MAPS Properties Limited

The Limes

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 04 and 06 November 2014 and was unannounced.

The service provides care and accommodation for up to 41 older people, who are living with dementia. On the days of our inspection there were 40 people living at this home.

The service is required to have a registered manager in day to day charge of the home and the registered manager has been in post since 2012. 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.

CQC monitors the operation of the Deprivation of Liberty Safeguards which applies to all care services. Proper policies and procedures were in place so that people who could not make decisions for themselves were protected. Relevant staff had been trained to understand when an application should be made and how to submit one.

Summary of findings

We last inspected this service on 11 July 2014, when we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to assessing and planning of care, treatment and support and monitoring and management of risks. Following that inspection the provider sent us an action plan setting out what actions they were going to take to improve. During this inspection we found that improvements had been made and that the breaches had been met.

At this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the safe storage of medicines, staffing numbers and the way the quality of the service was assessed.

We found that medicines were not being stored safely and securely and this represented a risk to people. Staff did not know at times what medicines were held on the premises. You can see what action we told the provider to take at the back of the full version of this report.

Staff were not always available to support people when they needed it and care was rushed or delayed. You can see what action we told the provider to take at the back of the full version of this report.

Systems for monitoring the quality of the service were not effective. Audits of the quality of the service were not being completed. Audits of records such as care plans would have identified shortfalls in the quality of the recording and missing information. This told us that the quality of the service was not being monitored. You can see what action we told the provider to take at the back of the full version of this report.

People spoke warmly about the staff and the care they provided. Staff gave good care to people in a kind and cheerful way. People's care records were being updated but food and fluid charts were not. This meant that we could not be sure people received sufficient nutrition and hydration. Records showed us that the service referred people to health professionals appropriately and in a timely way.

Staff treated people with respect and in a dignified way. All personal care was provided behind closed doors.

Staff received the training they needed that was relevant to their role. Staff were not receiving regular supervision and did not always feel supported.

People told us they enjoyed the meals at this service. People had choice about what they had to eat. Drinks were available throughout the day.

The people we spoke with said they would speak with a member of staff if they were worried about anything.

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?

Requires Improvement

The service was not consistently safe.

People who lived at the service were put at risk because medicines were not stored securely.

Staff received training relevant to their role. However there were not always enough of them on duty to support people safely, particularly in the morning, at the weekend and overnight.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were at risk because staff were not receiving regular supervision and appraisal that monitored their performance and identified any short fall in care provision.

Staff were seen to work hard but they told us that they felt unsupported.

Staff had received training about the Mental Capacity Act and Deprivation of Liberty Safeguards. However, no assessments of people's capacity to make decisions had been completed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us they felt well cared for and we saw that staff were kind and caring. They spoke politely to people and supported them to make decisions for themselves. This supported people's independence and well being.

Staff were not always available in communal areas to provide care and support.

Staff provided personal care discreetly and in a way that supported people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Although people were not aware of the complaints procedure, they told us they would speak with a member of staff if they had concerns.

People's needs had been assessed and care and support was provided in accordance with their care plans. We saw that people were referred appropriately and in a timely way to health and social care professionals when necessary.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

Quality monitoring arrangements were in place but inconsistently applied. Accidents and falls affecting people were not regularly audited to identify risks and put in place remedial measures.

People were being put at risk because staff competence was not being audited when administering and controlling medicines. Where competence had been checked when the staff member had first started administering medicines, this had not been recorded.

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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 inspection took place on 04 and 06 November 2014 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and the provider told us that was because it had not been received. We took this into account when we made the judgements in this report. We reviewed notifications that had been sent to us by the provider, referrals that had been made to the local safeguarding authority and complaints that had been made to us about the service. We also obtained information from the local authority's quality monitoring team.

During the course of the inspection we gathered information from a variety of sources. For example, 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 to us.

We looked at care records for three people including medication records and training records for all staff. We also reviewed records relating to the management of the service including assessments of risk.

We spoke with ten people using the service and two visitors to the home. We also interviewed three care staff, two senior care staff, housekeeping staff, the deputy manager and a deputy manager who was visiting from another of the provider's services. We spoke with the provider during the course of the inspection.

