Limetree Healthcare Limited

Limetree Care Centre

Inspection report

8 Limetree Close
London
SW2 3EN

Tel: 02086743437
Website: www.excelcareholdings.com

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Limetree Care Centre is a care home providing care and support to up to 92 older people living with dementia. 91 people were living in the service at the time of our inspection.

At our last inspection in January 2015 the service was rated as 'Good'. At this inspection we found the service remained Good.

The service had a registered manager at the time of the 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.

People continued to be kept safe by staff who were trained to protect them from abuse. Staff reduced people's risks of avoidable harm by assessing their risks and developing plans to mitigate them. Staff were deployed in sufficient numbers to ensure people's safety and the provider used appropriate vetting and selection methods to recruit staff. People received their medicines safely and the service good infection control practices were in evidence.

The service continued to be effective. Staff were trained, knowledgeable, supervised and skilled. The service understood its legal responsibilities under the Mental Capacity Act and Deprivation of Liberties Safeguards and supported people in accordance with them. People ate well and their nutrition and hydration were monitored. People were supported to stay healthy and were supported to access healthcare services whenever necessary.

People and relatives told us that the staff continued to be kind and caring. People were supported to maintain the relationships that mattered most to them. Staff protected people's confidentiality and supported people to maintain their independence. People were supported with tenderness and compassion at the end of their lives enabling them to die with dignity and pain free.

The provider continued to be responsive to people's needs by embracing the use of technology. Assessments were highly detailed and resulted in referrals to healthcare professionals when specialist input was required. The provider was imaginative in the activities it offered to people and responsive in supporting people to pursue their interests. The provider actively gathered people's views and acted decisively on the feedback they received.

The service continued to be well led. Robust audits were in place to ensure people received high quality care. The provider's partnership working including supporting the apprenticeships of local college students and piloting research with a university hospital. Communication throughout the service was effective ensuring that all staff were fully aware and had the most up to date information to deliver people's care. Staff commended the support they received from the registered manager.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Limetree Care Centre

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 25 and 27 April 2017 and unannounced. The inspection was undertaken by one inspector and one specialist advisor who reviewed nursing practices at the service.

Prior to the inspection we reviewed the information we held about Limetree Care Centre including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We asked provider to complete a Provider Information Return. 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. We used this information in the planning of the inspection.

During the inspection we spoke with 11 people, four relatives and two visitors. We also spoke with eight care and nursing staff, the clinical lead, activities coordinator, staff development manager, regional development manager and the registered manager. We reviewed 11 people's care records, risk assessments and medicines administration records. We reviewed 13 staff files which included pre-employment checks, training records and supervision notes. We read the provider's quality assurance information and audits. We looked at complaints and compliments from people and their relatives. During and following the inspection we received feedback from three health and social care professionals.

Good

Is the service safe?

Our findings

People told us they felt safe living at Limetree Care Centre. One person told us, "I am fine. I'm safe. I don't need to worry." Another person told us, "The staff are very good and make sure we are OK." People were supported by staff trained to keep them safe. All staff received safeguarding training. Staff we spoke with were able to tell us about different types of abuse, the signs of abuse and what they would do if they suspected abuse. One member of staff told us, "I would make verbal and written reports to the manager immediately." Another member of staff said, "There can be no hesitation. You have to inform senior staff straight away." We found that the provider raised safeguarding concerns appropriately with the local authority and notified CQC as required.

The provider reduced the risks of people experiencing avoidable harm. Peoples' risks were assessed and identified during their pre-admission assessment. Staff assessed 10 key areas of risk. These included malnutrition, pressure ulcers and falling. Where assessments identified risks plans were put in place to reduce them. For example, people at risk of dehydration were monitored using fluid charts and supported by a member of staff allocated to provide them with drinks and monitored their fluid intake. In another example, we found that staff made referrals to healthcare specialists when people were identified to be at risk of falling. Staff then acted on the healthcare specialist's recommendations by supporting people to use mobility equipment to manage their risk of falls.

Staff were deployed in sufficient numbers to ensure people's needs were safely met. One person told us, "You can always see the staff about the place." Another person told us, "I would say yes, the staff come along quickly whenever I call them." The registered manager and clinical lead planned and adjusted staffing levels to meet people's changing needs. We found staff were visible and engaged with people in the communal areas during our inspection. Records showed that people who declined to leave their bedrooms received planned support and hourly checks to ensure they remained safe.

