Leicestershire County Care Limited

The Limes

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Limes is a residential care home providing personal care to up to 40 people with a range of support needs. There were 34 people living at the service at the time of our inspection. The service provides support to older people some of whom are living with dementia.

The Limes is purpose built. It is split over two floors with communal areas on each floor.

People's experience of using this service and what we found
People were not protected from the risk of avoidable harm or abuse because the systems and processes in place to safeguard people were not effective. There were a high number of unwitnessed falls and opportunities to learn from accidents and incidents were missed.

There was not a registered manager. The acting manager did not receive sufficient support. There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high quality care. Quality assurance systems and processes failed to identify concerns relating to safe care. Where issues had been identified the service did not act in a timely manner to address these.

Care plans and risk assessments were not sufficiently detailed or accessible to staff. Areas of the service were dirty and in need of redecoration, refurbishment and maintenance.

Infection prevention and control procedures were not following expected guidance and requirements. Staff did not always wear the protective personal equipment such as face masks when in direct contact with people. They did not always follow effective handwashing or any handwashing between contact with different people. This meant people were put at increased risk especially during the COVID 19 pandemic.

Staffing numbers were not sufficient to meet people's needs or keep them safe.

There were risks that people would not get their prescribed medicines at the right time. Administration records were not always completed accurately. Medicine trained staff were not available on every shift and some staff had not had their competency to manage people's medicines assessed.

Staff did not have time to spend with people and could not always meet people's needs or keep them safe. People did not receive the reassurance and support they required when they were distressed because staff did not have time or did not have the skills required to support people living with dementia. People's privacy and dignity was not always protected.

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 24 January 2020) and there were multiple breaches of regulation. The rating for the service has changed from requires improvement to Inadequate. This is based on the findings at this inspection.

We received concerns in relation to the management of the service and peoples care needs. As a result, we undertook a focused inspection to review the key questions of safe, caring and well-led only.

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.

We also checked whether the Warning Notice we previously served in relation to breaches of regulation had been met. The overall rating for the service has changed following this focused inspection to inadequate.

Why we inspected
The inspection was prompted in part due to concerns received about failure to protect people from avoidable harm or abuse and improper treatment. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, caring, and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this report.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, dignity and respect, staffing and good governance.

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 safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Limes

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.

This inspection checked whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection was carried out by three inspectors. Two inspectors carried out a site visit, whilst a third coordinated documents sent by the location and telephone calls with relatives and staff.

Service and service type
The Limes 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 did not have a manager registered with the Care Quality Commission.

Notice of inspection
This inspection was announced. We gave the provider 10 minutes notice because we needed to check the current COVID 19 status for people and staff in the service.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection on 6 December 2019. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection we spoke with four relatives about their experience of the care provided. We spoke with nine members of staff including the acting manager, area manager, team leaders, care workers, housekeepers and activities coordinator.

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

After the inspection we continued to seek clarification from the provider to validate evidence found. This included, but was not limited to staff rota's, dependency tools, audits, training data, quality assurance records and risk assessments.

Inadequate

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 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.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to identify or effectively manage risks relating to the health safety and welfare of people. At this inspection we found continued failures to consistently assess, monitor and mitigate risks.

- There were a high number of falls, 21 in March and 23 in April with a high percentage being unwitnessed. There were insufficient risk assessments in place to manage falls and in some circumstances, severe injuries had been caused.
- One person had fallen from their wheelchair and sustained a head injury. There was a known risk of falls when this person first began using the service. The person's relatives had repeatedly warned about the risk of falling if the person was left unsupervised sitting in a wheelchair. The risk assessment stated the wheelchair should be used for transportation and staff had not followed this instruction.
- Risk assessments were very basic and lacked the detailed guidance staff needed regarding the measures to be taken to keep people safe from harm. For example, where people required assisted transfers because of reduced mobility, there was no detail about the size or type of sling to use, or the impact any health conditions or cognitive functioning may have on safety of the intended manoeuvre. Furthermore, staff did not always have access to these risk assessments.
- The passenger lift at the Limes was broken from 11 March to 29 May 2020, a period of 11 weeks. One person was regularly accessing the stairs throughout this period during the day and walking up and down with a walking frame and therefore risking serious injury. During this time staff had to carry hot and cold food up and down stairs several times a day posing a risk of tripping and injury.
- People did not have personal emergency evacuation plans (PEEPS). PEEPS are used by staff in the event of an emergency such as a fire, they instruct staff how to move people away from the risk in the safest and quickest way. This meant that risks were not managed properly. These risks were compounded because the premises did not comply with fire safety standards. This was identified in 2018 by Leicestershire Fire and Rescue but had not been rectified.
- During our inspection we saw the key to the sluice room on the first floor was accessible to people. There were chemicals hazardous to health within this room which posed a serious risk if accessed by people using the service, many of whom were living with dementia.
- Records did not demonstrate that people had been protected from the risk of poor nutrition and hydration. Food and fluid intake charts were not completed correctly because staff were not recording the actual amounts of food and fluids taken. There were no daily targets and daily amounts were not checked.