Requires Improvement

Is the service safe?

Our findings

People who lived in the home were not safe because they were not protected against the risks associated with the storage of medicines.

We found that the door to the room where some medicines were stored was frequently left unlocked allowing people to have access when the room was unoccupied. The room was untidy, with significant amounts of clutter about that belonged in alternative areas. There were unlocked cupboards where medicines were stored that also contained items such as unclaimed spectacles and false teeth. Most medicines were stored in locked trolleys that were fixed to the wall when not in use. However, other cupboards contained prescribed and homely medicines that were not locked away. Some medicines to be used when required were kept in a plastic pot on top of one of the trolleys. This meant they were not stored safely and unauthorised staff could access them. We also found some medicines that were out of date and staff did not know if they were still required.

We noted that medicines to be returned to the pharmacy were kept in a cupboard that had a broken padlock and so were not stored safely. Medicines due to be returned to the pharmacy were not recorded anywhere until such time as the staff had time to record them in the returns book. Staff told us this could be two to three weeks during which time no-one actually knew what medicines were held at the service. This told us that people were at risk because medicines were not controlled and stored securely.

We observed a senior member of staff administering medicines and noted that they followed safe practice. However, we saw that many of the medication administration records (MAR) did not contain a photograph of the person to aid identification. They also did not have information about the person's allergies at the front of the chart. In some instances, the wrong code was being used when people were offered and refused PRN (as required) medicines.

We were told that only senior care staff were able to administer medicines and they had received the appropriate training to do so. However, senior staff told us they had not had their competence checked to ensure their practice when administering medicines remained safe. The deputy manager told us that some competency checks had been done but not for a while and these had not been recorded.

These matters were in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of this inspection report.

On the second day of our inspection we noted that work was in hand to remedy the situation with the storage of medicines and one cupboard containing unused medicines had been fitted with a padlock.

People who lived in the home were not consistently safe because there were not always enough staff on duty during the day and night to safely meet people's needs.

Staff spoke of the difficulties they had in providing safe care, particularly in the mornings and at weekends. We spoke with five care staff and one staff member said, "We always seem to be short staffed." Another staff member told us, "We are short staffed. We are rushed. Residents need our time and we don't want to be rushed." Another member of staff said, "We are always short of time and very stressed. It affects everyone."

We were provided with copies of staff rotas for the four weeks prior to our inspection. These showed that staff were not provided in sufficient numbers throughout the day and night to ensure that effective care was given. The rotas showed significant staff absences and we were told that these could not always be filled at short notice. Staff spoke about morning and weekend shifts being particularly difficult as they were often short staffed at those times. One member of staff told us, "Every other weekend we are nearly always short staffed." Another member of staff said, "We are quite short staffed here. We work longer hours and extra days and we get quite run down. We are always flitting and rushing about."

We spoke with the deputy manager about how absences were covered and we were told that the senior member of staff on duty would contact staff members to see if they could cover but this was not always possible. The deputy manager was not able to tell us how staffing levels were

Requires Improvement

Is the service safe?

calculated to ensure sufficient staff were on duty as this was done by the registered manager. We also spoke with the provider who told us that extra staff were being recruited to ensure that all shifts were covered.

Our observations showed that people often had to wait for staff to be available to assist them with personal care. For example, we heard one person asking a member of staff to assist them to go to the toilet but it took 20 minutes before staff arrived with a hoist to assist this person. We saw that people were left unsupervised in communal areas for periods during the day as staff supported people with personal care.

These matters were in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. You can see what action we have told the provider to take at the back of this inspection report.

The staff we spoke with told us that they had received training about protecting people from abuse. They were able to describe the actions they would take if they suspected abuse was happening. Staff knew where the contact details for the safeguarding authority were kept in the event they felt they needed to make a referral.

