Primetower Care Broadstone Limited

The Links

Inspection report

1 Golf Links Road
Broadstone
Dorset
BH18 8BE

Tel: 01202974000
Website: www.thelinkshome.com

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18 December 2015

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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 was a comprehensive inspection, carried out over three days on 16, 17 and 18 December 2015. The first day was unannounced.

The Links is a care home for up to 68 people. It is a purpose-built home that specialises in caring for people who are living with dementia. Accommodation in single, ensuite bedrooms is mostly arranged over the ground, first and second floors. Nursing care is provided on the first and second floors. There are six additional rooms on the third floor. There are two passenger lifts to assist people to get to the upper floors. When we inspected, there were 45 people living there.

The home 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. 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. There has not been a registered manager since November 2015. The current home manager has applied to register as manager.

At the last inspection in December 2014 we identified breaches of the regulations and required the provider to make improvements to: the way they assessed and monitored the quality of the service, procedures for ordering and recording medicines, recording of consent and dietary needs, staff training, pain assessment, and care planning. This action has been completed.

Additionally, at our inspection in December 2014 we identified areas where improvements could be made. These related to dementia-friendly signage and arrangements for choosing meals. These improvements have been made.

People received the care and support they needed from staff who understood their care needs. They had a choice of food and snacks and drinks were available between meals. Their dietary needs were met. People's health needs were monitored and if necessary referrals made to other health care professionals such as GPs.

People were treated with kindness and compassion and staff respected their dignity. Staff worked within the principles of the Mental Capacity Act 2005, wherever possible obtaining people's consent to their care and respecting people's choices. People and their relatives were involved in choices and decisions about care. Where people did not have the mental capacity to consent to particular aspects of their care, staff followed the correct processes to make decisions about the care in the person's best interests.

People and their relatives were confident that people were safe at the home. Medicines were stored and managed safely. Staff understood how to keep people safe and how to report accidents, incidents or concerns. They felt confident in raising concerns with the management team. There were sufficient appropriately qualified and skilled staff on duty. The appropriate checks were made before people started working at the home to ensure they were suitable to work there.

There was a programme of regular checks and audits to ensure that care remained safe and effective and to help bring about improvements.

The home had a positive culture that was person-centred, caring and friendly. People, relatives and staff were proud of the home. People and relatives had regular opportunities to feed back their views about the home and quality of the service they received. There had been a significant turnover in staff following the change of manager during 2015. Most staff described morale as good, and expressed confidence in the current management. Staff were aware of the whistleblowing policy and felt that they could raise any concerns. They were supported through regular supervision and training. We observed that staff were calmer and more confident than they had appeared previously.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were managed and administered safely.

People felt safe. They were protected from avoidable harm and potential abuse.

The premises and equipment were well maintained.

Is the service effective?

Good

The service was effective.

Staff were supported through supervision and training to develop and maintain the skills they needed to care for people.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005.

People's health needs were monitored and where appropriate referrals were made to health and social care professionals.

Is the service caring?

Good

The service was caring.

People and families were all positive about the caring attitude of the staff.

Staff respected people's dignity and followed their preferences.

Staff showed concern for people's wellbeing in a caring and meaningful way, and responded to them quickly if they were distressed or needed something.

Is the service responsive?

Good

The service was responsive.

People received the care they needed from staff who understood their care needs. Care plans were regularly reviewed and kept up

to date.

People had opportunities to be involved in things that interested them through a range of organised and informal activities.

Complaints and concerns were taken seriously and used as an opportunity to improve the service.

Is the service well-led?

Good

The service was well led.

People, families and staff were confident in the home's leadership.

The management team had implemented a quality assurance system to monitor the quality of care provided and to drive improvements.

The Links

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 was a comprehensive inspection, carried out over three days on 16, 17 and 18 December 2015. The first day was unannounced. Prior to the inspection we had received information of concern relating to staffing and care. Two inspectors were present on the first and third days, and an inspector and a specialist advisor in nursing on the second day.

