I preferred a male or female carer and I said that because I've never had carers before I thought I would rather have a female carer. The agency is very good and have never sent me a male carer."

The provider had an equality and diversity policy in place and staff had received training in equality and

diversity. During the inspection we spoke with staff around supporting people with protected characteristics, however, we noted that some staff did not fully understand the needs of people who identified as lesbian, gay, bi-sexual or transgender (LGBT). This was discussed with the registered provider who confirmed that this would be addressed with staff at the next staff meeting.

Good

# Is the service responsive?

## Our findings

People and relatives told us they received personalised care which was responsive to their needs. One person told us, "I have regular review meetings with one of the managers where we talk about my care and how I get on with the carers and if there is anything that I am not happy with. They usually also ask me if I am struggling to do any additional tasks for myself so that we can think about whether I need to either increase the length of a visit, or have a carer come back for a second visit later in the day."

We observed that the care plan available at the home of the person we visited and the care plan in the office were the same, so staff had access to the most up to date care plan. Care plans were reviewed on a regular basis, but not always to what the service stipulated which was every three or six months.

Care plans were person centred and detailed all tasks that needed to be completed and prompts for staff to complete all records, report any falls, report any concerns and complete medicine records. A pre-service assessment was completed which noted people's needs and requirements and preferences. A health and safety checklist was also completed as part of the pre-service assessment.

People we spoke to had no complaints and they told us they could contact the office should they have any complaints. Comments from people included, "I've never had anything to complain about but I do know that the number is in the file and I would ask to speak to one of the managers who I have met for a review meeting," "I have had regular review meetings over the last few years so have got to know the managers quite well in that time. However, I have never had to make a complaint about anything so far, but if I did I would phone and speak to one of the managers that I have met. Knowing how I have been treated in the past, I am fairly certain they would listen to my concerns and do something about it" and "I have known everybody at the agency for quite some time now and I'm sure if I had a concern that they would listen to me and do something about it." However, one relative we spoke to raised concerns in respect of the attitude of previous carers, carers not staying the allotted time and not fully completing their tasks. This was discussed with the registered provider during the inspection who immediately reviewed the call logs and assured us she would contact the relative to discuss the concerns raised.

The service had a complaints policy and we saw that complaints were logged and investigated promptly with learning points identified and improvements made. An example of learning from a complaint was the implementation of a checklist for carers to complete after carrying out observations on the person using the service such as identifying signs of abuse or symptoms of deteriorating health which was to be reported back to the office. The provider had designated a senior member of staff to take responsibility of monitoring complaints, with the provider having final sign off when the complaint was investigated. For each complaint logged, there was a complaint record form which detailed the specifics of the complaint, who external to the organisation the details were shared with, such as social worker, the follow up actions taken to remedy and prevent reoccurrence.

The service requested feedback from people who confirmed this. One person told us, "I have filled in a couple of surveys over the time, which I don't mind doing but I can't recall ever hearing anything about them

once I had filled them in and send them back." Another person told us, "Now you come to mention it, I do remember filling in at least one questionnaire but I can't remember ever hearing anything about it again." We discussed people's feedback with the registered manager who told us that feedback from people was collated, analysed and a report was completed which outlined the findings and actions taken which included conducting additional reviews, increased spot-checks and liaising with people who provided negative feedback.

Good

# Is the service well-led?

## Our findings

People and staff spoke positively about the registered provider and the culture of the organisation. One person told us, "I understand that with some agencies it would be very rare to see or even know who the manager is. However, with this agency the manager is very visible and usually, every four or five months, she will do a review meeting with me. She always makes it clear that if I have any concerns whatsoever, all I have to do is pick up the phone and ask for her." Another person told us, "I see the manager whenever she comes to do a review meeting. I get on very well with her and find it to be very friendly and helpful." Staff told us that they felt supported by the registered provider. One member of staff told us, "I feel supported by [the registered provider] who is always available to help when needed. Another member of staff told us, "[The registered provider] is nice. I think she tries her best to maintain order. She always encourages us to come to her."

The office had an area designated for staff, both office based and field based to come to spend time. The area had computers for training and we observed staff reading through policies during the inspection. The area also contained information for staff in relation to supporting people living with dementia and the re-ablement service. We observed field based staff come to the office and have friendly conversations with the registered manager and other office based staff.

The service had a clear management structure in place with designated teams to support people and staff. Five teams were led by a care co-ordinator and a field supervisor who supported approximately 40 people and approximately 20 staff. Included in this was a re-ablement team which provided care for approximately 15 people on a short term basis.

Staff meetings took place on a regular basis and were held in a separate larger sized venue to accommodate people attending. Meetings took place over two hours and minutes indicated that staff were encouraged to participate. Service users forums took place every two to three months with the last forum having been held in June 2016. Minutes of the meeting produced demonstrated that people were asked for feedback, provided with the complaints procedure and consulted with about how they like to be contacted. The registered provider told us that they try to encourage attendance at the service user forums and receive positive feedback from people who attend.

Quality assurance systems were in place to monitor the quality of care delivered and staff competency. Monitoring visits were undertaken to people's homes to see if there were any concerns or issues. Monitoring visits were also undertaken where issues and concerns had been reported to the office so that these could be resolved directly with the person receiving care and/or their family. Where issues were related to care staff performance there was evidence that this was addressed with the care staff member and their performance was monitored. These concerns and issues were also logged as complaints. We also saw evidence of the service sending apology letters to people acknowledging their concerns and improvements that they had made as a result.

There was evidence that the registered manager checked care plans and staff files as part of an auditing

system and made comments and recommendations for improvement. A quarterly report was also produced for the main placing authority which detailed missed visits, accidents/incidents, safeguarding concerns and also detailed the actions taken to make improvements.

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<br><br>Regulation 12(1)(2)(a)(b)<br><br>The service provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users<br><br>Regulation 12(1)(2)(g)<br><br>Medicines were not always managed safely and effectively. |