Link Medical Staffing Solutions Ltd

Link Medical Staffing Solutions Ltd Haverhill Branch

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Link Medical Care Staffing Solutions Ltd Haverhill Branch is a domiciliary care service providing support to people in their own homes. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of our visit there were 17 people in receipt of the regulated activity of personal care.

People's experience of using this service and what we found

The provider did not have fully effective systems to monitor and assess the quality and safety of the service people received. Record keeping in areas such as care planning and risk assessing was not robust and did not support the consistent delivery of safe and effective care. A focus on meeting the requirements of the last inspection has resulted in other areas of the service and systems not being as closely monitored as needed.

At our previous inspection we found concerns with the oversight of the service and the management of infection control risk and the safe recruitment of staff. At that inspection this was a breach of the Regulations and we issued the provider with a warning notice. At this inspection whilst the provider had met the warning notice and there were some improvements, further work was still needed to make quality assurance systems more effective, and the provider remained in breach.

Quality assurance checks were not always effective and robust enough to provide effective oversight of the service as they had failed to identify the issues we found at this inspection. The provider acknowledged that improvements were needed in their governance systems and told us that they would take action to address this including the recruitment of a skilled and experienced manager.

Risks associated with people's care were not consistently assessed and well managed and some care plans were not completed.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. Improvements were needed to make sure best interests' decisions were made where people lacked the capacity to make their own decisions. We have made a recommendation that the provider ensure people's care and support needs are fully assessed, planned and completed in line with recognised Mental Capacity Act best practice and current legislation

Despite these concerns, people and their relatives were happy with the service and complimentary about the care they received. One person's relative said, "I would highly recommend [Link Medical Staffing Solutions] to anyone. They are absolutely accommodating, they actually listened and wanted to help."

People and their relatives told us they felt safe with the care provided and that they were supported by a regular team of care workers who attended their calls on time and stayed for the full duration of their visit.

People told us they received the support they required with their medicines however, the systems in place to oversee this were not always effective. We have made a recommendation that the provider reviews their approach to the auditing of medication administration records so that any gaps in records are explored and there is evidence of appropriate action being taken in response to prevent a reoccurrence.

There was improved oversight of care calls through an electronic system the provider had introduced.

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 9 September 2021) and there were breaches of regulation. Following the last inspection, we issued the provider with a warning notice relating to the breach of Regulation 17 Good Governance. We told the provider they needed to be compliant with the Regulations by 5 November 2021.

We have found improvements but also evidence that the provider needs to further their oversight and auditing. You can see what action we have asked the provider to take at the end of this full report.

Why we inspected
This inspection was carried out in order for us to follow up on a warning notice we issued the provider with.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

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. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider and request an action plan to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Link Medical Staffing Solutions Ltd Haverhill Branch

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 Health and Social Care Act 2008.

Inspection team
This inspection was undertaken by an inspector 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. The Expert by Experience made telephone calls to people and their relatives to seek their feedback.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post. This person was also the provider of the service. We have referred to them as 'the provider' throughout this report.

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

Inspection activity started on 29 July 2022 and ended on 11 August 2022. We visited the location's office on 29 July 2022.

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

During the inspection
We spoke with the relatives of ten people who used the service about their experience of the care provided. We spoke with four members of staff. We reviewed a range of records. This included six people's care records and medication records. A variety of records relating to the management of the service, including audits were also viewed.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has 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.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some of the concerns under regulation 12 had been addressed at this inspection and we noted improvements. However, we identified further concerns and there remains a breach in regulation 12.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Despite staff being familiar with people's care needs, improvements were needed to ensure there was detailed guidance to follow to mitigate risks to people.
- One person's care plan and risk assessment was blank. We saw from the care notes made by care staff that the person was in receipt of personal care, at risk of pressure ulcers and was diabetic. Neither of these were included in their care plan and risk assessments. This meant we could not be sure staff had all the information they needed to support the person and mitigate these risks from occurring.
- Whilst people told us their care met their individual needs and staff could describe the techniques they undertook; improvements were needed to develop catheter care plans further to ensure people's specific needs and potential risks were identified and mitigated.
- Record keeping and care planning where people were at risk of pressure ulcers required improvement. One person who had sore areas had no assessment of their skin integrity carried out. This along with an insufficient skin care plan had resulted in some inconsistencies in care.
- There was not a robust system in place for the provider to evidence how they learned lessons when things go wrong. The processes in place were not sufficient to ensure, for example, care plans were reviewed in a timely manner.

We found no evidence that people had been harmed however staff did not always have the information they needed to provide safe care. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they felt safe with the staff who delivered their care. One person's relative said, "The carers will always advise me what [family member] needs to keep them safe and comfortable and that in itself is reassuring." Another person's relative commented, "We have no concerns and [family member] is well looked after." A third person told us, "The care staff are the ones to notice if [family member] has any sore areas or is unwell and they let me know immediately really so we get on to solve it."

Staffing and recruitment

● At the last inspection people and their relatives described either receiving late calls or missed calls. At this inspection we found improvements.
● People and their relatives told us there were sufficient care staff to deliver care as planned. One person told us, "They do contact us if they are going to be late and they have never let us down." A second person's relative said, "[Family member] does know who's coming through the door, no carer ever arrives who [family member] hasn't met before or who doesn't know [family member]." A third relative commented, "[Care staff] go in three times a day to check on [family member] and I use their [electronic care planning] system so I can see what time and what needed to be done etc and it keeps me in the know."
● We noted improvements overall to the safe recruitment of staff however, employment gaps had not been fully explored. The provider took immediate action to follow this up.

We recommend that the provider undertakes audits of their staffing files to ensure they can consistently evidence staff are safely recruited.

