Care Worldwide (Links) Ltd

The Links Care Centre

Inspection report

The Links
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08 December 2020
09 December 2020
10 December 2020
16 December 2020
17 December 2020
18 December 2020

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26 January 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
The Links Care Centre is a nursing home providing nursing and personal care to people with dementia and other complex mental health issues. The home accommodates up to 85 people over five self-contained units. At the time of the site visit there were 66 people living at the home.

People's experience of using this service and what we found
Staff did not always follow the provider's COVID-19 policy or infection and protection government guidelines. This posed a risk that staff could transfer infection. Risks to people's health and safety were assessed. Plans were clear and up to date and contained person centred information. However, on the day we visited the service we saw they were not always followed. Audits and checks were in place to monitor the quality of the service. They had not identified the risks which were identified during the inspection.

People were supported by a consistent and experienced staff team. Recruitment was managed safely.

Staff understood the importance of safeguarding and the provider worked closely with local authorities.

Medicines were managed safely. There were close links with health professionals and other agencies to ensure people's health needs were met and changes responded to promptly.

The registered manager had commenced in post in June 2020. They had introduced wide ranging changes. Staff, people and relatives spoke highly of the registered manager and described the changes that were underway as positive. One long standing care worker at The Links said, " We have the continuity to create and maintain a new culture."

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

Rating at last inspection and update: The last rating for this service was requires improvement (published 17 April 2019) and there was one breach of regulation.The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 18 March 2019. A breach of legal requirements was found.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has stayed the same. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them.

Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The last rating for this service was requires improvement (published 17 April 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last two inspections.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Links Care Centre on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and good governance. Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Links Care Centre

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 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 care service.

Service and service type
The Links Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection Activity started on 8 December 2020 and ended on 18 December 2020. We visited the service on 8 December 2020.

What we did before the inspection
We reviewed information we had received. We asked for feedback from local authority commissioning and safeguarding teams. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well,

and improvements they plan to make. This information helps support our inspections.

During the inspection
We observed care and support in communal areas of the home. We spoke with seven people who used the service and six relatives. We spoke with 13 members of staff including the regional manager, registered manager, training and quality lead, nurses, care workers and an activity coordinator. We also spoke with an advocate and health and social care professionals about their experience of the care provided. We talked with relatives, staff and professionals on the telephone after the site visit.

We reviewed a range of records. This included people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- Staff did not always follow the provider's COVID-19 policy or infection prevention and control guidelines set out by the government. We observed some staff were wearing fabric masks. Where staff were wearing fluid resistant masks, they were not always wearing them properly. We observed poor practise across all units of the home. This posed a risk that staff could transfer infection.
- Social distancing guidance was not consistently followed. Armchairs were placed next to each other in lounges. The positioning of the dining tables and chairs did not support social distancing.
- Government guidance on promoting good ventilation was not always followed.

We found no evidence that people had been harmed. However, systems were not robust enough to demonstrate infection prevention control was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They issued clear guidance to staff about the use of personal protective equipment (PPE) and introduced enhanced monitoring.

- The home was restricting visitors in line with government guidance. They were building a 'visitor's pod' to facilitate safe visiting. There was a clear process in place for essential visitors including completing track and trace information and recording temperature checks.
- We were assured the provider was accessing COVID-19 testing for people using the service and staff.
- Staff had received training in infection prevention and control (IPC).
- The home was clean, tidy and odour free.

Assessing risk, safety monitoring and management

- Risks to people's health and safety were assessed and included in their care plans. During the inspection we observed one person who was assessed to be at a high risk of choking. Staff did not follow his eating and drinking care plan. We observed several instances over the course of the lunch-time service when the person was at risk of choking. This included them leaving the dining area unsupervised with food.

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

The provider responded immediately during and after the inspection. They discussed the concerns with senior staff and updated risk assessments. We were assured the person would receive increased levels of support when eating and drinking.

● Other risks to people's health and safety were assessed. A range of risk assessments were in place including information about bed rails, falls and pressure care. Where people experienced periods of distress due to their mental health care plans contained person-centred information about how to support people. Staff understood people's needs and how to manage any risks they were exposed to.
● Safety and environmental checks were undertaken, and action taken when issues were identified. The home had an ongoing refurbishment programme.

