Lime Trees Residential Care Homes Limited

The Lime Trees

Inspection report

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London
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Date of inspection visit:
13 March 2018
15 March 2018
19 March 2018

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We commenced an unannounced comprehensive inspection on 13 March 2018. We also visited the home unannounced at 04:10 on the morning of 15 March 2018 and completed the inspection on 19 March 2018.

This was the first inspection since the service was registered in March 2018 under a new provider's registration. The home had been in operation for a number of years previously.

The Lime Trees 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 Lime Trees is registered to accommodate up to 20 people and does not provide nursing care. On the dates of the inspection, there were 17 people living at the home.

The Lime Trees is set out over three floors with lift access. The building is both an older Victorian style and a new purpose built unit. There was a small garden at the back of the home which was mainly used as a smoking area.

There was a registered manager in place. 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 not safeguarded from abuse and neglect. People were sleeping in soiled and dirty bedding. People were showered in view of communal areas and as a result were exposed naked to other people, staff and visitors. Safeguarding incidents were not always recognised or reported to the local safeguarding authority.

People were deprived of their liberty without having appropriate legal safeguards in place.

People were not treated with dignity and respect. The majority of people we spoke with during the inspection told us of their unhappiness living at the Lime Trees. Most people told us that they were not respected and exercised little choice in how they lived their lives. We observed instances of staff and the registered manager treating people in a disrespectful manner.

The home was unclean. The premises and equipment within the home was not maintained to a safe standard. Strong offensive odours were detected throughout the home. Staff were not always adhering to basic infection control procedures.

There were not always enough staff deployed in the service to consistently meet people's needs. Care staff were deployed to non-care tasks such as cooking, laundry and cleaning. Staff were not able to respond to

people's needs in a prompt manner.

The provider did not always adhere to the Mental Capacity Act 2005.

People were not always receiving care from staff who were competent, skilled and experienced. The provider did not keep appropriate records of training.

The provider did not ensure safe staff recruitment. Not all staff had undergone appropriate recruitment checks prior to working with vulnerable people as an employment history or references had not been obtained. The provider had not carried out their own criminal records checks on some staff.

Care plans were not in place for all people receiving support. People's preferences were not appropriately recorded. Care plan reviews did not evidence people's involvement in planning their care.

People's health, safety and wellbeing was at risk because the provider failed to adequately assess risk and did not manage medicines safely.

Overall governance of the service was ineffective. The registered manager carried out regular monthly quality checks. Where these checks had identified concerns with aspects of care delivery, improvements had not been made.

Staff received regular supervision from the registered manager.

We received mixed feedback from people regarding the food choices on offer. Where people required assistance, we observed staff patiently provide assistance. Drinks were available at all times.

We observed one instance of an organised activity, however for the majority of the inspection; people were left sitting in chairs with little staff interaction. We observed some instances of staff kindness towards people.

Overall, we found significant shortfalls in the care provided to people. We identified breaches of regulations 9, 10, 11, 12, 13, 15, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
On 23 March 2018, we imposed a condition on the registration of the provider to restrict the admission of new service users without written authorisation from CQC.

On 18 July 2018, we issued a Notice of Decision to cancel the registration of the registered provider and registered manager. This decision was appealed to the First Tier Tribunal (Care Standards). The appeal was dismissed following a hearing in June 2019.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of

preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

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. People were not safeguarded from abuse and improper treatment. Safeguarding incidents were not always recognised, dealt with and reported appropriately.

Risks to people's health, safety and welfare were not assessed and mitigated.

There were not enough staff deployed at the service to meet people's needs.

Adequate infection control measures were not in place.

The service was unclean and in a poor state of repair. People were not always protected from environmental risks.

Safe recruitment practices were not always followed.

Medicines were not safely managed.

Is the service effective?

Inadequate

The service was not effective. People were being deprived of their liberty unlawfully.

Staff training was inconsistent as some staff had not received training.

