Leicestershire County Care Limited

The Limes

Inspection report

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08 October 2020
14 October 2020

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

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 24 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
Care plans and risk assessments were not updated in a timely manner and lacked clarity. As a result, people were put at continued risk of harm.

Infection prevention and control procedures were not following expected guidance and requirements. Staff did not always wear the recommended protective personal equipment when in direct contact with people. There was a cross contamination risk when disposing of clinical waste. This meant people were put at increased risk especially during the COVID 19 pandemic.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high quality care.

Staffing numbers were not sufficient to meet people's needs or keep them safe. New staff did not receive adequate induction and training before they started work at the home.

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

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was inadequate (report published 28 July 2020).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Why we inspected
We undertook this targeted inspection to check whether appropriate action had been taken since our last inspection in relation to the breaches of Regulation 10, 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Limes on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Follow up
We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? Inspected but not rated	**Inspected but not rated**
Is the service well-led? Inspected but not rated	**Inspected but not rated**

The Limes

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider had met the requirements of the specific concern we had received about safeguarding incidents. We will assess all of the key question at the next comprehensive inspection of the service

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

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 unannounced. 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
Before the inspection, we had received concerns from people and professionals about the safety of the service. We reviewed the information we received and discussed our concerns with the Local Authority Commissioning Team. We focused our inspection planning on concerns we had received, in order to assess if people were safe at the service.

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 9 June 2020. 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 eight members of care staff, two domestic staff, the interim manager and an independent care consultant working on behalf of the provider. We reviewed a range of records including twelve care records, medicine administration records, three staff recruitment files and training records. We also looked at a variety of other records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, staff rota's, dependency tools and risk assessments.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to explore the specific concerns we had about The Limes. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

● Risk assessments lacked clarity and did not support staff to keep people safe. For example, a person's choking risk assessment had differing risk levels. This conflicting information meant that staff may not have the correct guidance about how to meet the person's needs. Care plans did not provide clear instruction and direction for staff to protect the person from the risk of choking. A second person sustained a skin tear through staff using an inappropriate transfer sling. There was no specific moving and handling guidance in place to support staff.

● Following incidents risk assessments were not always reviewed appropriately. A person who had a history of falls new risk assessment stated, 'risk of occasional falls' despite two falls three days apart. The person had been found on the floor by their bed, there was no sensor mat to alert staff to movement and a crash mat had not been considered. Furthermore, the accident and incident review form recommended family to purchase socks with grips, this was not in the updated care plan. Therefore, risk of falls was not mitigated against. Another person sustained an injury as they were transported in a wheelchair that had not been assessed as suitable for their needs.

● Staff failed to follow instructions from risk assessments. It was observed during our inspection that one member of staff was assisting a person who required two staff for support. The persons care plan clearly stated two staff must provide care at all times. This person was put at risk of harm as moving and handling procedures were to be used that required two staff members. Furthermore, there were people at the home that required regular repositioning every two hours to protect them from the risk of skin breakdown. We reviewed care logs and found on occasion that this had not been recorded. Therefore, records did not match instructions from care plans and risk assessments.

● Records were not maintained and poorly recorded. Staff failed to log people's food and nutrition in take accurately. There were no records of food offered, eaten and refused. There was also no evidence of a review of daily food and fluid intake. This is not in line with best practice for MUST (Malnutrition Universal Screening Tool) and puts people at a nutritional risk.

● The service had recently met all its recommendations for its recent fire review. In addition all people had PEEPs (Personal Emergency Evacuation Plans) in place in the eventuality of a fire.

Preventing and controlling infection

● People continued not to be protected from the risk of infection because systems and processes did not comply with COVID 19 government guidance.

● There were still insufficient staff to complete cleaning schedules. For example, on 7 September 2020, 8

September 2020 and 18 September 2020 records suggested that no cleaning tasks had been completed at all. There were several gaps showing that not all the cleaning required in the cleaning schedule from 1 October to 13 October 2020 had been completed. Due to the lack of cleaning people were being put at risk of harm.

● New domestic staff had not received any COVID 19 specific training or induction training. Therefore, without any clear guidance for them to follow, there was no guarantee cleaning would ensure infection risks were reduced.

