The Limes Residential Care Home Limited

The Limes Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Overall summary

We carried out a focused inspection on 19 November 2015 to check whether The Limes has taken action to meet the requirements of two warning notices we issued on 24 August 2015. This report only covers our findings in relation to these topics.

We undertook an unannounced comprehensive inspection at The Limes on 7 and 10 July 2015 at which breaches of regulations were found. You can read the report from our lastcomprehensive inspection, by selecting the 'all reports' link for 'The Limes Residential Home' on our website at www.cqc.org.uk'.

The Limes Residential Home is registered to provide accommodation for persons requiring nursing or personal care. The Limes is a residential care home for up to 32 people. At the time of our inspection 27 people were living at The Limes some of whom had physical disabilities or were living with dementia.

The home had a registered manager at the time of our inspection. 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.

At The Limes care is provided on three floors. A passenger lift is available for people to access the rooms on the upper floors. A large dining room and three lounges are located on the ground floor. The garden was well maintained and people had access to the outside areas.

Care provided at The Limes was not always safe. Risks to people's health and wellbeing were not always assessed effectively and action was not always taken to reduce those risks. When people's needs and risks increased, assessments were not always updated. Key information in relation to risks to people's health and wellbeing was not recorded consistently and communicated in an effective way to all relevant staff.

Summary of findings

Some aspects of medicines management were not safe. Systems were in place to ensure people received their medicines at the appropriate time. Staff administered medicines in a discreet and caring manner and recorded what was administered accurately.

People felt safe with care staff. Staff were aware of the signs that might indicate abuse and knew what to do to if they had concerns. They were confident about reporting abuse and demonstrated personal accountability in relation to people's safety. Safeguarding concerns were reported appropriately and investigated thoroughly.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Some risks to people's health and wellbeing were not assessed and action was not taken to reduce the risk. Risks were not communicated to relevant staff effectively to ensure people were cared for safely.

Some aspects of medicines management were not safe.

Staff were aware of signs of abuse and were confident to report concerns when necessary.

The Limes Residential Home

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 was a focused inspection in response to concerns raised about the safety of the service. We checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the "Safe" domain.

This inspection took place on 19 November 2015 and was unannounced. The inspection was carried out by one inspector.

We reviewed the previous inspection report and information we held about the service including notifications. A notification is information about important events which the service is required to send us by law.

We spoke with three people living in the home and two relatives. We also spoke with the registered manager, two deputy managers, four care staff and the provider's representative. We observed staff providing care and support to people in the lounges, looked at care plans and associated records for four people living in the home. We checked medicine administration records, and some of the provider's policies, procedures.

Inadequate

Is the service safe?

Our findings

At the last inspection we found that medicines were not managed safely. Risks to people's health and wellbeing were not assessed effectively and action was not always taken to reduce the risks. At this inspection we found improvements had not been made to ensure people were cared for safely. Improvements had been made to the management of medicines, however some aspects of medicine storage and administration were still not always safe.

People's care plans included assessment of risks to their health and wellbeing, such as falls, pressure injury, malnutrition and for behaviour that put themselves and others at risk. However, risk assessments for some people were not accurate or complete. One person frequently became anxious and physically aggressive when care staff tried to carry out personal care. They had a risk assessment in place which had been reviewed on 31/10/15. This stated that the person had experienced 'no incidents' since the last review. However, records of aggressive behaviour showed that staff had recorded at least eight incidents of physical aggression in that period. The behaviour record was not detailed and did not allow for an analysis of incidents in order to establish a possible pattern and take action to reduce the risks. Records showed that staff responded inconsistently during these episodes. Whilst some staff followed the person's care plan, which advised staff to retreat to allow the person to calm down, other staff continued to carry out the task that had triggered the person's aggressive episode.

Specialist guidance in relation to the person's needs had not been implemented. The guidance suggested approaches to the person's care that could reduce their anxiety and aggression. The registered manager acknowledged they had not implemented the guidance in relation to providing the person with care in a safer manner.

Another person became increasingly unwell over a period of a week. The increased risks to their health and mobility were not communicated to staff, and medical intervention was not sought when it became clear that the person's health was declining. Their care plan and risk assessments had not been updated to reflect their increased needs and no clear guidance existed for staff to ensure they supported the person to mobilise safely.

The failure to assess and manage risks to people's health and safety was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of risks to other people living in the home. They knew what action to take to protect people, for example, ensuring sufficient numbers of staff supported people to mobilise around the home. One person was at risk of malnutrition. Their care plan stated they should be offered high calorie snacks between meals. Although these were not recorded, staff, and the person's relative confirmed the person was given fruit smoothies and milkshakes throughout the day.

Some aspects of medicines management were not safe. Stocks of 'as required' medicines had not been recorded so it was not possible to check these. Two of these medicines had loose tablets in the box. Staff administering medicines did not know why or when they had been removed from the packaging and left loose in the box. Stocks of other medicines, including drugs controlled by law, were accurate.

The failure to ensure medicines were managed safely was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Storage facilities for medicines were appropriate and secure. The temperature of the storage facilities was recorded to ensure medicines were stored according to the manufacturer's guidance.

Guidance was in place for medicines that were prescribed on an 'as required' basis. This indicated to staff how much of the medicine to give and what action to take if the medicine did not work within a specified timescale. Body maps were in place to guide staff where they should apply creams; these were detailed and specific.

Staff administering medicines did so in a safe manner. They checked the medicines administration records (MAR) and the person's photo before giving people their medicines and signed the record once the person had taken their medicines. People received their medicines at the appropriate time and staff did this in a discreet and caring manner. People were asked if they would like their

Inadequate

Is the service safe?

medicines and were provided with a drink where this was appropriate. Staff said, “Are you ready for the next one?” and waited for the person to indicate they were ready before giving them their next medicine.

People and their relatives said they felt safe. One person said, “They look after me; I feel safe” adding that, “staff are lovely”. A relative said their family member was, “looked after very well”, and another said, “I have never seen anything here that alarmed me”.

An appropriate safeguarding policy was in place; staff knew what should be reported to the local authority safeguarding team and the procedure to report their concerns. Forms were in place for staff to report any unexplained injury or incident resulting in harm to people. Incidents were recorded and reported appropriately. Staff were knowledgeable about abuse and the signs to look for in people they cared for. People said they felt safe with staff. One person said, “They are very caring; no one has ever been unkind or sharp with me; they’re lovely”. People had no concerns about their safety but knew who to talk to if they did. Where a form of restraint was deemed necessary in order to care for a person safely, this decision had been taken in accordance with the law and to protect the person’s rights.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services did not receive safe care and treatment because risks to their health and wellbeing were not always assessed and managed; Some aspects of medicines management were not safe. Regulation 12 (1), (2) (a), (b), (g)

The enforcement action we took:
We issued a warning notice to be met by 31 January 2016.