Before our inspection we reviewed the information we held about the home, including notifications of incidents the provider had sent us since our last inspection in December 2014. We also spoke with the local authority safeguarding and commissioning teams. In February 2015 the provider completed a Provider Information Return (PIR) and we used this during our preparation. This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. As this inspection was brought forward in response to information of concern, we did not request a further PIR.

During our inspection we spoke with nine people who lived in the home and with seven relatives. Some people were living with dementia and were not all able to tell us about their experiences at The Links, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with a visiting health and social professional, five registered nurses, eight other staff involved with care, the chef, four members of administrative and ancillary staff, two senior nurses, home manager and the operations manager. We observed care and support in communal areas and looked at the care records for nine people and medicines administration records on the ground, first and second floors. We also looked at records that related to how the home was managed, including four staff files, staff rotas and the provider's quality assurance records.

Following the inspection, we obtained feedback from six health and social care professionals who have

contact with the home.

Good

Is the service safe?

Our findings

People we spoke with all felt that they or their relatives were safe. For example, a relative commented, "When I go home from here I don't worry about her".

At our last inspection in December 2014, we identified a risk that people might not receive their medicines as prescribed or when they needed them. Staff did not have adequate guidance to know when people needed to take medicines prescribed on an 'as necessary' (PRN) basis. Procedures for ordering medicines were not robust. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan stating they taken action to meet the regulation by 22 April 2015.

At this inspection we found that people's medicines were managed and administered safely. Medicines were stored securely and records were kept so that the amount stored could be accounted for. Sufficient medicines were kept in stock so that people did not run out, although there were occasional hiccups in communication between the home, the GP surgeries and the pharmacy regarding prescriptions. Most oral medicines were supplied in blister packs, each blister containing the correct dose for a particular time and day, to help ensure people received their medicines as prescribed. Where people were prescribed PRN medicines, there were written guidelines for staff setting out what each medicine was for, when the person might need it, the maximum dose in 24 hours and the minimum interval between doses. Some people had their medicines disguised in food or drink as they lacked the mental capacity to consent to taking the medicine. The required paperwork, such as mental capacity assessments and best interest decisions, and evidence of liaison with the pharmacy, was in place.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. They were able to tell us about signs of possible abuse and how they should report this. Since the last inspection, a 'bruise pathway' had been introduced. This prompted staff to record bruises properly. The management team reviewed these for any additional care that might be needed to maintain the person's safety, monitoring for any trends and making safeguarding referrals where appropriate. Similarly, accidents and incidents were audited to help ensure people were safe from further injury or harm and to monitor for developing trends.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. Risk assessments were specific to the person, covering concerns that had been highlighted during assessments or reviews, or in response to accidents and incidents. They covered areas such as falls, the use of bed rails, pressure ulcers, malnutrition, swallowing difficulties and verbal and physical aggression. For example, a person required a pressure-relieving mattress because of their risk of developing pressure ulcers and this was adjusted to the setting specified in their care plan. However, in general, pressure sore risk assessment documentation did not itself document what action was to be undertaken for a particular level of risk. This is an area for improvement.

There were arrangements in place to keep people safe in an emergency. Each person had a specific emergency evacuation plan clearly documented within their records, setting out the assistance and equipment they would need if the building had to be evacuated. A fire risk assessment had been undertaken the previous month by a specialist contractor. Quotations had been obtained for work that was necessary to address identified shortcomings, and this was scheduled for the new year.

The premises were maintained in good repair. The building smelt fresh and was kept at a comfortable temperature. The management team informed us that the provider had authorised the purchase of specialist chairs to enable people with a high level of mobility needs to spend more time in communal areas. Equipment, such as lifts, hoists, scales and the call bell system, was regularly serviced and had current service certificates. All of the equipment we saw was visibly clean and hoist slings were dedicated for use with individual people to reduce the risk of cross contamination. Safety needles, to reduce the risk of nurses receiving needlestick injuries when they gave injections, were not in use. We drew this to the attention of the management team, who undertook to ensure they were provided in future.