We looked at the care records for three people and saw that there were processes in place to identify risks to people. At the time of our inspection they were slightly overdue for review to ensure they remained relevant. We saw that risk assessments and risk reduction plans were in place. For example, one person was at high risk of developing pressure ulcers and a plan was put in place to reduce the risk. However, another person was at medium risk of malnutrition and the plan stated that the person should be weighed weekly from 10 October 2014 onwards. We found only one weight record for this person dated 03 November 2014. Staff were unable to explain why this had happened. Failure to do this meant that the person's care was not delivered in a way that ensured their safety and welfare. Staff would not be aware if the person experienced significant weight loss requiring treatment or intervention from health professionals.

Hoist equipment was serviced and maintained in line with the manufacturers instructions to ensure it remained safe for people to use. We observed staff using hoist equipment and this was done safely. During our inspection we saw that corridors and exits from the building were kept clear in the event that an emergency evacuation was required. Each person had an evacuation plan showing how their safety in the event of fire needed to be promoted.

Requires Improvement

Is the service effective?

Our findings

People told us that they enjoyed their food. One person said, "The food is good." A visitor also agreed that the food was good and enjoyed by their relative.

We observed the arrangements over the lunchtime period and saw that people were enjoying their food. Meals were freshly prepared and cooked each day and looked appetising. The meals were served in the kitchen and staff were aware of how much people liked to have on their plate. Four weeks menus were provided and we could see that choices were available at every meal time. One person told us, "The food is not bad at all. You always get a choice of food."

Staff told us that food supplements were used for some people and we checked in one person's daily records. However these did not record that the supplements were being given as prescribed. This person was at medium risk of malnutrition. This person had been referred to the dietician for advice and guidance. The entries on the food and fluid charts did not specify the quantity people had eaten or drunk. As a result we could not be confident that they were receiving the fluid and dietary intake they needed to keep them well. Drinks were available to people at any time and also at pre-arranged drinks rounds.

Some people experienced good support at lunchtime. For example, one member of staff explained the choices on offer for the dessert at lunchtime but the person couldn't understand. The member of staff collected dishes containing the choices on offer so the person could see and choose for themselves.

Staff told us that they had not received regular supervision, with one staff member saying they had one supervision in over a year. Another member of staff said they had received one supervision and one appraisal in two years. We were told that the registered manager conducted all staff supervision and appraisal.

Staff told us that they did not always feel supported by the manager and that it was sometimes difficult to speak with the manager about concerns. We shared our concerns about this with the provider, who said that they would deal with the matter.

Staff training records were provided and they showed that staff had access to training that was relevant to their role and the needs of people. For example, only senior staff who had completed medication training were permitted to administer medicines. Several care staff had completed training about managing behaviours that challenge and dementia awareness. Staff told us that refresher training was available and the manager advised them when their training was due. We saw training events advertised in the medication room for staff to nominate themselves to attend. Nine members of staff had completed qualifications in either care, housekeeping or catering. This told us that staff had access to training and personal development that was relevant to their role.

Staff had received training about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and understood about obtaining the person's consent wherever possible before providing care and support. Senior staff said that consent to care and treatment was obtained either from the person or their relative but this had not been recorded. We were told that one application had been made to the authorising body for authority to deprive a person of their liberty. We did not see anyone being deprived of their liberty or being restrained during our visit.

Records showed that the GP was called if they were needed and a report of their visit was kept in the person's care plan. A community nurse was seen at the time of our inspection but was unable to speak with us other than to say they were called appropriately when needed. We also saw records that showed other health professionals being contacted in a timely way for advice and guidance. We saw that any concerns were acted on quickly.

Requires Improvement

Is the service caring?

Our findings

People who were able to speak with us told us that the staff were kind and lovely. One person told us, “This is a lovely place. I love it here. Staff are beautiful and ever so kind. You couldn’t want a better place.” Another person said, “Staff are all very good.” A visitor told us, “The staff are caring and lovely.” We spent time with people and noted that they were comfortable in the presence of staff. Staff spoke kindly and showed a caring attitude towards people.

We saw that staff treated people with kindness and compassion. Even though staff were clearly rushed, we saw that they gave people time to express themselves and they listened to what they had to say. Staff spoke to people politely and respectfully.