People received care from suitable staff. The provider used safe and appropriate procedures when recruiting nurses and care staff. Prospective staff submitted applications and were interviewed. Successful applicants had two references taken up and provided the service with proof of their identities, addresses and eligibility to work in the UK. The provider checked staff details against criminal records and lists of people barred from working with vulnerable adults. Staff files noted the expiry and renewal dates of vetting checks. New staff completed a probationary period during which time the registered manager assured themselves of their ability to deliver care and support to people safely.

People received their medicines safely from staff who were trained to administer them. One healthcare professional told us, "The staff work with patient safety in mind and perform well." Medicines were stored safely and securely and staff recorded the administration of people's medicines. Medicines records and stocks were regularly audited. Audits included checks to confirm that the correct codes had been entered into medicines records to explain when people had refused their medicines. Care records gave staff clear guidance on the use of 'when required' medicines and staff we spoke with knew the actions they would take if they identified a medicines error. These included informing the registered manager and GP.

People were protected against the risk of infection. Staff used personal protective equipment (PPE) to reduce the risk of bacterial cross contamination. For example, staff wore single use aprons and gloves when supporting people with their personal care. A member of staff on each of the service's three floors was designated an 'infection control champion'. The role of the infection control champion was to give advice and support to colleagues as well as conducting spot checks and observations. The service took action in the event of infection outbreaks. People were supported with barrier nursing when required to reduce the risk of cross infection and staff monitored people who developed symptoms. This included the date and time when symptoms started to present themselves and hourly observations thereafter. We found that people were supported with increased hydration and weight monitoring during and following an outbreak and additional domestic staff were deployed to ensure the cleanliness of the home.

People's safety was enhanced by the service's preparedness to respond to a fire emergency. People had detailed personal emergency evacuation plans (PEEPs) in place. PEEPs detailed the support people required to safely exit the building in an emergency. An emergency box was stored near the reception which contained people's details, torches, batteries, PPE, the telephone numbers of every member of staff, emergency snacks and thermal blankets. This meant people could receive continuity of care in the event of a full building evacuation. Staff regularly tested fire and smoke alarms and evacuations were rehearsed in periodic drills. All doors in the service were fire doors designed to withstand heat and smoke.

Good

Is the service effective?

Our findings

People continued to receive care and support from skilled staff. People and their relatives told us that staff were capable and competent. One person told us, "The nurses do all the nursing things you would expect and they're friendly too." Another person told us, "I think the staff have good care skills." A relative we spoke with said, "All of the staff that I've encountered are highly capable which is a very positive situation."

The care people received was delivered by trained staff. A development manager oversaw the training programme of care staff. This included moving and handling, fire safety, infection control and safeguarding vulnerable adults training. A member of staff told us, "We get a lot of training." The service's clinical lead ensured that the nursing staff maintained training in line with the requirements of their registration. We found that nurses also completed specialist training in areas such pressure ulcer care, wound management and catheter care. The registered manager ensured that accurate records of staff training were maintained. Staff undertook refresher training as required to ensure their knowledge and skills were up to date.

New staff were inducted into the service. The development manager and department heads delivered a three day induction to new staff. A member of staff told us, "We had induction training and were introduced to people and staff. There was a lot to learn at the start but it meant we were ready when we began caring." New staff shadowed experienced colleagues as part of their induction and a buddy system was used to informally help new staff settle into the service. When agency staff were deployed they received an induction prior to supporting people and worked under close supervision. Upon joining the team new care staff were supported to complete the care certificate in order to familiarise themselves with best practice.

People were supported by staff who were supervised. Staff delivering care to people attended regular one to one supervision meetings with their line managers. These were used to discuss people's needs and good practice. For example, we reviewed staff supervision records and read discussions about routes of infection, handwashing and the disposal of soiled laundry. Managers recorded observations of care staff as they supported people. These observations were recorded and later discussed with staff. For example, we read, "I observed [staff member] consistently approaching people from the front and giving them time and space to respond." The member of staff was informed that this was good practice.

The performance of staff was evaluated. Staff received annual supervision from their line manager.
The aspects of staff performances that were reviewed during appraisals included liaising with families, respecting confidentiality and promoting a friendly atmosphere within the home. Appraisals contained a self-appraisal element. This included, "What are your strengths" and "what are your weaknesses." Where improvements were required in staff performances this was made clear in their appraisal records and the outcome from actions to achieve improvements were reviewed during subsequent supervision meetings.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that where DoLS had been authorised documentation was in place including mental capacity assessments and the DoLS expiry date. Records were retained where DoLS applications had been submitted to the local authority but where assessments were yet to be undertaken.

