Sanctuary Care Limited

# Lime Tree Court Residential Care Home

## Inspection report

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15 June 2018

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

The inspection took place on 14 and 15 June 2018 and was unannounced. At the last inspection of the service in October 2017 we rated the provider as Requires Improvement in all five of the key questions. At this inspection, we found that although improvements had been made, further work was required.

Lime Tree Court Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Lime Tree Court accommodates 60 older people, who may have a diagnosis of Dementia in one adapted building. At the time of the inspection, there were 49 people living at the home.

There was a registered manager in post. 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 were supported by staff who knew how to manage risks and report concerns to keep people safe. There were sufficient numbers of staff available to support people, infection control procedures were effective and medication was given in a safe way.

Although people's rights were upheld in relation to Mental Capacity Act , further work was required to ensure that all best interest decisions were specific to the decision that required making and that all people who should be involved in decisions were consulted. People had sufficient amounts to eat and drink and had access to healthcare services where required. The design and decoration of the building met people's needs.

People were supported by staff who were kind and caring. People were treated with dignity and respect and supported to maintain relationships with those closest to them. Advocacy services were available for people where required.

People were involved in the planning and review of their care and were supported by staff who knew them well. Activities required improvement to ensure that these were available when the activity co-ordinator was not present. Complaints made had been investigated and resolved.

Further work was required on records to ensure these were detailed and accurate. Audits in place to monitor the quality of the service had been effective in identifying areas for improvement. People were given opportunity to feedback on their experience of the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Good**

The service was safe.

People were supported by staff who knew how to manage risks to keep them safe.

Staff were recruited safely and there were sufficient numbers of staff available to meet people's needs.

Medications were given in a safe way.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Records in relation to people's mental capacity were not always reviewed where people's capacity to consent changed.

People were supported by staff who had appropriate training and supervision.

People had sufficient amounts to eat and drink and had access to healthcare services where required.

### Is the service caring?

**Good**

The service was caring.

People were supported by staff who were kind and caring to them.

People were treated with dignity and respect.

People had access to advocacy services where required.

### Is the service responsive?

**Good**

The service was responsive.

People were involved In the planning and review of their care.

Activities were available and the provider was aware that further

improvements to the availability of activities was needed and was acting on this.

Complaints made were investigated and resolved.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

Records held in relation to people's care was not always detailed or accurate.

Audits were in place to monitor the quality of the service.

People were supported to feedback their experience of the service.

# Lime Tree Court Residential Care Home

**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.'

The inspection was prompted in part by notification from the commissioning local authority that a high number of falls had occurred at the service. These concerns were looked at during this inspection.

This inspection took place on 14 and 15 June 2018 and was unannounced. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has experience of using, or caring for a person who uses this type of care service.

We reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority to gather their feedback about the service.

We spoke with seven people living at the service and two relatives. As some people were unable to share their experience of the service, we completed a 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 with us. We also spoke with a volunteer, two care staff, two senior care assistants, the activity co-ordinator, the assistant cook, the deputy manager, the registered manager and the regional manager.

We looked at five care files, two staff recruitment files and seven medication records. We also looked at

records held in relation to accidents and incidents, complaints and audits completed to monitor the quality of the service.

Good

# Is the service safe?

## Our findings

People told us they felt safe. One person said, "I am not worried about anything and I think I do feel safe here". Another person added, "I think I am safe as everyone is so kind". Staff we spoke with were aware of how to raise concerns if they suspected someone was at risk of harm. One member of staff told us, "I would report any concern straight to a senior or the manager". We found there were systems in place to ensure that concerns raised were reported and investigated and that the registered manager had referred incidents to the local authority safeguarding team where required.

Prior to the inspection, we had been made aware by the local authority who commission services that a high number of falls had occurred at the service. Some of these had resulted in serious injury. At this inspection, we found that although a high number of falls had occurred in previous months, the registered manager had implemented systems to monitor and act on falls to reduce the risks to people in future. This was beginning to have a positive impact with the number of falls per month reducing.

