A A Toorabally

The Limes Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Limes Care Home is a residential care home providing personal care to 17 people aged 65 and over some of whom were living with dementia at the time of our inspection. The Limes Care Home can support up to 40 people across two floors, due to the number of people using the service only the ground floor was in use.

People's experience of using this service and what we found
People were not protected from the risk of abuse. Infection control measures were ineffective and government guidance was not followed or adhered to in order to reduce the risk of possible transmission of COVID-19. There were not enough adequately trained staff to support people safely. Staff were not recruited safely.

Medicines were not managed safely, and little action had been taken since our last inspection to address known issues. Care plans were not updated as people's needs changed, and people had not been adequately assessed prior to moving into the home. Risk management and oversight remained poor.

Management of the service was inadequate. A large number of people had been admitted into the service unsafely in a short space of time. A number of issues which had been identified to the provider during our last inspection had not been addressed. The provider had no systems and processes in place to assess risk and monitor quality and safety. There was no oversight of the quality of care which placed people at risk of harm.

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 (published 26 February 2022).

Why we inspected
The inspection was prompted due to concerns regarding people being admitted unsafely to the home, staffing, management, infection control, and how people were safeguarded from the risk of abuse. Due to the increasing concerns a decision was made for us to inspect much sooner than planned and examine those risks.

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 COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

We have found evidence that the provider needs to make improvements. You can see what action we have

asked the provider to take at the end of this full report.

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

Enforcement
We have identified breaches of regulations in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, staffing, fit and proper persons and good governance.

Please see the action we have told the provider to take at the end of this report.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Follow up
We will meet with the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Limes Care Home

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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 Care Home 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; however, an interim manager had been recently appointed. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The Inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our

inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with eight members of staff including the interim manager, provider's representative, deputy manager, senior care worker and care workers.

We reviewed a range of records. This included ten people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We reviewed training data and further records relating to the management of the service. Some information such as contact details for relatives and staff were requested but we did not receive these meaning we were not able to speak to any further staff or relatives of people using the service.

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 we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people, manage medicines safely and ensure infection prevention control measures were effective. This was a breach of regulation 12 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

- Risks were not effectively assessed, managed or monitored in order to keep people safe from harm. Risks associated with pressure area care were poorly managed.
- Risk assessments and detailed plans were not in place for people who were at risk of serious skin damage. One person had been reported as having open wounds on handover documentation. However, the care plans for the person made no reference to pressure damage. No action had been taken to obtain professional clinical advice. There was a delay in seeking professional advice when issues were found which placed people at risk of further damage to their pressure areas.
- Care plans did not direct staff what action to take when they discover pressure damage. There were no detailed and accurate pressure area risk assessments in place which highlighted people at risk of pressure area damage for any people. This placed all people at heightened risk of developing pressure damage.
- Water temperature monitoring had not been completed consistently and action had not been taken following our last inspection. We found in one room water remained scalding hot and was still accessible for all people at the service. This placed people at risk of receiving burns from scalding water
- Electrical equipment had not been effectively monitored which meant some equipment which we observed to be in use had not been safety tested in years. Failure to manage and monitor equipment placed people at risk of harm.

Using medicines safely

- Medicines were not managed safely which placed people at risk of not receiving their prescribed medicines.
- People did not always receive their prescribed medicines at the correct time. We found several medicine errors which had not been picked up or acted upon in a timely manner. This placed people at risk of harm.
- Prescribed supplements were not stored correctly and found in the kitchen in black bins. It was unknown who these supplements were for or why they were there. Failure to safely manage the storage of medicines can result in the medicine becoming ineffective or even toxic.
- Used injection needles were found to be left on the top of filing cabinet and not disposed of safely. This is

not in line with best practice guidance or the providers own policy. Failure to dispose of used sharps places people and staff at risk of needlestick injury.
● There continued to be no records in place relating to medicines which were required 'as needed'. For example, some of these medicines included pain relief and rescue medicines for chest pain. This meant staff did not have instructions in how to safely give these types of medicines for each person or when to give them. This placed people at risk of harm and increased pain.

Preventing and controlling infection
● People were at risk of infection due to poor infection prevention and control practices.
● Best practice guidance was not consistently followed to help reduce the risk of COVID-19. For example, staff did not practice effective hand hygiene. We observed multiple staff supporting different people throughout our inspection, without sanitising or washing their hands. This placed people at risk of harm.
● Cleaning records had not been completed to ensure the home had been cleaned effectively and there were many areas which required cleaning. For example, bathrooms had visible dust and stains around the bath. Bars of soap were also found in communal bathrooms and staff did not know who these belonged to, this placed people at risk of possible cross infection.
● During our inspection we found staff were not testing in line with current guidance. For example, one staff member entered the building and collected a lateral flow test (LFT), they then completed their LFT and entered the lounge without waiting for their result. Two other staff had sat in the lounge with people before they undertook a test and returned without waiting for their result. This is not in line with current guidance.
● There were no individual risk assessments in place for anyone admitted to the home from 20 January 2022 until 3 February 2022 in regard to COVID -19. This was not in line with Government guidance.
● We found bed sheets in two people's room to be stained with bodily fluid and sheets soiled with faeces to be left to soak in a bucket. One washing machine was broken and the other washing machine did not reach a hot temperature to effectively clean people's clothes. There was no plan in place to address this issue despite one washing machine being broken since December 2021.

