New Hope Specialist Care Ltd

The Limes

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 31 May and 01 June 2018. At the last inspection of the service in January 2017, a rating of 'Requires Improvement' was given due to ineffective governance and recruitment systems. At this inspection we found that improvements had not been made and the service remains as Requires Improvement.

The Limes 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.

The Limes accommodates eight people in one adapted building. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

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.'

The provider did not ensure that the building was consistently safe for people. Where essential safety checks were required, these had not been completed. Where potential safeguarding incidents had occurred, these had not been considered in line with safeguarding procedures. Staff were recruited appropriately and there were sufficient numbers of staff available for people. There were safe systems in place for the management of medication.

The design and decoration of the building did not meet people's needs and left people at risk of injury. People's capacity had not been assessed in line with the Mental Capacity Act although people were not being restricted or deprived of their liberty by staff. People had sufficient amounts to eat and drink and had access to healthcare services where required. People's needs had been assessed and people were supported by staff who had received training and supervision.

People were supported by staff who were kind, caring and promoted their independence. People were treated with dignity and given privacy where requested. People had access to advocacy services if needed.

People were involved in the planning and review of their care. There were systems in place to ensure that people were able to partake in meaningful activities that reflected their individual interests. Where complaints had been made, these were investigated and resolved. People's potential end of life needs had been considered when care planning.

The systems in place to monitor the quality of the service had been ineffective in ensuring the building was safe for people. Where areas for improvement had been identified, these were not acted upon in a timely way. 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?

Requires Improvement

The service was not always safe.

The provider did not have systems in place to ensure the safety of the building to minimise risks to people.

Incidents that had the potential to be safeguarding concerns had not been considered under safeguarding procedures.

Staff were appropriately recruited and there were sufficient numbers available to support people.

Medications were managed in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

The design and decoration of the building did not meet people's needs and left them at risk of injury.

People's rights had been upheld in line with Mental Capacity Act although capacity assessments had not been considered or completed.

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

People's needs had been assessed and they were supported by staff who were given appropriate training.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind, caring and ensured their dignity.

People were encouraged to maintain their independence.

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. People's end of life care needs had been considered.

People were supported to take part in activities that reflected their individual interests.

Complaints made were investigated and resolved.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality monitoring systems had not identified significant shortfalls in building safety. Where issues were identified, these were not acted upon in a timely way.

People were given opportunity to feedback on their experience of the service and this feedback was acted upon.

The Limes

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 information of concern received from the local authority who commission services at The Limes. The information related to concerns around the health and safety of the premises.

This inspection took place on 31 May and 01 June 2018 and was unannounced. The inspection was carried out by one inspector.

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 six people who lived at the service. We also spoke with one member of care staff, one senior carer, the registered manager, the operations manager and the provider.

We looked at the care records for three people, alongside five medication records. We also looked at two staff recruitment files, staff training information and records held in relation to quality assurance.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe in their home. One person told us, "It's alright here". Another person added, "I am not worried at all, I have no problems and I am fine". Staff we spoke with told us they had received training in how to recognise abuse and knew how they could report any concerns they had. One member of staff told us, "I would go to my manager [with a safeguarding concern] and tell her everything and then document it". Although staff were aware of how to identify and report concerns of abuse, we found that incidents had occurred at the service that should have been considered under the localir safeguarding procedures. However, this action had not been taken. Although staff had acted when incidents occurred to ensure the safety of people, the provider had not considered whether these required reporting to the local authority safeguarding team and Care Quality Commission as required.

Risks to people had not always been managed in a timely way. We found that parts of the home were in a poor state of repair. Whilst the provider was acting on these to reduce risks, we found that some of the issues had been outstanding for a number of months. For example, we found that one person's carpet was lifting and had posed a risk to the person as they could trip and fall over this. This had been identified in January 2018 but was not resolved until May 2018. This meant that the risks posed to the person had not been acted upon to ensure their safety. We raised this with the provider who could not provide an explanation as to why this risk was not addressed in a more timely way. In addition, we found that essential checks to the premises that were required to ensure people's safety had not been completed for a number of years. These included gas safety and electrical checks. At the inspection, we saw that these checks were completed or in the process of being completed. However, the provider had not acted on this potential risk to people by ensuring that these essential safety checks had been completed when they should have been.