Where people were at risk of falls, we found that these risks had been assessed and action's identified to reduce this risk. For example, equipment such as bed sensors and crash mats had been put into place. Staff we spoke with were knowledgeable about the risks to people who may fall and how they could reduce this risk. The registered manager showed us how they maintained close observations of people following falls, made referrals to other healthcare professionals to identify possible causes of the fall and accessed the support of falls teams to reduce the risk in future. This showed that the registered manager had been proactive in addressing the high number of falls at the service and as a result, had successfully reduced the falls that people experienced.

People gave mixed feedback when asked if there were enough staff to meet their needs. One person told us, "They [the provider] could always do with a few more staff but they look after us well and respond if I need anything". Another person added, "I don't think they are short of staff really. You can tell because everyone is well cared for. Nobody is pushed to one side, nobody is shunned, there is always someone there to help people". Family members we spoke with did not feel there were enough staff. One family member told us, "I feel [person's name] is safe here but there really aren't enough staff. People have to wait for basic attention at times".

Our observations showed that staff were consistently available within communal areas, and that where people required support this was provided in a timely way. People who chose to spend time in their room told us that they received regular visits from staff. One person said, "They [staff] come and help me and stop by to say hello". Staff we spoke with confirmed they were not rushed and felt the staffing levels met people's needs. One member of staff told us, "I think the staff do have time to spend time with people". We saw that the registered manager had used a dependency tool to assess the number of staff required to support people and found that the assessed numbers of staff matched what was available. However, an assessment had not been completed to determine how many staff were required at night for people. The registered manager informed us that they would be assessing this shortly to ensure that night time staffing levels reflected people's needs.

There were safe recruitment systems in place to reduce the risk of unsuitable people being employed. We found that staff had been required to provide references and complete a check with the Disclosure and Barring Service (DBS) before they could commence work. The DBS would show if a prospective employee had a criminal record or had been banned from working with vulnerable adults.

People were happy with the support they received with their medication. One person told us, "If I need any painkillers then I just ask and I get all of my other tablets on time too". We observed staff supporting people with their medication and saw that this was done safely. The staff member informed the person that it was time for their medication and stayed with them while they took this. We checked medication records and saw that records had been completed accurately and that the supplies of medication matched what was recorded. This indicated that medication had been given as prescribed. We found that medication had been stored safely. However, the fridge where medication was stored had been too warm for the previous seven days. This had been recorded by staff but had not been shared with the registered manager to act upon. Medication can be adversely affected by being stored at incorrect temperatures. We raised this with the registered manager who immediately acted to ensure the safe storage of these medications.

There was safe infection control practices in place. We saw that the home was clean and odour free. Staff were seen to be using Personal Protective Equipment (PPE) such as gloves and aprons when supporting people and understood the need to use this equipment to prevent the spread of infection.

The registered manager showed they were keen to learn and make improvements when things went wrong. For example, they had acted on the high number of falls that occurred to improve the care provided and reduce the number of falls. The registered manager had also been working closely with the regional manager to make improvements to the service based on the findings of the last inspection; such as improving systems in relation to Deprivation of Liberty Safeguards.

Requires Improvement

# Is the service effective?

## Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. Staff we spoke with understood the importance of seeking consent from people before supporting them and we saw staff put this into practice. We saw that mental capacity assessments had taken place but that while some of these had been decision specific as required, others were not and did not specify the nature of the decision to be made. For example, one assessment stated it was for 'Daily Decisions' but did not say what these decisions were in relation too. Following the inspection, we were informed by the provider that this had been addressed. We also found that capacity assessments were not revisited where people's capacity to make certain decisions had changed. We found that due to deteriorating health, one person's ability to make decisions with regards to their care would have changed. However, we could not see that any further assessments of capacity had taken place. We spoke with the registered manager about this who advised this would be addressed to ensure the records were complete. Following the inspection, the provider sent us an updated capacity assessment indicating that the person no longer had capacity. For one person who no longer had capacity to make a decision with regards to their care, we found that the registered manager and management team were not clear on the actions they should take to ensure that the care decision made was in their best interests. Inspectors intervened in this instance to ensure that the person's rights were upheld and provided guidance to the management team on how to ensure that the decision made followed the principles of the MCA.