This meant staff did not identify or take action when people did not have sufficient amounts to eat or drink. One person's records showed they had only drank 400mls of fluid in 24 hours which was well below there expected minimum requirement and the amounts of food eaten were not recorded. This person was known to be at risk of dehydration and malnutrition.

● People did not have effective plans in place when risk was identified for developing pressure sores or had developed pressure sores. Records showed that people were not always supported to have their position changed frequently enough to reduce further risk.

Preventing and controlling infection

At our last inspection the provider had failed to follow procedures to prevent and control infection. At this inspection we found continued failures to follow infection prevention and control procedures and the service was not clean.

● People were not protected from the risk of infection because systems and processes did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

● Areas of the premises were poorly maintained and dirty. There were items of furniture covered in stains.

● The medical room had a dirty stained sink where medications pots had been washed, broken ceiling tiles, rubbish on the floor, debris from storage, storage items such as multiple folders and boxes, holes in walls where raw plugs appeared to have been removed and holes not filled. The entire room was part tiled and part painted and did not support safe infection control for a clinical area.

● Vinyl flooring was uplifted in communal toilets making them difficult to clean which could harbour bacteria posing an infection control risk to people.

● The sluice room on the first floor was contaminated with a chemical spillage. People had access to this room which could pose a health and safety risk.

● There were insufficient numbers of staff to complete cleaning tasks. The Cleaning schedules in place were basic and staff did not have time to perform all cleaning duties. Therefore due to the lack of cleaning people were being put at risk due to poor infection control practices.

● These risks associated with infection prevention and control procedures were exacerbated by the current Covid-19 pandemic. Not all staff were adhering to infection control protocols and it was observed by inspectors on three separate occasions that care staff were not wearing masks and consequently putting service users at risk due to cross contamination.

● It was identified from training records that only 46% of staff had received specific COVID 19 training.

Learning lessons when things go wrong

At our last inspection we found lessons were not always learned when things went wrong. At this inspection we found improvements had not been made and opportunities to learn from adverse incidents continued to be missed.

● Systems and audits designed to review accidents and incidents had not always identified action required to reduce further risk.

● Some people had frequent falls and any action taken had not been effective to reduce ongoing risk or learn from accidents. Risk assessments were not always updated following accidents and incidents.

Using medicines safely

At our last inspection we found people did not always receive their medicines as prescribed. At this inspection we found some improvements had been made. However, there were continued shortfalls in the management of people's medicines and this put people at risk.

● Staff told us medicine rounds took a long time. This meant they did not have the time to carry out checks

and audits to ensure safe and proper use of medicines.
● One of the medicine rooms was not in use because the room needed maintenance and decoration and there was broken equipment.
● There were missing signatures on the medicine administration charts and on the register of controlled medicines.
● Only staff who had received additional training were responsible for managing people's medicines. However, there was not always a medicine trained member of staff on duty and not all staff had had their competency assessed or checked. This meant there was a risk people did not always receive their prescribed medicines in the right way.