People were supported by sufficient numbers of staff with the right skills and knowledge to meet their individual needs. They and their relatives told us there were enough staff on duty at any one time and requests for assistance were responded to promptly. Our observations were consistent with this. Staff confirmed that within existing staffing levels they were sometimes busy but were able to provide the support people needed. The home manager explained that staffing was generally planned on a ratio of one staff member to four residents, although it was sometimes increased if people's needs intensified. There were additional staff on duty during the inspection as the provider was due to open another home in the area and its staff were undertaking their induction at The Links. Staff commented that agency staff were used sometimes, especially at night, although this was reducing. At the time of the inspection all vacancies for registered nurses had been recruited to.

The service followed safe recruitment practices. Staff files included application forms, full employment history, records of interview, evidence of qualifications and appropriate references. Checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work in a care setting. Records seen confirmed that staff members were entitled to work in the UK.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled in meeting their needs. For example, a person told us, "I like it here and the staff are very nice". A relative told us how staff had been understanding of their family member's health conditions and were able to provide the right support. People told us they liked the food and were able to make choices about what they had to eat.

At our last inspection in December 2014, we found care staff did not all have the knowledge and understanding to meet people's complex needs associated with dementia that would be expected in a dementia specialist care home. Staff were not all supported through regular supervision.
This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan stating they would meet the regulation by 18 May 2015.

At this inspection in December 2015 we found that staff had the training and supervision they needed in order to be able to provide the care people needed. Staff told us they had access to training and skills development. For example, a member of staff said they had received "loads of training" since they started in post earlier in the year and another staff member said they were always booked on the training they needed. Registered nurses confirmed they were able to meet their post-registration professional education requirements. Staff had induction training when they started working at the home and were expected to update this training at regular intervals. The management team explained that staff were undertook two days' dementia training and training records showed that staff also had training in the Mental Capacity Act 2005 and in managing behaviour that challenges. Other training included moving and handling, safeguarding, fire safety, first aid, infection control and food hygiene. Registered nurses and other staff who administered medicines had training in medication management.

People were supported by staff who received regular supervision through one-to-one meetings with their line manager. Staff confirmed that supervision meetings happened regularly and enabled them to discuss any training needs or concerns they had. The management team had audited supervision within the past month to check that staff supervision was up to date and identify who was due supervision. As a result of the audit, a member of the management team had undertaken night visits to provide supervision for night staff and to undertake medicines competency assessments that had fallen due.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection in December 2014, we found there was a risk that people might receive care or treatment to which they had not consented because records were not readily available to care staff. Care records did not all contain details of lasting powers of attorney or other legal authority that people's representatives had to give consent on people's behalf. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 17(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan stating they would meet the regulation by 31 May 2015.

At this inspection in December 2015 we checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that people or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. Care records contained a record of people's consent to various aspects of their care, or if they were unable to give consent, that decisions had been made by others with legal authority to do so. Details of lasting powers of attorney for health and welfare, where these were held, were kept in people's care records. Where someone lacked capacity to make a specific decision and there was no-one legally authorised to do so for the person, staff made a mental capacity assessment and took a best interests decision on the person's behalf.

People's rights were protected because the staff acted in accordance with the MCA. The home manager had identified a number of people who they believed were being deprived of their liberty. They had applied to the appropriate supervisory body for this to be authorised under DoLS. Where deprivation of liberty had been authorised under DoLS, the authorisations were in date and there was a system for monitoring when renewal applications would be due. The authorisations we looked at had no special conditions.

At our last inspection in December 2014 we found that people did not all have access to food and drinks between meals. We also found that there were no arrangements to ensure that people living with dementia always had meals of their choice, as menu decisions had to be made a long time ahead of meals. We recommended that food and drink was made available between meals, and that arrangements were made to ensure that people living with dementia had a meaningful choice of meals.