We saw that where people required these, DoLS authorisations were in place. Records we looked at showed that these had been applied for appropriately. Staff could not inform us of who had DoLS authorisations in place, which meant that staff could not ensure they were working in line with these authorisations and any associated conditions. However, all staff spoken with were aware of where they would be able to find this information and we did not see anything that would indicate that the authorisations were not being adhered too.

Prior to people moving in the home, an assessment of their needs took place to ensure that their care and treatment needs could be met. Records we looked at showed that these assessments looked at people's medical history as well as their current care needs. The assessments also assessed people's needs in relation to protected characteristics under the equality act such as religious / cultural needs.

People told us they felt staff had the skills and knowledge required to support them effectively. Staff spoken

with told us that they had received an induction prior to starting work that included completing training and shadowing a more experienced member of staff. One member of staff told us, "There was an induction booklet to be completed. I also did a week of shadowing with a senior care staff". We found that new care staff were enrolled onto the Care Certificate. The Care Certificate is an identified set of standards that care workers must adhere too.

Staff also had access to ongoing training that reflected the individual needs of people. One member of staff told us, "There is a lot of training. I never realised how much training would be involved". Staff told us they were able to request additional training if they needed this. One staff member said, "The manager is always asking If I want to go on advanced training". Records we looked at confirmed that training was completed by staff. Staff explained that the registered manager would periodically check staff knowledge of how to support people to ensure they continued to have the knowledge they required. One member of staff told us, "The managers will come upstairs and just asked staff what they understood about mental capacity". This evidenced that in addition to planned training, the registered manager had an ongoing system to ensure staff continued understanding of their role.

People were happy with the meals they were provided with. One person told us, "The food is nice here". Another person added, "There is a good variety of food and there is a choice everyday". We saw that although the menu was set by the provider, the kitchen staff at the service had made amendments to these to suit the preferences of people at the home. We saw that people were given options of what they would like to eat at mealtimes and where people required support to understand their choices, staff would show them each meal to support their decision making. People who required support to eat were provided with this support in a respectful way; with staff talking to people while they eat and patiently waiting until they were ready for another piece of food. We saw that mealtimes were relaxed and people made conversation with each other and staff while they eat. We spoke with the assistant cook who had an understanding of people's specific dietary requirements; including any allergies, soft diets and preferred portion size. We saw that details of people with specific dietary needs had been displayed in the kitchen area so that all staff preparing meals were aware of people's needs.

People had access to healthcare services where required. We saw from records that people had been supported to visit services including Physiotherapists, District Nurses and Speech and Language Therapists. We also saw that people had been seen by their GP as and when needed and that people were supported to have regular eye tests with their optician.

The design and decoration of the service met people's needs. We found that the home was spacious, that people had access to outside spaces and that consideration had been given to people who may have dementia, with communal areas having memory aids placed around the hallways. The regional manager informed us that work was beginning on a redecoration of the service with the aim of enhancing the environment for people with Dementia. They intended to ensure that colour contrasts between walls, floors and handrails were better to support independence in moving around and to improve on the current reminiscence aids around the hallways. We saw from records held from residents meetings that people were being encouraged to become involved in the redecoration and that they had been given opportunity to say how they would like to see their home decorated.

Good

# Is the service caring?

## Our findings

People told us that staff were kind and caring to them. One person told us, "The staff are all very, very nice – every one of them and you can tell they love their job". Another person added, "The staff are lovely". Family members we spoke with also spoke positively about the caring nature of staff. One family member said, "The staff are friendly and likeable". Staff we spoke with displayed warmth when discussing their role and the people they support. One member of staff told us, "The job is more rewarding than I ever thought it would be". We saw positive interactions between staff and people when support was being provided. It was clear from people's happy and positive reactions to staff that friendly relationships had been developed.