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 continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection we found there were not always enough staff to ensure people's safety. At this inspection we found improvements had not been made and there were not enough staff to meet people's needs or keep them safe.
● The staffing levels determined by the provider did not effectively take into account the dependency needs of people or the risks associated with receiving care.
● There were 15 people needing two staff to attend to mobility needs and one person who at times required three staff. 10 people had been identified as at risk of falling and required staff to monitor and supervise them to keep them safe. 10 people required assistance or monitoring with food and fluids. Many people were living with dementia and were dependent on staff for all of their physical and emotional needs.
● Staffing numbers determined by the provider were six care staff during day time hours and three care staff at night. These numbers were not sufficient to meet the identified needs of people using the service and did not take into account the layout of the service which consists of several communal areas.
● This is reaffirmed by the number of unwitnessed falls that occurred at the service during March and April 2020. Many of these falls occurred in communal areas because there were insufficient numbers of staff deployed to support people's safety needs.
● At night when three staff were assisting one person, this meant there were no other staff available to respond to people's needs.
● Staffing numbers fell below the services identified requirements. During the period 27 April to 16 June 2020, staffing rotas showed that only four care staff were on duty during the morning on four occasions, only five care staff were on duty during the morning shift on 6 occasions, only five care staff were on duty during the afternoon/evening on five occasions. At night there were 12 occasions when no permanent staff were on duty. The night shifts were staffed entirely with agency staff who were less familiar with people's needs and with the services policies and procedures.

The failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Staff knew how to recognise the signs of abuse and knew how to report their concerns. Most staff we spoke with believed appropriate action would be taken if concerns were raised with their managers. However, CQC were contacted by multiple staff before this inspection who did not feel confident concerns were being taken seriously, investigated or referred to appropriate authorities such as the local authority safeguarding team.

● Some staff told us they did not feel able to keep people safe and did not always have time to provide the care and support people required and this meant people were at risk of harm and neglect. Staff had discussed their concerns with their manager, but it took some time before any action was taken.
● The local authority were actively investigating several safeguarding concerns at the time of our inspection. None of which were ever reported to CQC in line with our requirements.
● There were no effective procedures in place to support people to understand what keeping safe means or to encourage or empower people to raise concerns.
● When safeguarding incidents had occurred, staff had not discussed with the appropriate local authorities and made relevant notifications to safeguarding authorities or the CQC. This meant external agencies had not been able to take timely action or any intervention required to keep people safe from further harm.

The failure to safeguard people from abuse and improper treatment was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not always treated with kindness and compassion because staff did not have the time to support them or meet their needs.
- There were times when no medicine trained staff were on duty, this could result in delay and unnecessary suffering for people receiving their prescribed medicines for pain or anxiety.
- Some staff lacked the skills and knowledge needed to support people living with dementia.
- Some people displayed risky or distressed behaviour that compromised their safety and dignity or that of others. Positive behaviour plans lacked the detail required for staff to identify known triggers or to provide the support or reassurance they required.
- We saw a person living with dementia was in distress and repeatedly asking to go home. Although staff witnessed this, they did not stop to support the person or offer any reassurance because they were too busy supporting other people.
- Some staff told us they didn't always have time to support people with personal care because they were so busy. They told us there had been some improvements, but they had left their shift knowing a lot of things were not done which made them feel stressed and worried.
- Some staff were clearly stressed because they were emotionally invested in people's wellbeing and did not always feel able support them in the right way.
- We spoke with four people's relatives, all told us that staff were kind and caring in their attitude. One person's relative told us that while staff were caring, they didn't always have time to offer the care and support people required.

Supporting people to express their views and be involved in making decisions about their care

- There were times when none of the provider's permanent staff were on duty during the night. This meant people were being supported by agency staff who may not know them well or understand their needs.
- Not all staff had access to care records and risk assessments to assist them in meeting people's individual needs and preferences. Many people were living with dementia and could not clearly tell staff verbally their support needs or preferences.
- Some staff lacked the skills and knowledge needed to support people living with dementia.

Respecting and promoting people's privacy, dignity and independence

- People did not have their privacy and dignity protected.
- We saw a person living with dementia was disorientated in the communal corridor entering other people's

private rooms. One person was in a state of undress and another person was unwell and resting when this person entered their rooms uninvited. There were no staff in attendance to offer support or reassurance.
● People were not cared for in a clean environment. Areas of the premises needed decorating with wallpaper hanging off bedroom walls. This did not support people's dignity.