● Staff told us they had the training they needed to carry out their job roles safely and that there was investment in their learning as the provider had enrolled them all onto health and social care vocational qualification courses.

Preventing and controlling infection
● At the last inspection we were not assured that the provider was keeping people safe from COVID-19 transmission. This was because COVID-19 testing for staff could not be evidenced and the use of personal protective equipment (PPE) by staff was not always within current guidance. This had improved.
● Staff followed safe infection prevention and control (IPC) procedures. The provider's policies and procedures to deal with the Covid-19 pandemic were in line with recommended best practice and current legislation.
● Staff used appropriate personal protective equipment when delivering care and support for people.
● COVID-19 testing for staff was in place in line with Government guidance.

Using medicines safely
● People received the support they needed to safely manage their medicines. One person's relative told us, "They deal with all [family member's] medication which is great, between them and the pharmacy it's sorted out." Another relative said, "There are a few different carers and one forgot [family member's] medication but that was dealt with immediately and that carer never came back."
● The provider had introduced an electronic Medication Administration Record (MAR) chart system however improvements were needed to ensure the provider maintained oversight of any medicines not administered. For example, there were recordings of medicines not being administered but no reasoning why on the MAR chart or in the person's care notes.

We recommend the provider reviews their approach to the auditing of medication administration records so that any gaps in records are explored and there is evidence of appropriate action being taken in response to prevent a reoccurrence.

Systems and processes to safeguard people from the risk of abuse
● The provider had systems in place to safeguard people from abuse. People's relatives told us they felt their family member was safe with the care they received. One relative said, "My [family member] is very demanding but they are brilliant with [family member] and there is nothing they can't handle."
● Staff had received safeguarding training and understood their responsibilities to report any concerns to the managers. Staff were confident that their concerns would be followed up.

● The provider understood their responsibility to report any concerns to the local authority and to CQC to ensure any allegations or suspected abuse were investigated.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating for this key question has remained Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- Assessments of people's needs were not always completed to enable a plan of care to be developed.
- The providers systems to assess people's needs and develop care plans were not always effective. Some of the information in care plans was either missing or did not contain sufficient information to enable staff to be clear on the level of need.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- We were not assured of the provider's competence at making timely referrals to healthcare professionals when people's needs deteriorated, or a care need arose. For example, where one person had a deterioration in their skin health, staff took a photograph, but no referral was made to a healthcare professional for review.

Staff support: induction, training, skills and experience

- People were supported by staff who received training and support for their roles. People and their relatives told us that staff had the training and experience needed to deliver effective care.
- Staff were complimentary about the support they received from the provider and the easy access to online training they had been given at the start of their employment.
- Recently employed staff told us there had not been a competency assessment of their practice in certain healthcare tasks before working with people on their own.

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Care workers received training on the MCA which covered obtaining people's consent prior to delivering any care and the principles of the MCA. Despite this, records did not demonstrate that the MCA had been followed.
● Improvements were required to ensure all decisions, where a person lacked capacity to consent, were clearly recorded as being in the persons best interests.
● The provider told us it was not clear whether one person had the capacity to make their own decisions or not but that they were working with healthcare professionals to provide the least restrictive options.

We recommend that people's care and support needs are fully assessed, planned and completed in line with recognised MCA best practice and current legislation.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff prepared food and drink for people when requested. Care plans explained to staff what foods people liked.

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 our last inspection we rated this key question Requires Improvement. At this inspection the rating for 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

At our last inspection the provider had failed to ensure systems and processes were established and operated effectively at all times to monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our last inspection, we issued the provider with a warning notice requiring them to become compliant with Regulation 17. This was particularly in relation to safe infection control practices and the safe recruitment of staff. We found improvements in these areas at this inspection and the provider had met the warning notice. However, other concerns with governance meant the provider continued to be in breach of Regulation 17.

- The provider did not always use quality assurance systems and processes effectively to monitor and mitigate any risks relating to the health, safety and welfare of people using the service. We found missing care plans and key care information not in place. This placed people at the risk of potential harm.
- There were no consistent processes to check the quality and accuracy of risk assessments and care plans. This meant people were potentially at risk because staff did not have the guidance they needed to support people safely
- The provider failed to understand risk in a meaningful way, for example, there was a lack of evidence that the risk assessments completed protected people from harm as there were no clear actions recorded to reduce risk in the documents we reviewed.
- The provider had not consistently sought the views of people using the service. Two surveys had been sent out in 2022, however, there was no evidence that the findings of these had transferred into an action plan to drive improvements for people.

Governance systems were either not in place or robust enough to demonstrate the service was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider recognised the need to recruit an effective and experienced manager to run the service on a day to day basis. Whilst this was something they had previously explored, they told us it was a priority for them moving forward in order to lay the foundations for future oversight and leadership.
● We have reported on some of the improvements the provider has made since our last inspection and we were encouraged by this. For example, there were some improvements in the medicines administration systems. However, this is a work in progress and further improvements were needed with the oversight and governance arrangements in the service to ensure safe and consistent care. We received positive feedback about people's experience of using the service and of staff feeling supported in their role and did not receive any quality care concerns

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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
● Despite the lack of effective oversight and auditing, all of the people who used the service, and their relatives that we spoke with, were highly complementary about the service. One person's relative told us, "I think the [provider] does a good job. They keep in touch with me about any changes that need to be made." Another person's relative said, "I would have no qualms about recommending this service."

Working in partnership with others
● Relatives said they were kept informed and had regular contact with the provider and staff team. They said the staff were friendly, polite and engaged with them when they visited.

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 plans and assessments of risk were not always completed to mitigate against avoidable harm.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance and governance arrangements were not effective to identify shortfalls and promote improvements.