Some feedback provided by people suggested that although staff were caring, they did not always have the time to sit and spend time with people due to being busy with other tasks. One family member told us, "Although staff always greet people, they are very limited in how much time they spend talking to people one to one". Another family member added, "In all the time [person's name] has lived here, I have never seen staff sit and talk to them". We saw that staff were limited in the time they were spending with people outside of providing care. Staff were always present in communal areas but were not consistently with people, spending time and making conversation with them. We raised this with the registered manager who advised of the work that was ongoing to ensure that staff were free to spend time with people, including completing paperwork while sitting with people to encourage conversation. However, she acknowledged that further work may be required in this area.

People told us they were involved in their care and were given choices. One person told us, "I can get up and go to bed whenever I want". Another person said, "You can do what you want with your time". We saw that staff respected people's right to make choices and we saw some good examples of staff promoting choice. For example, we saw staff asking people where they would like to sit, what activities they would like to take part in and what they would like to drink.

People felt that staff were respectful and ensured they were treated with dignity. One person told us, "They [staff] always greet you by name and are kind and caring in their approach". Another person said, "They [staff] take their time with me even though they are busy and they are always respectful to me". Staff we spoke with could provide examples of how they ensure people are treated with dignity One member of staff told us, "I do things like closing doors when supporting with personal care and covering people's legs when they are hoisted so they are not exposed". We saw a number of positive interactions in which people's dignity was respected. For example, we saw staff knocking on people's doors and waiting for consent before entering their room and being discreet when offering personal care support so that others could not hear.

We saw that people were encouraged to maintain positive relationships with those closest to them. We saw people have visitors visit them throughout the day and other people were supported and encouraged to use the telephone to speak with their loved ones.

People had access to advocacy services where required. An advocate can be used when people may have difficulty making decisions and require this support to voice their views and wishes. We spoke with the

registered manager who was aware of how to make referrals for people where required.

Good

# Is the service responsive?

## Our findings

We found that people's needs had been assessed prior to moving to the service and that the information gathered informed people's care records. The initial assessments looked at people's care needs as well as their preferences with regards to their care. Care records we viewed took into account people's physical, emotional and social needs and family members told us that they and their relative had been involved in these. One family member told us, "We are involved as a family in care review meetings".

People told us that staff knew them well. One person told us, "I believe they [staff] know me and know what I like". Another person said, "They [staff] all know me". Records we looked at held personalised information about people including their life history, likes and dislikes. The knowledge staff demonstrated about people reflected what was in their care records. For example, we spoke with one member of staff who told us all about one person's life prior to moving to the service; including the person's family and past jobs. This evidenced that staff had taken the time to get to know people well; in addition to knowing about their care needs.

We found that although people in receipt of end of life care received care that was in line with their wishes, records held in relation to this were vague and required further information. We discussed with the registered manager about a person who was receiving end of life care. The registered manager had informed us of the actions they had taken to ensure that the person's final days were how they would want them to be. This included putting flowers in the room as this was a past hobby of the person, and speaking with the persons loved ones about their religious wishes. However, this was not reflected in the person's care records. This meant that although the person's final wishes were being adhered too, the positive work being completed by staff for the person required reflecting in care records to ensure consistency of care.

People gave mixed feedback about the activities on offer. One person told us, "There are very few activities and no one tells you of any. Nothing goes on". Another person added, "There aren't any activities but I do like to go out and sit on the bench". Other people we spoke with were happy with the activities available for them to take part in. One person told us, "We do painting and have done some today. There are lots of activities and we can sit out in the garden too". A family member added, "[Person's name] has tried some activities but has limited capacity, they [staff] do offer plenty".