These failures to treat people with dignity and respect were a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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 deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection we found that systems to ensure the quality and safety of the service were not fully 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The acting manager was not registered with the CQC. They were new to this level of responsibility and had not received the help and support they required. We were told this was because of the COVID 19 pandemic and senior managers were not visiting the service.
- The concerns and breaches to regulation identified during this inspection had not been identified by the provider. This meant risks relating to the health, safety and welfare of service users and others were not identified or mitigated.
- Infection prevention and control did not follow requirements and guidance and the service was visibly dirty. This was of particular importance during the COVID 19 Pandemic and put people and staff at increased risk. There were no COVID 19 related risk assessments for people, staff or the environment.
- Timely action had not been taken to address environmental concerns. An environmental refurbishment plan completed in 2019 identified several areas requiring redecoration and maintenance. The majority of this work remained outstanding and had missed the timescale for completion deadlines. This included holes in walls, flooring requiring replacement and wallpaper hanging off walls. The passenger lift was out of order for more than 11 weeks causing serious risk of harm to people and staff.
- A fire risk assessment carried out on 16 March 2020 identified actions required to ensure adequate fire safety and protection. The actions required had not been completed. We were told this was because of the COVID19 Pandemic. Fire risks were compounded by insufficient numbers of staff and a lack of PEEPS. Therefore, in the eventuality of a fire people would be put at serious risk.
- CQC requirements to notify of incidents such as death and serious injury were not met. Accidents resulting in fractures and head injuries requiring hospital treatment had not been notified to CQC.
- CQC had not been notified about the lift being out of order as they were required to. CQC were made aware of this by a member of staff following whistle blowing procedures.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff did not always work together as a cohesive team. Staff morale was low and they did not always feel

listened to.
● Some staff told us they had reported concerns to managers, but no action was taken. Staff acknowledged that the acting manager was working hard and had achieved some improvements but staff shortages had been ongoing for a long time and this had resulted in risk not being managed and people experiencing neglect.
● Staff did not always have access to current information about people's care needs. Both paper and electronic records were used and not all staff had access to the electronic records. Paper records were not sufficiently detailed about people's needs and preferences.
● The CQC were contacted by several staff using whistle blowing procedures because they had no confidence in the provider listening to them or taking action.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Systems designed to involve people in the development of the service were not effective. Staff did not have time to engage people. Relative told us staff contacted them frequently to update them of any changes during the COVID 19 pandemic, but relatives were not able to visit the service during this time in order to limit the risk of spreading this virus.
● One relative told us their requests regarding transferring a person had been ignored and they had not been listened to when they pointed out a potential risk to their relative.
● Some staff told us they were not listened to or engaged or involved in service development.

Continuous learning and improving care.
● Breaches to regulations and concerns identified at our last inspection in December 2019 had not been addressed. Improvements had not been made and some areas had deteriorated further.
● Lessons were not learned following accidents and incidents. Arrangements in place for reporting and reviewing accidents and incidents were not effective in protecting people from the risk of harm.

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
● The provider's systems and processes failed to identify incidents when things went wrong which meant they had not always exercised their responsibility under duty of candour. For example, when accidents or incidents had occurred.
● A relative told us they had not received any explanation or information about an accident and serious injury sustained by their relative.

Working in partnership with others
● The provider had not always shared information with partner agencies about safeguarding incidents and accidents that had occurred. This meant external agencies had not been able to take timely action or any intervention required to keep people safe from further harm.
● Staff made referrals to healthcare professionals such as community nurses and doctors so that people could access the healthcare support they required.

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 breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was not always protected.

The enforcement action we took:

NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from risk and avoidable harm. Infection prevention and control procedures were ineffective. People's medicines were not always managed in a safe way.

The enforcement action we took:

Urgent notice of decision to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from abuse or improper treatment.

The enforcement action we took:

urgent notice of decision to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Leadership and governance was not effective. Risks were not identified or managed.

The enforcement action we took:

Imposition of conditions.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing numbers were not sufficient to meet people's needs or keep them safe.

The enforcement action we took:

Imposition of conditions.