At this inspection in December 2015 we found people were supported to have a meal of their choice. Menu choices were now made in various ways according to the needs and preference of the individual. For example, some people liked to plan their meal early in the day whereas others, such as people living with advancing dementia, were shown plated meals as the meal was being served. The home's chef kept a record of people's dietary needs and preferences and made provision for these. For example, we saw a person having a lunch they could pick up with their fingers as this was what they could manage to do for themselves. Pureed meals were presented as attractively as possible, each food on the plate being pureed separately. Food and drink was made available between meals.

At our last inspection in December 2014 we found that signage was not adapted to the needs of people living with dementia. Many doors looked the same and toilets and bathrooms were not identified other than with small written signs. We recommended that the provider reviewed the use of signage around the home in line with recognised good practice guidance.

At this inspection in December 2015 signage had improved. People's rooms were labelled in a way that helped the person recognise them. Bathrooms and toilets were more easily identifiable.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals such as community mental health staff,

physiotherapists or occupational therapists. Health and social care professionals confirmed that referrals had been made appropriately and that staff had acted on their advice. Care records showed that relevant professionals, such as GPs, dentists, opticians and chiropodists were involved with people's care. Care plans were in place to meet people's needs in these areas and were regularly reviewed.

Good

Is the service caring?

Our findings

People and relatives we spoke with all commented positively about the friendliness and warmth of all staff. For example, a person told us that staff were kind, and smiled and introduced me to "my nurse". They said that staff had been understanding and supportive with a situation they had recently found difficult. Another person commented, "They're all lovely ladies to me". A different person's relative told us, "I know Mum is loved and cared for by the staff". A further relative commented, "They know when we're struggling and look after us. They are professional and very caring, all the staff".

People were treated with kindness and compassion in their day-to-day care and staff respected their dignity. Care was not rushed and we saw many instances of staff sitting and chatting with people, not just when they were delivering care. Staff prompted and assisted people discreetly and personal care took place behind closed doors. Where possible, a screen was positioned to stop others watching people being assisted with hoist transfers.

Staff showed concern for people's wellbeing in a caring and meaningful way, and responded to them quickly if they were distressed or otherwise needed assistance. For example, a person was anxious whilst sitting in a hoist sling. The two staff assisting the person to transfer gently and calmly explained what was happening, providing reassurance throughout the procedure. Another person started shouting in their room and staff quickly went to them, calmly speaking with them by name and finding out what they needed. When staff discussed people's care with us, they spoke about them in a passionately caring, respectful manner.

People were kept informed about their or their relative's care. For example, a relative commented, "They keep me up to date with everything… Families are so included in things". Another relative commented that they and their family member were involved in regular care plan reviews. Records showed that people and their relatives had been consulted as part of their monthly reviews. People could have visitors at any time they wished.

Staff were aware of people's preferences and respected their choices. People's records included information about their personal circumstances and how they wished to be supported. For example, some people preferred to spend time in the lounge whereas others preferred to be in quieter areas or their rooms. Where people had a strong preference this was recorded in their care plan, but we also observed staff asking where people would like to sit and respecting their choice. One person wore a hat as they went to lunch; staff explained that the person often liked to wear a hat.

People were able to bring in items of furniture, as well as pictures, photographs and ornaments, to make their rooms feel homely.

Staff spoke about people's care out of the earshot of others. However, we saw a set of care records on an unattended desk. Additionally, people's dietary needs and preferences were displayed on a kitchenette wall where others might see them. We drew these matters to the attention of the management team. These are

areas for improvement.

Good

Is the service responsive?

Our findings

People and their relatives said that staff provided the care people required and were quick to respond to any needs. For example, a relative who spent a lot of time at the home said that staff came quickly if call bells rang.

At our last inspection in December 2014, we found there were continuing shortfalls in the planning and delivery of care to meet people's individual needs and ensure their safety and welfare. Some care plans lacked clear guidance for staff about the care people needed. Care plans were not always promptly or accurately updated in response to people's changing needs. Pain assessments were not routinely used when people were living with conditions that could make it difficult for them to tell staff about their pain. Care plans were not always followed. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan stating they would meet the regulation by 31 May 2015.