Systems had not been established to robustly assess the risks relating to the health safety and welfare of people, manage medicines safely and ensure infection prevention control measures were effective. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to safely recruit suitably qualified and competent staff. This was a breach of both regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 and regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulations 18 and regulation 19.

Staffing and recruitment
● New staff were still not recruited safely.
● Staff files we reviewed did not all contain information to ensure staff were recruited safely. One staff file we reviewed did not contain information such as references and a Disclosure and Barring service check to ensure they were suitable to work at the service. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. There were no interview notes for three staff members current roles at the service. This placed people at risk of receiving care from unsuitable

people.
● One staff member was working at the service during our inspection having started their employment the week before. This staff member worked independently entering service users' rooms and sitting alone with service users in the lounge. The staff file did not contain a DBS or risk assessment in place. There was no evidence of induction, supervisions, shadowing or training for staff member.
● Another staff member had started working at the service on 29 January 2022. There was no evidence of induction, supervisions, shadowing or training for this staff member. Their recruitment file was not present, and we had to request information such as references. Another staff member lacked the evidence to support effective staff recruitment.
● Management at the service had been recruited unsafely. The provider had appointed people to roles without any assurance checks taking place. A new manager had been appointed without any assurance checks being made in regards to their management experience.
● Not all staff had received training in key areas such as safeguarding and infection control. Our observations supported that staff required further training in these areas in order to support people safely. For example, staff in charge during the morning of our inspection did not address or challenge any of the poor infection control practices we observed placing people at risk.
● During our inspection of the home there were still no trained staff available to clean the home effectively in order to protect people from risk of cross infection. The provider had taken inadequate action to have the home effectively cleaned since our last inspection and following their COVID-19 outbreak. For example, large balls of dust were found in the home, toiletries were found in communal bathrooms which had not been moved since our last inspection and grime was visible around these items.

The provider had failed to safely recruit staff and ensure they were trained and competent. This was a continued breach of both regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 and regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

At our last inspection the provider had failed to safeguard people from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 13.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Systems and process in place did not protect people from the risk of abuse.
● Incidents of abuse were not reviewed, audited or analysed. This left service users at risk of ongoing abuse and harm. It also meant lessons were not being learnt or implemented.
● During handover on 10 February 2022 a staff member disclosed incidents during the night whereby they removed moving and handling equipment from a person which they used to safely mobilise. The staff failed to recognise this as a safeguarding incident, and it was not reported. Staff management of the incident was highly inappropriate. The staff all failed to recognise this as an incident of abuse.
● The provider did not ensure safeguarding concerns were always recognised, recorded or reported on appropriately to the local authority safeguarding team or to the Commission as is required by law. This placed people at risk of continued abuse.
● Incidents were not learnt from and little or no action was taken following incidents occurring. For example, one person fell regularly, and insufficient action had been taken in order to prevent further falls.

The provider failed to ensure that people were protected from abuse and improper treatment. This was a continued breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 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 our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained 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 the provider had failed to monitor and drive service improvement in order to provide safe care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had not been made at this inspection and the provider remained in breach of regulation 17.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Failings found at our previous inspections had seen limited improvements, we received significant concerns following our last inspection in January 2022, which meant we returned much sooner than anticipated.
- The provider had failed to learn from previous issues raised, there had been limited input or oversight from the provider. Action was only taken by the provider when serious issues were raised, however, these had not improved the quality of the care that people received.
- Audits were not completed in order to drive service improvement or identify risk. For example, medicine audits had not been completed sufficiently therefore issues we found were not highlighted so improvements could not be made. This placed people at risk of harm.
- Lack of managerial oversight of care records meant these were not consistent or robust to enable new staff to follow them. Care plans and risk assessments did not provide staff with accurate information in order to support people safely. This placed people at risk of harm.
- We found several incidents which should have been reported to both safeguarding teams and CQC but had not. The provider had failed to ensure the management team within the home were aware of their legal responsibility to report incidents which impact people.
- The home had appointed an interim manager at our last inspection visit. However, since then there had been another change in management at the home. Management was not stable and staff job roles changed regularly without any assurance checks that they were suitable or qualified to undertake specific roles.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

- The culture was not person centred, open or inclusive. This meant people were at risk of receiving poor care.
- Care plans we reviewed did not demonstrate people or their relatives had been involved in planning or

making decisions about their care.
● There were no meetings held with people or their relatives to discuss the service or what changes they would like.
● People we spoke with told us they had no say in how the home was run. For example, one person we spoke with told us, "I have no say in what happens here, no one ever asks me."
● Staff were not supported in their roles; we found little evidence that staff had received adequate support or supervisions since our last inspection. One staff member we spoke with told us, "The support is next to nothing from the provider, I get told what to do which is often not the right thing in my opinion."

Working in partnership with others
● The service did not always refer to health and social care professionals in order to seek specialist advice. We found a delay in referring to multiple specialist teams such as district nurses and the falls team. This placed people at risk of harm. When referrals were made there was differences of opinions as to how the communication, care and treatment of people was progressing.

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
● We found no evidence that relatives had been informed of the findings of our last inspection and no assurances had been provided to people or their relatives of what action they would take to ensure the service was safe.
● The lack of investigation, poor oversight and failure to report safeguarding concerns indicated that the provider was not fully aware of their legal responsibility to be open and honest with people.

The provider had continued to fail to monitor and drive service improvement in order to provide safe care. They had also failed to seek and act on feedback in order to improve care. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.