●When we inspected on 14 October 2020, a procedure that had been implemented indicated that from Monday 12 October 2020 cleaning would be carried out where COVID 19 is identified or people are symptomatic of COVID 19 at least three times a day for high touch areas. Staff were unaware of this and cleaning schedules completed indicate that this is only being carried out twice a day, despite eight people being symptomatic.

● Staff were not following infection control protocols and on 17 separate occasions were seen without masks on 1, 8 and 14 October 2020. For example, on the morning of 14 October 2020 we observed two care staff not wearing masks at 06:45 and 07:02 in the ground floor reception area.

● The home had an insufficient amount of clinical waste bins. Staff were required to walk throughout the service to dispose of clinical waste. It was observed by inspectors that bins did not always have bags. Furthermore, there were no PPE stations located next to clinical waste bins so staff could not don and doff PPE. This created a significant cross contamination risk for people using the service.

● It was identified that two people had COVID 19 symptoms during our inspection. No isolation signs or PPE stations were placed by their bedrooms. This put staff and other people in the service at risk of harm because they did not have immediate access to personal protective equipment and there was no identification of the infection risk to staff.

● One person identified by staff as symptomatic of COVID 19 was observed by the inspection team in the lounge sitting amongst other people. There was no social distancing taking place and another service user was sitting directly next to them less than a metre away. It was observed there were no social distancing protocols in place. This exposed all people to the risk of harm.

● There was only one working hoist in the service that was used between 13 people that included those symptomatic of COVID 19. It was observed that it was not being cleaned between use. When staff were questioned, they said they did not have access to wipes. All PPE stations outside rooms were checked and it was confirmed there were no wipes in situ. This poses a severe infection control risk and due to poor cleaning practices people could have unwillingly been exposed.

● Cleaning materials including hand wipes and sanitizer did not conform to expected guidance around the management of COVID 19. The Department of Health and Social Care guidance 'Admission of Care and Residents a Care Home During COVID 19' Version 2 updated 16 September 2020 gives clear instruction. It states a combined detergent disinfection solution at a dilution of 1000 parts per million available chlorine should be used to clean hard surfaces. This guidance also states alcohol-based hand rub should be placed in prominent places where possible. Therefore, due to the failure of the Home to disinfect and use of inadequate cleaning materials this could aid the spread of infection.

Staffing and recruitment

● At night there were no permanent staff 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.

● It was identified from looking at staffing rota's and the services training matrix that not all permanent staff had completed mandatory training and induction. The provider could not evidence agency staff having the necessary training and competency checks. People were put at risk of harm due to inappropriately trained staff.

Using medicines safely

● There was not always a medicine trained member of staff on duty particularly at night. It was observed from medication records that PRN (medicines taken "as needed") were sometimes administered at night. This meant there was a risk people did not always receive their prescribed medicines in the right way.

● The interim manager also confirmed that not all supervisors had received medicine competency assessments and checks. People were put at increased risks of medication errors.

Inspected but not rated

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 inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to explore the specific concerns we had about The Limes. We will assess all of the key question at the next comprehensive inspection of the service.

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

At our last inspection the provider had failed to ensure 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.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The registered provider had no manager registered with the CQC in place. There was an interim manager and independent consultant in situ, but they could not give us any assurance how long they would be in post. We were told that senior managers were not visiting the service.
- Infection prevention and control did not follow requirements and guidance. The provider had recently conducted an internal review of infection prevention and control and had identified the service was failing. However, there were no clear action plans with timescales in place to improve the homes environment. This was putting people who live at the service at risk particularly with the current COVID 19 pandemic.
- The service had recently been submitting statutory notifications and analysing accidents and incidents. However, actions have not been robust enough and people continue to be put at risk of harm.

Continuous learning and improving care

- Breaches to regulations and concerns identified at our last inspection on 09 June 2020 had not all been addressed. Improvements have been made however some areas such as infection control and staffing have deteriorated further.

Working in partnership with others

- The service had started to share information with partner agencies about safeguarding incidents and accidents that have occurred. However, interim management did not always have access to systems or knowledge of individual clients to provide a robust response to partner agency requests.