Although the home was generally clean and odour free, further work was required to ensure that infection control practices were followed. For example, although paper towel holders were available in each of the bathrooms and toilets, there were no paper towels available, meaning that adequate hand drying facilities were not available. Further, on the first day of inspection, we identified that hazardous chemicals were kept in a locked cupboard under the sink. However, the cupboard doors were unsafe and were not secured onto the hinges which meant that these chemicals were not securely stored. The following day, we found that the provider had arranged to have the cupboard doors replaced but had not put a lock on this, meaning that these chemicals were now easily accessible to people using the kitchen. We raised this with the provider who informed us they would have a lock fitted to this area.

People were happy with the support they were given with their medications. We saw that where able, people were encouraged to do their own medication under the supervision of staff. We saw that medication was stored safely and that temperature checks were completed daily where medication was kept. It is important to check the temperature of these areas some medications can be adversely affected by the temperature. Where people had medication on an 'as and when required' basis, we found that protocols were in place informing staff on when these should be given.

We looked at Medication Administration Records (MAR) and found that the amount of medications recorded

did not always match the amount available. It was unclear whether this was a recording issue or whether medications may have been missed. We raised this with the registered manager and they informed us they would look into this.

The provider did not always learn from where things went wrong. For example, concerns around health and safety had been raised in the previous two inspections of the home. However at this inspection, we found that there continued to be issues with the health and safety at the services; including essential safety checks not taking place and fixtures and fittings being in poor condition. This meant that the provider had not learnt from previous issues and developed how they worked to ensure the safety of people.

We found that the recruitment systems in place reduced the risk of unsuitable people being employed. Staff told us that they had been required to provide references and complete a check with the Disclosure and Barring Service (DBS). The DBS check would show if a potential employee had a criminal record or had been barred from working with adults. Records we looked at showed that these checks had taken place.

People told us that they felt there was enough staff available to support them. One person told us, "We have got enough staff here yes". Staff we spoke with also felt there was enough staff to meet people's needs. One member of staff told us, "I think there is enough staff. If people want to go on a day trip, we can always get extra staff in". We saw that people were very independent and the support they required from staff was minimal however staff were always visible within communal areas should anyone require any support.

We found that the provider had recently increased their staffing numbers during the night following concerns raised by the commissioning authority. The provider's assessed staffing levels had been considered unsafe in the event of fire as there would not be enough staff to support an evacuation. The provider had responded to this concern and increased the numbers of staff available at night to ensure people's safety. The provider gave assurances that this increase of staff at night would remain in place.

Requires Improvement

Is the service effective?

Our findings

People's needs had not been met by the design and decoration of the service. The kitchen area where people were preparing their food and drink throughout the day was in a poor state of repair and cupboards were not always secure, meaning that there was a potential that injury could occur while people used this area. In other areas including the first floor hallway, we found the carpet to be lifting which could pose a risk to people who may trip and fall. The decoration of the service required further work. We saw that the carpet on the stairs was worn and ripped in places and the settee in the communal lounge was also torn. We did see that people had access to adequate outdoor space where they wished and the provider had recently taken action to ensure this area was safe for use.

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, although they understood the need to gain consent from people, did not display an understanding of the MCA and DoLS. When asked about this one member of staff told us, "I have come across it but I don't know what it is". However, we did see that staff sought people's consent prior to supporting them with daily tasks. We also found that no capacity assessments had taken place to ensure that people had the capacity to make certain decisions even though people had signed consent forms held within their care file. We spoke with the registered manager about this who confirmed that they had not considered whether capacity assessments were required but felt that people did have capacity to make these decisions.

People told us that they felt the staff were knowledgeable and had the skills required to support them effectively. One person told us, "They [staff] know me very well". All of the staff spoken with had worked at the home for a number of years but told us that they had received an induction when they started work that included completing training and shadowing a more experienced member of staff. Staff told us that they were required to complete training on an ongoing basis. One member of staff told us, "We get all of the mandatory training. It is good and if I am not understanding anything, then they will put me back onto more training". We saw that staff had completed a number of training courses that included training that was specific to the needs of people living at the home. Staff told us that if they felt they needed extra support, they could ask for this. One member of staff told us, "I can ask for extra training if I want it".