People gave their consent to the care and support they received. For example, people agreed to participate in therapeutic activities and to receive support with their personal care. Where people were unable to give consent they were supported with best interest meetings. We read that one person was supported with a "best interest" meeting to review and make a decision about a procedure that would result in the person receiving their foods directly into their stomachs. The person, their GP, their dietician, staff, relative, speech and language therapist and consultant participated in the decision making process.

People were supported with nutritious diets. Staff assessed people's nutritional needs and received training in nutrition from dieticians at training sessions that relatives were invited to attend. Where people required special diets, foods of a consistency that enabled them to swallow easily or the support of staff to eat, this was stated in care records. Drinks and snacks including sandwiches were available 24 hours a day.

People were supported to access healthcare services whenever they required. Records showed the involvement of dieticians, podiatrists, tissue viability nurses, GPs, opticians and dentists in people's care. Details of treatment plans and the guidance from healthcare professionals was available in people's care records.

The environment of the home supported people's dementia needs. The colour schemes of the service's three floors were different so that people could orientate to each space. The service was homely with images, pictures and photographs on display. Most pictures on display contained shape contrasts to support failing eyesight and their dementia care needs. The nurse's stations on each floor were located at the point where corridors intersected. This meant people had the reassurance of being continually able to see nursing staff whilst maximising the nurse's field of vision. The service was wheelchair accessible throughout and had a lift to support people to move between floors.

Good

Is the service caring?

Our findings

People continued to receive their care from caring staff. People told us that the nurses and care staff supporting them were caring and kind. One person said, "They are very friendly and nice and chatty." Another person told us, "I think they have a caring nature." A relative we spoke with described the staff team as, "Such a lovely bunch."

People were supported to maintain relationships with those who were important to them. Relatives and friends were encouraged to visit people and were made to feel welcome when they did. One relative said, "The staff are nice to me when I come here." Another relative told us, "Whenever I visit [relative] I never feel like an intruder or in the way. The staff are friendly." People's care records noted the contact details for all of the relatives and friends that people wanted to list. This enabled people to keep in touch with those they cared about. Where required staff supported people to make phone calls and to write letters and cards to relatives and friends.

People were supported by staff who knew them well. Each person had an allocated nurse and a named keyworker among the care staff. A keyworker is a member of staff with special responsibilities for developing a rapport with people, arranging activities and appointments, ensuring that people's material needs are met and liaising with families. Each day on each floor keyworkers coordinated 'resident of the day' activities. A member of staff told us, "The resident of the day arrangement is great. It allows us to focus on one person and make them feel special on that day. They choose a special activity and anything they want to eat at each mealtime. The cook prepares it specially."

People's independence was promoted and risks associated with their independence were assessed. For example, one person at risk of falls wanted to continue to use the toilet independently. This was made possible by the person having an alarm when inside the toilet and a member of staff waiting outside it. People who chose to were supported to bring equipment they were familiar with from their own homes into the care home. For example, people brought their own Zimmer frames and wheelchairs. These were then assessed for their suitability and meant people's independence was maintained.

People told us their confidentiality and privacy were respected. One person told us, "The staff are discreet. They don't talk about my business in front of anyone else." Another person told us, "Staff will knock my door before coming in." We read one person state in their care records, "I don't like people to disturb me when I am in my room." Another person's care records stated that they did not wish to have their photograph on their care plan. This decision was respected and documented. Staff signed confidentiality agreements prior to joining the service and managers regularly reminded staff about the importance of protecting people's confidentiality. For example, we read in the minutes of a team meeting that staff were instructed to, "Apologise to [callers] demanding confidential information on the phone and say you cannot give such information."

People approaching the end of their lives were treated with compassion and dignity. People were supported to discuss and decide what was important to them at the end of their lives. Care plans stated people's

wishes for the dying phase of their care. This included ensuring people were pain free. End of life care plans stated whether people wished their last days to be in the care home, in hospital or in a hospice. The service received support from palliative care specialists and staff received end of life care training. A member of staff told us, "We increase tactility with people as they near the end. We give people hand and head messages and make sure their mouths are moistened and never dry and that anticipatory medicines are always there." Another member of staff told us, "Some people like their perfumes and their rooms to be scented. It is important to talk kindly to people right up to the end. They might not respond but they can hear. If a person doesn't like music or a lot of people around when they are unwell this needs to be respected." Where people did not want to discuss end of life care this was noted in care records.