Staff understood the specific needs of people and supported them in the way that respected their rights. Although some people were kept waiting for support at times due to staff shortages, staff assisted people as quickly as they could. Where people became distressed, staff quickly and sensitively supported the person so that they became calm and content with the activity they were engaged in.

Most people were unable to be actively involved in planning their care and their relatives were encouraged to do so on their behalf. Care plans did not provide staff with information about the person’s life history which meant that they could not be sure they were offering support in a way that was appropriate to the person. However, staff offered people choices and they respected the choices that people made. Where necessary staff offered guidance and support to people to help them make the right decisions for themselves. Staff supported people to be as independent as possible.

For the most part, staff provided discreet personal support to people that respected their privacy and dignity. There was only one example of a staff member talking across the room to another staff member about a person who had asked to be taken to the toilet. The person would have been aware that they were being spoken about. All personal care was provided in private and behind closed doors.

We noted that the lunchtime experience was not good for everyone. Some people sitting in the dining room complained about feeling cold, whilst another person eating their meal in the lounge was slouched behind their table and dropping their meal down their clothes. Staff said that the person liked to eat unaided and preferred to sit in their chair in the lounge.

We saw that people looked well cared for. People wore clean clothes and wore protectors where necessary at lunchtime so that their clothes did not become soiled. People looked tidy and wore either shoes or slippers on their feet. One member of staff told us, “In our eyes, we want to help a resident before making the bed or closing curtains.” Another member of staff said, “We look after people the best that we can” and they went on to say that they felt all the staff were good and polite to people.

Requires Improvement

Is the service responsive?

Our findings

New care plan documentation was being introduced at the time of inspection and those we looked at had been written at the end of September 2014. We looked at the care records for three people and noted that work was in hand to re-write the care plans onto new documentation. This process did not include the involvement of people or their relatives at this time. For example, we saw in one person's care plan that a notice 'Do not attempt pulmonary cardiac resuscitation' (DNACPR) had been completed and signed by the GP and manager, but there was no evidence that this important decision had been discussed either with the person or their relatives.

Because people and their relatives were not involved in the development of the new care plans we could not be sure that they were person-centred and reflected how the person wanted to be supported. We spoke with the deputy manager from another of the group homes who was at the home during our inspection. They told us that they were providing training to staff to help them write effective care plans. They told us that not all the staff were receptive to the new care plan and required additional training. We saw that people's personal histories were not being completed in the new care plan formats in every case. Care plans were reviewed each month but there was no evidence that people or their relatives were involved in this process. We spoke about this with the provider who accepted that people needed to be listened to better.

We saw that some of the information in the care plans was undated so that it was difficult to see if the person was receiving the support they needed. Not all of the care plan documents had been completed so it was not always clear if the person needed support. For example, in several instances the activities care plan had not been completed so staff would not have known what leisure activities and hobbies the person would enjoy.

Some aspects of good practice were seen. For example we saw that for a person who had frequent falls a care plan had been developed and a risk assessment completed and that an appropriate referral had been made to the falls team. We saw information within one care plan that a person was experiencing weight loss and this matter had been referred to the dietician. There was also evidence that referrals were made in a timely way to other health professionals such as the GP and community nurse team. This told us that people had their health care needs met.

Our observations showed that people received support when they needed it, although they were required to wait for assistance in some instances. Staff showed that they had a good understanding of the individual needs of people and we saw examples of staff responding appropriately to people even though they had difficulty in explaining what they wanted.

One person spoke about how they spent their day and told us, "I'm bored. I'm a busy person and I like to work hard. There's nothing to do." A visitor said, "The staff are caring and lovely. My one concern is that there are no activities at the moment."

We noted that there was an activities programme displayed in the entrance hall but throughout the two days of the inspection no activities took place. Staff told us they were too busy providing care to be able to do activities with people. A member of staff told us, "I managed to do activities one day last week." A visitor told us that there used to be a person employed to engage people in meaningful occupation and hobbies but the person left and had not been replaced. They went on to tell us that staff sometimes played Bingo on an afternoon but most people couldn't manage to play along. The deputy manager was unable to tell us what arrangements were in place to recruit a new activities co-ordinator.