People told us they were happy with the meals they were offered at the home. One person told us, "The food is nice". Another person added, "The food is alright". One person told us that everyone living at the home joined in with devising a weekly menu and that everyone got a say on the meal choices. People then

developed a cooking rota, in which each person would take it in turns to prepare a main meal for the others with support from staff. We saw that mealtimes were individual and that people were able to eat at a time and place to suit them. For example, one person chose to eat lunch in the garden at a later time to when others ate. People prepared their own meals and we saw that where they did this, they had chosen what they wished to eat, even if this was on the devised menu. We found that people's dietary needs were met by staff who were aware of where people had specific dietary requirements such as diabetes.

We saw that people were supported to access healthcare services where required. We saw that people had accessed GP services where required and had attended their annual health checks to maintain their health and well-being. Records we looked at also showed that people had annual visits to the dentist and optician. We saw that the provider had taken pro-active steps to work with other healthcare services and developed 'Grab and Go' information packs that can be taken with people when they receive healthcare treatment to ensure that other services have access to information about people's needs.

Before people moved into the home, an initial assessment took place that gave the person opportunity to discuss their needs. These assessments looked into people's medical history and any specific care needs they may have. The assessments also took into account any protected characteristics under the Equality Act and asked people about their religious and cultural needs as well as their sexuality.

Good

Is the service caring?

Our findings

People told us that staff were kind to them and that they got along well with staff. One person told us, "Staff are lovely. Every morning they come and say hello and ask if I am fine". We saw that there was a small staff team in place and that positive, friendly relationships had been developed between people and staff. For example, we saw that staff would sit and joke with people and that people responded positively to the light hearted conversations taking place. People were visibly comfortable in the company of staff.

Where people had specific communication needs, we found that these needs were being met. For example, we saw that some people due to their mental health needs, would communicate in differing ways depending on their feelings. We found detailed records providing staff with guidance on how specific people communicate and how staff should support them in communicating in a way that they are comfortable with. Staff we spoke with understood how to communicate effectively with specific people and their knowledge reflected the information held in the care record.

People were supported to be involved in their care and were given choices. One person told us, "I do choose what time I get up and go to bed". Another person added, "If you want to go somewhere, you can go". We saw that people were given choices. For example, we saw people were asked about the food they wished to eat, the activities they wished to take part in and what part of the home they wanted to spend time in.

People told us that they felt treated with dignity and were given privacy when they requested this. We saw that people were able to move freely around the home and that when they went to their bedroom for time alone, staff respected this and ensured people's privacy was respected. We found that where people liked to be referred to by a different name, all staff were aware of this and ensured that they spoke with people using their chosen name. Staff we spoke with were able to give examples of how they ensured people's dignity. One member of staff told us, "To ensure dignity, I will always ask people if they want me to stay with them while they use the toilet. If they don't want me there, I will wait outside the door so that they can have privacy". Other staff members gave examples that included giving people a choice of male or female carers to ensure they are comfortable.

People were supported to maintain their independence where possible. We saw that people were able to access the community independently and that this was actively encouraged by staff. We found people ironing their own clothes, putting their washed clothes on the washing line and preparing their own meals. People we spoke with were proud of completing tasks for themselves and one person told us, "I always do my own cooking, we take it in turns to cook for everyone". This meant that where people were able, they are supported to maintain their independent living skills; with staff supervision where required.

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

Good

Is the service responsive?

Our findings

People told us they had active involvement in their care records and could update these as they wished. One person told us, "They [staff] go through the care plan with me". We saw that records were reviewed regularly and that people had been involved in these and given opportunity to express their wishes with regards to their care. For example, we saw that people had been asked about whether they wished to receive support to vote, have access to keys to their room and whether they wished to explore finding relationships with others. Records we looked at were individual to people and gave detailed explanations about how people would like their support to be delivered. Our discussions with staff showed that staff knew people well and their knowledge reflected the information held within care records.

Although no one currently living at the home had needs relating to the end of their life, we saw that people had been asked about any wishes or religious and cultural needs they would like to see actioned should they require end of life care. We saw that where people had consented to discuss this, detailed plans were in place that covered what support they would like and what they would like to happen following their passing. This meant that the provider had all of the information they required to ensure that if anyone were to require end of life care, this would be done in line with the person's wishes.