People were supported to attend a memorial service each year to remember people from the service who had died. This helped people and relatives celebrate their lives. The registered manager produced a booklet for the memorial service which contained photographs and recollections of people. People attending the event were supported to light candles and the relatives of people who had passed away were invited to attend.

Good

Is the service responsive?

Our findings

People received care and support that was highly responsive to people's needs. The provider made full use of technology to monitor people's changing needs and to plan people's care. People's care records were computerised. All staff had training in the use of the electronic care records and access points to the system were located throughout the service. Access points included nurse's stations, the offices of senior staff and standing computer terminals in corridors. This meant people's care records could be viewed and updated quickly by staff.

The provider used innovative systems to closely monitor and support people's health needs. Staff used people's electronic care records to identify changes to the care people required. For example, we saw that a person was admitted into the service with a pressure ulcer. Staff regularly photographed and measured the pressure ulcer and uploaded the images to the electronic care record. At the same time staff detailed the treatment the person received throughout each day. These notes included the changing of dressings and the person's repositioning into pressure relieving positions. This meant visiting healthcare professionals could review the effectiveness of the treatment plan staff followed.

People were supported with a comprehensive assessment of their needs by senior staff and nurses 48 hours prior to living at the service. This was to ensure that the service could meet people's needs. People were supported with 10 mandatory assessments which included their health and mobility. Where mandatory assessments identified needs the electronic care records automatically triggered further assessments. For example, when people's mental health assessments identified that they might experience depression, the electronic care record triggered a separate and additional depression assessment to be undertaken. Similarly, if people's mental health needs assessments identified that they may be living with dementia, the electronic care records opened a dementia dependency assessment tool for staff to complete. For each need identified the electronic care records directed staff to take appropriate action. For example, when nutritional assessments identified that people may be at risk of not eating enough staff were directed to make referrals to the GP and dietician. The system alerted managers if referrals had not been made.

People's care records guided staff as to how people preferred their needs met. Where people were no longer able to communicate verbally and did not have relatives, staff built up a profile within their electronic care record of the things they observed people to like. For example, one person was noted to enjoy specific television programmes whilst another person liked to be present when there were sing-a-longs. Staff recorded when people living with dementia presented with signs of distress. Staff noted how people showed distress, what happened before and what happened afterwards. These records were reviewed by healthcare professionals to identify potential causes and to devise guidelines to support people's emotional wellbeing.

There was an imaginative approach to activities in the home. Each Spring incubated duck eggs were brought into the service so that ducklings could be hatched and raised by people for a week. One person said, "It's wonderful, they are so cute." Another person told us, "It's lovely looking after the little chicks." Staff took photographs throughout the week which people could review when they chose. Following people's expression of wishes to nurture and grow items in the garden the provider enlisted the services of a

conservation charity, the Wild Life Trust. As a result the service adapted the garden to use fully to tend flowers and vegetables. One person told us, "I love being in the garden. It makes me so happy." Another person said "It's good to grow stuff. I graft from time to time with the guys in the garden." The service also made creative use of the garden for events in the summer. These included barbeques, parties and outdoor big screen events including sports events such as football tournaments and classic films.

The service was responsive in supporting people's interests. For people interested in current affairs the service arranged a newsround group. Within these sessions people looked at newspapers and news headlines and staff provided people with the opportunity to discuss events current and historic, political and sporting. People for whom the royal family held importance were supported with their interests too. Staff supported people who chose to, to celebrate royal events including the Queen's birthday and coronation as well as royal births. People were support to send cards and letters to the Queen at significant times and the embossed letters received in reply from Buckingham Palace were framed and displayed for people to see. The service had a pub for people to socialise in. Called the Lime and the tree, the pub contained a hatch door counter beneath a neon lit pub sign. Events in the pub included quiz nights and fish and chips evenings. One person told us, "The pub is great."

People were supported to participate in a range of activities. These included reminiscence sessions, cake decorating, ballet, seated exercises, dominos, flower arranging, karaoke and board games. People described as "active walkers" were supported to walk in the community each day with staff. Activities were creative and incorporated good practice guidance for caring with people with dementia. The home provided activities under a programme called Namaste which has been found to benefit people with dementia. People who were living with dementia received support staff to use the Namaste care programme. Namaste is a sensory care programme in which people are supported through all five senses. For example, people's sense of touch was stimulated through the massaging of their hands, head, feet and face. People's sense of smell was stimulated by scents, perfumes and aromatherapy oils. This meant people living with dementia were support through recognised good practice to reduce the anxiety associated with dementia and to increase their sense of wellbeing.

