The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Link Community Care**

Provider: **Link Community Care Ltd**

Date of Inspection: **21 August 2025**

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider:	Link Community Care Ltd
Responsible Person:	Mr Henry Loney
Registered Manager:	Mrs Beverley Loney
Service Profile – Link Community Care is a domiciliary care agency which provides a range of personal care and support to service users living in their own home. Services are commissioned by the South Eastern Health and Social Care Trust (SEHSCT).	

2.0 Inspection summary

An unannounced inspection was undertaken on 21 August 2025, between 9.40 am and 4.15 pm by a care Inspector.

The inspection was undertaken to evidence how the care agency is performing in relation to the regulations and standards and to assess progress with the areas for improvement identified by RQIA, during the last care inspection on 13 May 2024. Two areas for improvement identified during the previous inspection, were assessed as having been addressed by the provider. These are discussed in more detail in sections 4.5 and 4.6.

The inspection established that the service was well- led, that care delivery was safe and that effective and compassionate care was delivered to service users, however, improvements were required to ensure the effectiveness and oversight of certain aspects of the agency.

There were four new areas for improvement identified during this inspection. These relate to the recording and management of medication incidents, staff training, content of monthly monitoring reports and review of policy documents. Full details of these new areas for improvement identified can be found in the main body of this report and in the quality improvement plan (QIP) in Section 5.

We would like to thank the manager and staff for their assistance throughout the inspection.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how agency was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this service. This included any previous areas for improvement issued, registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors will seek the views of those receiving support, as well as those working within the agency and review a sample of records to evidence how it is performing in relation to the regulations and standards.

Information was provided to service users, relatives, staff and other stakeholders on how they could provide feedback on the quality of services. This included questionnaires and an electronic survey.

3.2 What people told us about the service and their quality of life

Through actively listening to a range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans. We approached service users, relatives, care staff and HSC professionals to seek their views of Link Community Care. The information provided indicated that there were no concerns in relation to the care and support provided to service users.

Service users and relatives who provided feedback on the service indicated that they were satisfied with the care and support provided by the agency.

One service user who spoke with the inspector said: "Everything is going well they are all lovely – staff couldn't be better".

Relatives who spoke with the inspector advised that they were happy with the carers and that the staff in the office were responsive if they needed anything.

Staff who spoke with the inspector indicated that the service users get good care and support from the agency, that the training was useful and that the manager was approachable and supportive. One staff member indicated that it can be difficult to get a break between the morning and afternoon runs due to the number of calls. This was shared with the manager who agreed to review the rotas and ensure staff are afforded adequate breaks.

HSC professionals who spoke with the inspector advised that the staff are very helpful and responsive and that the agency is good at communicating any concerns with caring, friendly and helpful staff.

4.0 Inspection findings

4.1 What are the systems in place for identifying and addressing risks?

The agency's provision for the welfare, care and protection of service users was reviewed. The organisation's adult safeguarding policy and procedures were reflective of the Department of Health's (DoH) regional policy and outlined the procedure for staff for reporting concerns. The policy had not been reviewed in a substantial period and did not have a review date. This has been identified as an area for improvement and is discussed further in section 4.6. The organisation had an identified Adult Safeguarding Champion (ASC).

Discussions with the manager established that they were knowledgeable in matters relating to adult safeguarding, the role of the ASC and the process for reporting and managing adult safeguarding concerns. The manager advised that there had been no adult safeguarding concerns raised since the last inspection.

Staff were required to complete adult safeguarding training during induction and every two years thereafter. It was identified that one staff member had not completed refresher training however the manager has since confirmed that all staff are now up to date with their adult safeguarding training. Staff who spoke with the inspector had a clear understanding of their responsibility in identifying and reporting any actual or suspected incidences of abuse and the process for reporting concerns in normal business hours and out of hours. They could also describe their role in relation to reporting poor practice and their understanding of the agency's policy and procedure with regard to raising concerns in the public interest (Whistleblowing).