People had access to a variety of activities that met their individual interests. People were enthusiastic about the activities they took part in and were visibly excited when discussing these. One person had a keen interest in gardening and had been supported to plant fruit trees within the garden. They told us that when the fruit appears, they pick these and share with other people in the home. The person told us, "I do my gardening and I like that". Another person told us how they were looking forward to an upcoming trip to Liverpool as it was a place they had always wanted to visit. The person said, "We are going to see The Beatles. I like them". We saw people freely come and go from the home throughout the day to take part in activities that included shopping and attending a local leisure centre for exercise. People had spent the previous evening eating out at a restaurant and watching a film at the cinema. This has resulted in lots of conversations between people about the film and what they would like to see next. This showed that people were supported to take part in activities that they enjoyed and at times to suit them.

People told us they knew how to complain. One person told us, "If I was worried I would tell my care worker". Another person said, "I haven't got anything to worry about but if I did I would go to [registered manager's name]". We saw that details of how people could complain was displayed around the home. This was in an accessible format for people who required this. We saw that where complaints had been made, a record of these had been made and we could see that these had been investigated and resolved.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place to monitor the quality of the service. However, these had been ineffective in identifying the significant concerns around the safety of the building. For example, health and safety audits had taken place but these had not identified that essential gas safety checks had not taken place for two years when these should be completed annually. Further, the audits in place had not identified that the electrical installation checks expired in 2012 and Legionella checks on the water supplies at the home had not been completed since 2016. As these concerns had not been identified through the quality monitoring systems, the provider had not ensured that these checks were renewed to ensure the safety of the building for the people who lived there. These issues continued to not be identified by the provider until a local authority Health and Safety officer visited the service and raised the concerns. At the time of our inspection, the provider was in the process of addressing these concerns. However, it is a concern that these essential safety checks on the property had not been monitored and acted upon by the provider previously.

We further found that the quality monitoring systems in place had not identified the potential fire hazards around the building. We saw that a fire officer had recently visited the service and identified areas that required improvement to ensure that people would be protected in case of a fire. This had included door closure systems and ensuring there were no gaps in pipework through walls to prevent the spread of fire. We found that the provider had begun acting on these concerns to ensure the building was safe, but the provider's own quality assurance audits had not identified these concerns.

Where the health and safety audits had identified areas for improvement, these were not acted upon in a timely way. For example, the registered manager had identified in audits dated from January 2018 that the kitchen cupboards were in need of repair. Our observations showed that this had not been addressed at the time of inspection. We spoke with the registered manager about this who advised that this issue had been shared with the provider each time the audits were completed but that no action had been taken to address this. Further, we found that where areas of carpet had lifted and posed a trip hazard, action was not taken to ensure people's safety. This hazard had been recorded in the registered manager's audits from January 2018 but no action had been taken until May 2018 to ensure the area was safe. We raised this with the registered manager who could not provide an explanation as to why the identified works had not been completed. The registered manager informed us that they had shared these issues with the provider but that they had not been acted upon.

Although we found that complaints made had been investigated and resolved, this had not occurred in a timely way. We saw that one complaint had been made verbally in December 2017. The person did not receive a resolution to this complaint and so put this in writing in January 2018. It then took a further three weeks for the provider to act on the complaint. We queried the delay with the provider and registered manager who agreed that the complaint took too long to resolve and could not provide an explanation why this occurred.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they knew who the registered manager was and felt they had a good relationship with her. We saw that the registered manager was visible throughout the home and that she knew people well. Staff told us they felt confident in the manager and were comfortable in raising concerns. All staff spoken with were aware of how they could whistle blow if they needed too. A whistleblower is a person who reports wrongdoing in the workplace. Staff also told us they took part in regular meetings with the registered manager to discuss the service.

We saw that people were given opportunity to feedback on their experience of the service. People told us that they held regular meetings with the registered manager to discuss how they would like to see the service improved. We found that there was space on a communal noticeboard for people to write in advance any areas for discussion they would like to see at the meeting. People told us that where they made suggestions, these were acted upon. For example, the upcoming trip to Liverpool was planned following suggestions from people.

It is a requirement that providers display their latest inspection rating on any website ran in relation to the service and within the home. We found that the provider was meeting this requirement.