The provider was highly effective in its responses to feedback from people and their relatives. People were supported to meet each month in residents meetings whilst relatives meetings took place every three months. At the January 2017 residents meeting we read in the minutes that people requested an increase in the amount and types of activities provided. The provider responded by employing a full-time activities coordinator and increasing the activities available each day. We found that following feedback from relatives who stated that they would like more information about dementia, the provider arranged for an expert trainer to deliver a training session to relatives. The service had a suggestion book available at reception and feedback boxes were located on each floor. Feedback boxes had forms beneath them which people and visitors could complete. The forms and the feedback boxes were entitled "How did we do today?" and were regularly checked by managers.

People told us they knew how to make a complaint if they were unhappy with their care. A Freephone telephone number was available for people, relatives and visitors to make complaints to and its details were displayed prominently throughout the service. We found that the provider had acknowledged all complaints within the timeframe set out in its complaints policy and responded to all complaints in writing.

Good

Is the service well-led?

Our findings

Good governance was evident at the service. A range of audits were carried out by staff and the registered manager reviewed all audits completed. Audits included checks of medicines records, infection control, health and safety, housekeeping, staff files and care records. The staff file audit checked the continued eligibility of staff to work in the UK and the quality of the information noted in supervision records. The audits of care records included the expiry date of people's DoLS authorisations and confirmation of support and treatment in line with people's planned care. All audits were recorded electronically. The system used by the service ensured that any action identified during an audit could not be closed on the system until verified as completed satisfactorily by a line manager. In the case of actions carried out by the registered manager these required the approval of a regional manager.

People received care and support from a team that felt well led. One health and social care professional told us, "Managers are seen as approachable and supportive in both professional and personal matters." Staff expressed a high degree of confidence in the registered manager and her open approach. One member of staff told us, "Every manager in the world has an open door policy except their faces say something else when you need to talk to them. Our manager is genuinely welcoming when you want to talk." Another member of staff told us, "I feel I can talk to her about any subject and I can expect good guidance in her response." A third member of staff said, "The manager is easy to approach. She is very knowledgeable and full of little gems. This is a supportive environment." A fourth member of staff told us the registered manager was, "so supportive". The provider arranged for free English classes to be delivered to staff for whom English was not their first language. These sessions were delivered by an external lecturer three times each week to staff at the service. This meant people received care from staff who were continually supported to improve their ability to support them.

The provider shared collaborative and pioneering partnerships with others. The service had participated in a number of research projects and at the time of the inspection was engaged with a university nursing hospital. This research involved the piloting of a specialist care plan for frail, older people with life-limiting illnesses who were anticipated to be in the last year of their life. Additionally, the service worked with a regional beacon hospice service and the registered manager delivered training on end of life care to community based nurses.

The provider developed deep community roots which extended to a local college. The provider supported students from the college who were studying on a healthcare course to complete a one year apprenticeship placement at the service. Three of the service's current staff had completed this apprenticeship programme and had gone on to progress into senior staff positions at the service. These staff had become role models for students from the local community to aspire towards.

The registered manager promoted care and support that was in line with best practice. A number of staff were designated champions for specific areas of need for people. These included staff being tasked on each of the nursing home's three floors with being infection control champions, end of life care champions and dementia care champions. These staff shared information with and observed colleagues and role modelled

best practice. The registered manager ensured that successes in championed areas were celebrated. For example, a trophy and certificates were on display celebrating the service's 730 days without a pressure ulcer developing at the service.

The registered manager ensured effective communication throughout the service. All senior staff gathered for a meeting each day. Termed 'dashboard meetings', these followed the same format each day to ensure participants were familiar with the agenda. Issues shared during dashboard meetings included hospital admissions, staff numbers on each floor, maintenance issues, visiting health professionals and activities planned for the day. We observed discussion at one dashboards meeting about the implementation of recommendations and good practice guidelines from a dietician and strategies to support a person refusing personal care. This meant people received care from staff directed by managers acting on the most up-to-date information about people's changing needs. The registered manager also ensured that records were maintained and circulated of handovers between senior staff, daily briefings for nursing staff and general staff meetings. The service had an electronic communications system which enabled managers to send and receive messages to all staff and to see when they were read. The system promoted transparency because managers and staff were notified when staff had read their messages.

The registered manager understood the legal responsibilities of their registration with CQC and the requirement to keep us informed of important events through notifications when required.