Some people were seen chatting with the person beside them, but most sat looking at the television or were asleep. We did not see anyone engaged in a hobby or interest during our inspection. One person was walking up and down the corridors and they told us that they were looking for something to do.

People we spoke with did not know who they could speak with if they had concerns or worries. One person told us, "I would speak with staff but I don't know who they are." A visitor said they would feel confident in reporting any concerns to the manager and expected that they would be taken seriously, stating that they found the manager very approachable. Staff told us that they would be able to tell if someone was unhappy by a change in their mood or behaviour and this would be reported to the manager if

Requires Improvement

Is the service responsive?

necessary. The complaints folder was not available at the time of the inspection for us to review how the service considered comments and concerns raised about the quality of the care and service provided.

The complaints procedure was displayed in the entrance hall for visitors to access and contained details about how a complaint could be escalated if the person was dissatisfied with the response. Most of the people living at the home would require support to make a formal complaint about the service due to their dementia. We have received complaints from relatives about this service in the last year that have either been referred to the manager or looked into by us.

Inadequate

Is the service well-led?

Our findings

We looked at the quality monitoring arrangements in place and found that they were inconsistent. For example, accident records were completed by staff in a timely way but no audit of accidents in the home was found. Consequently the service could not show that it was assessing risks to people and putting in place actions to minimise them. We were particularly concerned that one person was experiencing frequent falls but no audit had been done to establish if there was a pattern to their falls.

We also asked to see the complaints audit but this could not be found. Records of checks on the safety in respect of the environment were not available.

Although some staff had received supervision and appraisal we were told that these were infrequent and not constructive. Staff spoke about not being able to remember when they last received a supervision so that they could discuss how well they were doing and how they could develop professionally.

Issues relating to staffing numbers and deployment had not been addressed and people experienced rushed care and often had to wait for long periods for their personal care. The lack of staff time to carry out meaningful hobbies and interests had continued with people observed to be sitting or sleeping. None of these failings had been addressed by the manager leading to breaches in regulations.

Systems for monitoring quality were not effective in that they did not identify shortfalls found at this inspection. For example, the deputy manager told us that staff competency to administer medication was not kept under review. We also identified that whilst staff told us that care was delivered as people needed it, the records to support these statements were not always completed. Regular audits of care records would have identified these shortfalls and alerted staff to the need to improve recording.

We discussed the absence of auditing records and other management issues with the provider, who was aware that currently the service was failing to operate to the required standard and we were told that measures would be put in place to improve the service. We were told that additional management support would be provided to the service.

These matters were in breach of Regulation 10 (1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of this inspection report.

People were not able to tell us if they had resident meetings where matters about the service were discussed. We saw that staff meetings were taking place and we reviewed the minutes that were provided to us. These showed that staff were kept informed of developments at the service.

We spoke with staff about how they shared ideas and suggestions to develop the care and activities. One member of staff told us that they found it difficult to raise issues with the manager and they found them unreceptive to ideas or suggestions. Two staff spoke about not wishing to raise concerns with the manager but they would speak with the deputy manager instead. One member of staff said, “The manager doesn’t listen to staff.” This meant that there was not an open culture at the service where staff were able to share the manager’s values and vision for the home.

A relative told us that they had received a telephone call on one occasion when they were asked for their views on the quality of the service. They had not received any questionnaire to complete seeking their opinions but would appreciate the opportunity to do so on a regular basis.

People we spoke with were unable to tell us if they had been asked for their views about the service. The deputy manager was unable to say if questionnaires had been sent out to relatives and health professionals so that an improvement plan could be developed for the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use services and others were not protected against the risks associated with unsafe management of medicines because medicines were not stored securely. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People who use services and others were not protected against the risks associated with staffing because there were not sufficient numbers of suitably skilled and experienced staff employed to meet people's needs. Regulation 22.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use services and others were not protected against the risks associated with assessing and monitoring the quality of service provision because regular auditing and monitoring was not taking place. Regulation 10.