Systems and processes to safeguard people from the risk of abuse; learning lessons when things go wrong
● People and relatives said they felt safe and secure living at the home. One person said, "Staff are kind and caring." A relative said, "[Person] is safe and happy. I can tell because if [person] wasn't their behaviour would deteriorate. [Person] is settled."
● Staff received safeguarding training and they demonstrated an understanding of abuse. They said they were confident about reporting any concerns and said they felt people living at the home were safe.
● Accidents and incidents were reported and there was a detailed monthly analysis completed to identify any themes and trends. We saw examples of lessons being learned and follow up action taken. For example, there was a discussion in a team meeting about a recent incident. Staff were involved in reviewing this in order to improve future practise.

Staffing and recruitment
● People and relatives said there were enough staff.
● The provider used a formal dependency tool to calculate the number of care staff needed. This was reviewed regularly.
● Staff spoke positively about the induction and training they received. The training manager was based on site. This meant sessions were organised flexibly to ensure staff' knowledge and skills were maintained. One care worker said, "I love the training. It is 100% designed around the home."
● Robust recruitment procedures were in place to ensure only staff suitable to work were employed. There had been a recent significant reduction in the use of agency staff. This meant people were supported by a consistent and experienced team.

Using medicines safely
● We observed people were supported with their medicines kindly and patiently.
● Medicines systems were organised, and people were receiving their medicines when they should. Staff received training and their competency was assessed.
● Some protocols for 'as required' medicines were not in place. This was addressed on the day of the inspection.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last inspection the provider had failed to maintain accurate records of people's care and treatment. Systems to assess, monitor and improve the quality of and safety of the service were not always effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● A range of audits and checks took place to identify concerns and improve service provision. This included buildings, staffing levels, medicines and care plans. Generally, they were effective and where issues had been identified follow up action had been taken. However, audits and oversight by senior staff had not identified the concerns relating to infection prevention and control and risk to people identified on the day of the inspection.
● There had been no registered manager at the home since January 2019. We received confirmation the manager had been registered with CQC whilst we were undertaking the inspection. Staff, people and relatives told us there had been significant changes in the home over recent months. We received positive feedback about this. One care worker said, "The home feels better. They are all good changes. There are no bad changes."
● The registered manager had complied with the requirement to notify CQC of various incidents, so we could monitor events happening within the service. The provider understood the duty of candour and kept people and relatives informed about key changes within the home.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Some of the language used suggested an institutionalised approach to care. A white board was displayed prominently in a communal area with a list of tasks for staff to complete. This did not reflect a person-centred approach. However, we also observed positive and warm interactions between people and staff.
● The registered manager spoke passionately about teamwork and the ongoing and planned quality

improvements. They we saw examples of how the changes had improved people's independence and wellbeing.
● The registered manager was visible and approachable. People, relatives and staff spoke highly of the impact the registered manager had on the quality of the service. One care worker said they had brought a "new lease of life". A relative described the home as having a "complete turnaround".

Continuous learning and improving care
● Accidents and incidents were reviewed and used to inform plans.
● The registered manager was receptive to feedback throughout the inspection and responded quickly to address concerns and improve the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with other
● Records showed staff engaged with a range of professionals. One health care professional described the staff as being "professional and forthcoming".
● Staff meetings and individual supervision sessions were held regularly.
● Meetings were held with people who used the home to seek their views. The time was also used to discuss people's mental health conditions as a way of supporting respect and understanding of each other.
● People and relatives said they had been kept informed about changes due to the pandemic. One relative said, "It's very difficult for us as a family not to being able to see [person]. The way The Links have managed it has been very good. I only have complimentary things to say about 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
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 safe care and treatment The provider failed to assess or manage risks associated with people's care. Systems were not robust enough to demonstrate infection prevention and control were well managed. Reg 12 (2) (a) (b) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance Robust systems and processes were not always in place to assess, monitor and improve the safety of the service. Reg 17 (2) (a) (b)