The manager was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI).

The agency also retained records of all accidents and incidents that had occurred. A review of these records indicated that some recorded medication errors, had not been inadequately reviewed to ensure staff competency around administration of medication. An area for improvement has been identified. Advice was given to the manager in respect of implementing a system to track any trends arising from all accidents and incidents including medication errors so that any themes can be easily identified and any further training or competency assessments can be arranged in a timely way. The manager confirmed that a tracking system is in the process of being implemented to manage all accidents and incidents appropriately going forward.

4.2 Mental Capacity Act and Restrictive Practice

The Mental Capacity (Northern Ireland) Act 2016 (MCA) provides a legal framework for making decisions on behalf of service users who may lack the mental capacity to do so for themselves.

The MCA requires that, as far as possible, service users make their own decisions and are helped to do so when needed. When service users lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

On review of training records a number of staff had yet to complete Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. This is discussed further in section 4.4. The manager reported that none of the service users service user were subject to DoLS or restrictive practice.

4.3 Staff Selection, Recruitment and Induction

A review of the agency's staff recruitment records confirmed that all pre-employment checks, including criminal record checks (AccessNI), were completed and verified before staff members commenced employment and had direct engagement with service users. Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC). There was a system in place for professional registrations to be monitored by the manager. Staff were aware of their responsibilities to keep their registrations up to date. There were no volunteers deployed within the agency.

To ensure compliance with regulations a full employment history of all potential employees must be obtained. On inspection of the most recently recruited staff however, it was noted that full details of all employees' work histories from the age of 18 and reasons for leaving any care positions were not captured within the recruitment records. Following inspection, the manager shared plans to evidence how this information will be captured for any future employees thereby ensuring more robust recruitment practices in compliance with the Regulations. This will be reviewed at a future inspection.

There were no volunteers deployed within the agency.

There was evidence that all newly appointed staff had completed a structured orientation and induction, having regard to NISCC's Induction Standards for new workers in social care, to ensure they were competent to carry out the duties of their job in line with the agency's policies and procedures. There was a robust, structured, induction programme which also included shadowing of a more experienced staff member. Written records were retained by the agency of all training, including induction and professional development activities undertaken.

4.4 Staff Training and Development

Staff were provided with training appropriate to the requirements of their role as part of induction to the agency. The agency held an electronic record of all training undertaken by staff which on review, indicated that a number of staff were outstanding refresher training in mandatory training areas including, Adult Safeguarding, Fire Safety, Manual Handling, Infection Control and DoLS training. An area for improvement has been identified. The manager advised that some of the refresher dates on the training record system were inaccurate and therefore a review of this alongside the training needs of all staff was required to ensure compliance. It was recommended that ongoing review of staff training takes place at regular intervals to ensure that any training needs of staff can be identified and arranged in a timely manner. It was positive to

note that staff who spoke with the inspector advised that they felt that training was useful and that they were aware of the need to keep their mandatory training up to date.

The manager reported that a number of service users required the use of specialised equipment to assist them with moving and that this was included within the agency's mandatory training programme.

All staff had been provided with training in relation to medicines management and were required to complete competency assessment prior to undertaking this task.

4.5 Care Records and Service User Input

A sample of service users' care records was examined and contained detailed information about the level of support required. Discussions with staff and review of service users' care records reflected the multi-disciplinary input and the collaborative working undertaken to ensure service users' health and social care needs were met within the agency. There was evidence that staff made referrals to the multi-disciplinary team and these interventions were proactive, timely and appropriate

A number of service users were assessed by Speech and Language Therapist (SALT) with recommendations provided and some required their food and fluids to be of a specific consistency. During the previous inspection, an area for improvement was identified in relation the review of SALT recommendations within service user care records. A review of a sample of care records evidenced that staff were given clear indications where SALT recommendations were in place and this was recorded both on the service user's care records and on an electronic record which the manager kept under regular review. Staff were familiar with how food and fluids should be modified and implemented the specific recommendations of the SALT to ensure the care received in the setting was safe and effective. On this basis the previous area for improvement was deemed to have been addressed by the provider.