We saw that a number of activities were available throughout the day; including dominoes and listening to music. We also saw that local school children visited people and supported with painting bird boxes for the garden. People were visibly enjoying this activity and the company of the school children. There was one activity co-ordinator in post who was responsible for implementing activities across the three floors of the service. This meant that when the activity co-ordinator was elsewhere in the building, activities in other areas paused as staff did not continue with these. We spoke with the registered manager about this and the importance of care staff continuing the planned activities when the activity co-ordinator was not present. The registered manager, alongside the regional manager had already recognised this an area for improvement and were implementing plans to provide more meaningful activities for people.

People told us they had no cause to complain but knew how they could do this if they so wished. One person told us, "If I needed to complain, I would approach the manager". Another person said, "I am quite happy really and have never had to raise any complaints". We saw that information was available informing people how they could make a complaint if they wished. This information was not readily available but a member of staff advised that this could be sought from the provider's head office if people required the information in a separate format. We looked at record held in relation to complaints and found that where complaints had been made, these had been investigated and the conclusion had been communicated to the complainant.

Requires Improvement

# Is the service well-led?

## Our findings

We found that records held in relation to people's care were not always fully completed or detailed. For example, we found that one person required support to reposition to reduce the risk of pressure areas forming. We asked to see the records for this to evidence that this care was being provided and found that some of the daily records were missing. Further, the person's care records stated that this support should be given hourly, when the current position was that this should be provided two hourly. The registered manager informed us that this was an error. However, it meant that the records for the person were not accurate. However, staff we spoke with were aware of the action they needed to take in relation to pressure areas and we found that this support was being provided as the person did not have any sore skin. We also found that further detail was required in records relating to mental capacity and people's specific wishes at the end of their life. Although staff we spoke with were aware of these care needs for people, the records required improvement to ensure that care was provided consistently in these areas. Following the inspection, the provider sent us an updated plan that included the person's end of life wishes.

People did not always know who the registered manager was. One Person told us, "I don't know who the manager is but I do think it is well run". Another person said, "There has been a change of manager so I am not really sure who it is. I would happily recommend the place". Other people we spoke with however, did know the registered manager with one person telling us, "I know the manager well, she is really nice". We saw that the registered manager had a visible presence around the home and took time to speak with people as she saw them.

Staff told us that they felt supported by the management team and felt they had bought stability to the service for people. All staff spoken with felt comfortable in raising concerns with the registered manager but knew how they could whistle blow if needed. We found that the registered manager had been open and transparent where incidents occurred and had notified us of incidents where required.

There were systems in place to monitor the quality of the service. These systems included auditing medications, care records and people's dependency levels. We found that the areas for improvement identified at this inspection had already been highlighted in a recent audit and that the registered manager had begun to action these. For example, we found that an audit had identified that people were not consistently happy with the activities available. In response to this, the registered manager was implementing a tool that would ensure activities provided were more meaningful to the people taking part. The audits had also identified that further work was required in relation to the accuracy and level of detail in people's care records. The registered manager was beginning to address this by including staff in the completion of care plans. This meant that the systems in place for monitoring the quality of the service had been effective as the areas we found that required improvement had already been identified and acted upon by the provider.

People told us they were given opportunity to feedback on their experience of the care provided at the service. One family member told us, "I attend the meetings which are held and often raise points". We saw that people were given opportunity to discuss changes that they would like to see at the service and that

these were being acted upon. Records showed that people were being encouraged to discuss to upcoming re-decoration of the service at these meetings and have a say on what work they would like to see completed.

The provider had clear plans for the future of the service. The regional manager informed us that plans were In place to improve the care planning system and move this to an electronic system later in the year. The regional manager informed us that the intention of the change would be to improve the quality of the records maintained and make records easier to complete.

It is a requirement that providers display their most current rating both in the home and on their website. We found that the provider had done this. The rating was clearly visible on the provider website and the reception area of the home.