At this inspection in December 2015 we found that assessments and care plans were kept under regular review and were up to date. The home operated a 'resident of the day' scheme, where each day, particular people's care was scheduled for a thorough review, so that everyone's care was reviewed every month or so and care plans updated accordingly. Pain assessments were routinely used where people may not have been able easily to tell staff they were in pain.

People received the care they needed. Care plans clearly explained their care needs and reflected their preferences about how their care should be delivered. Staff were able to explain the care people needed and we observed that they followed care plans. For example, a person's care plan stated that they wore glasses and used a walking stick; we saw the person had their glasses on and their walking stick close to hand. A person who needed assistance to swallow without choking and sometimes ate meals in their room had the relevant part of their care plan on hand in their room for staff to refer to. Similarly, where people had particular moving and handling needs, these instructions were available for staff in their rooms.

Handovers between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. The handovers we observed were focussed on people's particular needs at that time.

Activities organisers provided a range of activities people could be involved in. A relative who visited often described the activities as "vibrant". People were able to choose what activities they took part in and suggest other activities they would like to complete. On one of the inspection days there was a festive gala lunch for people and their relatives, with a musical entertainer in the afternoon. People who did not want to attend a large occasion were able to have a quieter meal upstairs. As well as organised activities, there were things around the building to stimulate people's interest. These included books, rummage objects such as wool and beads, sheets to fold and pictures of local interest.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. People and their relatives said they felt able to raise any issues. For example, a relative told us, "I would have no hesitation in raising a concern should I ever need to". There had been three complaints since the current manager started in post in November 2015. These had been investigated thoroughly and people and their relatives were satisfied with their responses.

Good

Is the service well-led?

Our findings

People commented positively about the leadership of the service. A group of relatives told us they had seen lots of changes over the years but things were "on the up". Another relative whose family member had been at the home for a few years and who visited regularly said, "The management structure that's here now is the best it's ever been… They've got nothing to hide… Managers no longer avoid your gaze".

At our last inspection in December 2014, we found the management team was taking steps to introduce more robust quality assurance processes following the previous inspection. However, these were not complete and there were still shortfalls in record keeping and quality monitoring. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan stating they had taken action to meet the regulation by 22 April 2015.

At this inspection in December 2015 we found robust quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. Records were mostly complete and up to date.

There was a programme of regular checks and audits to ensure that care remained safe and effective. For example, accidents and incidents were audited to establish possible trends in times, locations and people involved, and to check that any injuries had been managed appropriately. Similarly, wounds, infections, bruises, and weights and malnutrition risk were monitored monthly for any trends and to check that people had received the appropriate care and treatment. Call bell response times were also monitored randomly, with any longer than three minutes being investigated and the reasons documented, although this was a rare occurrence.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. In addition to care plan reviews every month or so, there were regular residents' and relatives' meetings at which people could discuss events at the home and their views on how the home was run. A relative commented that if anything was raised at the meetings it was dealt with. People's experience of care and satisfaction with the home had been monitored through a residents' and relatives' survey completed in October 2015. Most of the responses from 25 people were positive. However, where people had raised specific points and given their names, there were individual action plans addressing these.

The service had a positive culture that was person-centred, caring and friendly. People, relatives and staff remained loyal to and proud of the home. Staff were aware of the whistleblowing policy and felt that they could raise any concerns to management. Staff commented that there was now strong leadership and they knew what was expected of them. We observed that staff were calmer and more confident than they had appeared previously. There had been a significant turnover in staff following the change in manager during 2015 and a small minority of staff commented that this had caused some apprehension and difficulties with communication. However, other staff described morale as very good although they acknowledged not

everyone had found the changes easy to deal with.

The home manager, who had started in post during 2015, was not registered with the Commission but had applied to register. The last registered manager left in October 2015. Having a registered manager is a condition of the home's registration. The home manager had notified the Commission about significant events. We use this information to monitor the service and ensure they respond appropriately to keep people safe.