4.6 Governance and Managerial Oversight

A review of a selection of policies and procedures indicated that some documents including the Complaints Policy, Adult Safeguarding Policy, Incidents/Accidents and Medication Policy had not been reviewed in a considerable period and did not have a set review date. This is identified as an area for improvement.

An area for improvement identified during the previous inspection had been restated for the second time and related to monthly monitoring reports which were not available at the time of inspection. A review of this area for improvement established that monthly monitoring arrangements had taken place in compliance with the Regulations and Standards. This area for improvement was therefore deemed to have been addressed by the provider. On further examination of the content of a sample of these monthly monitoring reports however, there was evidence of duplicate comments being stated in subsequent reports with respect to service users', relatives, staff and stakeholders' views. Unique identifiers were not used with respect to those care records that were reviewed and therefore it could not be established what actions, if any, required to be carried forward to the following monitoring visit. An area for improvement has been identified.

The agency's registration certificate was up to date and displayed appropriately along with current certificates of public and employers' liability insurance. The Annual Quality Report was reviewed and was satisfactory.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure which also required review. On examination of the complaints received since the last inspection, it was confirmed that they had been appropriately managed and were reviewed as part of the agency's quality monitoring process.

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAI) procedure.

5.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	2	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Beverly Loney, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Domiciliary Care Agency Regulations (Northern Ireland) 2007	
Area for improvement 1 **Ref:** Regulation 16 (2) (a) **Stated:** First time **To be completed by:** Immediate and ongoing from date of inspection	The registered person shall ensure each employee of the agency receives training and appraisal which are appropriate to the work he is to perform. This relates to the need to ensure staff training is kept up to date and under regular review. Ref: 4.4
	Response by registered person detailing the actions taken: Link Community Care now holds a traffic light spread sheet indicating when training is approaching due dates. The system used for online training has annual updates, this varies to the Mandatory training dates advised by the Minimum Care Standards. The Inspection did highlight training that was due completion and this is now updated. We are confident the new system will be more efficient and make it easier to monitor.
Area for improvement 2 **Ref:** Regulation 23 (1) (2) (a) (b) (i) (ii) (c) (3)(4)(5) **Stated:** First time **To be completed by:** Immediate and ongoing from date of inspection	The registered person shall establish and maintain a system for evaluation the quality of the services which the agency provides. It will provide a report that describes how the agency arranges good quality services, taking into account the views of service users and their representatives regarding the services provided to them; and that they have responded to recommendations imposed by RQIA. The report will detail the measures taken to in order to improve the quality and delivery of the services provided by the agency. Ref: 4.6
	Response by registered person detailing the actions taken: The manager will ensure the Quality Monitoring Report will be reflective of the activity within the agency and will flow from planned action to completion on the monthly report.The document used is under review for improvement. .

Action required to ensure compliance with Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for Improvement 3 **Ref:** Standard 7.14 **Stated:** First time **To be completed by:** Immediate and ongoing from date of inspection	The registered person shall ensure that the management of medicines is systematically audited to ensure they are consistent with the agency's policy and procedures and action is taken when necessary to ensure medication is administered safely as required. Ref: 4.1
	Response by registered person detailing the actions taken: Link Community Care have put a spread sheet tracker in place to identify any possible triggers in medicaiton errors, this will hopefully lesson the number of incidents occurring, since the inspection and with this system in place there is a notable improvement.
Area for improvement 4 **Ref:** Standard 9.5 **Stated:** First time **To be completed by:** Immediately and ongoing Standard	The registered person shall ensure that all policies and procedures are subject to a systematic 3 yearly review; any revision to or introduction of new policies and procedures are to be ratified by the registered person**.** Ref: 4.6
	Response by registered person detailing the actions taken: The agency Policies are currently under review and will be updated where necessary. Completion by December 2025

Please ensure this document is completed in full and returned via the Web Portal

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