Not all people consented to their care. Care plans were not always signed. Capacity assessments or best interest decisions were not carried out where people lacked capacity.

People were supported to access health professionals.

Some people told us they did not receive a food choice. Drinks were offered to people on a regular basis.

Staff received regular supervision with the registered manager.

Is the service caring?

Inadequate

The service was not caring. People were not always treated with

dignity and respect.

Most people we spoke to told us they were not respected and exercised little choice in their daily living routine.

It was not evident that people had been consulted or involved in planning their care.

Is the service responsive?

Inadequate

The service was not responsive. People were not receiving care appropriate to their needs or preferences.

People were not receiving support to manage their continence needs.

Care plans were not in place for all people who used the service.

Activities were limited and there was little to interest or occupy people.

Is the service well-led?

Inadequate

The service was not well-led. Most people we spoke to were not positive about living at The Lime Trees.

There were significant shortfalls in the leadership and management of the service.

The provider did not have effective systems and processes in place to assess, monitor and improve the service.

The Lime Trees

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 by concerns raised when we visited the service in February 2018 as part of our registration process. The Lime Trees had been operating for a number of years under a different registered provider.

This unannounced inspection took place on 13, 15 and 19 March 2018 and the first two visits were unannounced. The inspection team consisted of two adult social care inspectors and an expert by experience who obtained feedback from people using the service on the first day of the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection, we reviewed the information that we held about the service and the providers including notifications affecting the safety and well-being of people who used the service and safeguarding information received by us.

During our inspection, we spoke with 10 people who lived at the service and one visiting relative. We observed interactions between people and staff. We spoke with the director, nominated individual, the registered manager and four care staff. We looked at care records for ten people, seven staff files and documents related to the running of the service which included staff rotas and quality audits.

During the inspection, we liaised with the local authority safeguarding team and two visiting health and social care professionals.

Inadequate

Is the service safe?

Our findings

Care and treatment was not always being provided in a safe way. When we asked people if they felt safe living at The Lime Trees, we received a mixed response. One person told us, "I want to escape from here it is terrible and I will escape." A second person told us, "They are nasty people; they will not let me out." A third person told us, "I cannot wait to go home my nerves are bad, anxious, I want to go back to [place name]." A fourth person told us, "Yes, it is alright I think."

A walk in shower room was situated at the end of the corridor facing the living room. When the shower room was in use and due to a lack of space, the door was left open and a shower curtain hung across the hallway. From the living room we could see feet and lower legs under the shower curtain as the bottom of the shower curtain was hanging approximately two feet off the floor. The shower curtain had not been affixed correctly and the top was hanging down in one part. This meant that whenever the staff member went in and out we could see the person being showered from the living room or corridor when passing. On the morning of 15 March 2018, we observed three people being showered by a staff member, where they had been exposed in their entirety to the corridor and living room. On one occasion, a person who was passing the shower, pulled open the curtain and exposed the person being showered to the corridor and living room. Another person was required to walk back to their bedroom naked as they had nowhere to dress themselves in the space contained within the shower curtain in the corridor.

On the afternoon of 13 March 2018, we found faeces between a person's bed and wall. On the morning of 15 March 2018, we found that people had been sleeping in soiled bedding, which included mattresses, sheets, duvets and pillows. Some mattresses were significantly stained with urine and faeces. Duvets, sheets and pillows were soiled with urine and faecal matter and despite beds being made and bedrooms cleaned; the soiled bedding had not been removed from beds. Examples included a faeces soiled bed sheet being covered by a duvet, for another person, a urine soaked pillow had been covered with a clean pillow case and for another person, a urine soaked duvet had been placed into their wardrobe and left to dry. Another person had to use newspaper to sit on as their mattress was soaked with urine. This meant that people had been subjected to degrading treatment which included people sleeping in soiled bedding and being left naked and inappropriately clothed.

On commencement of the inspection, we were alerted to an incident by the registered manager where a person had been injured by a falling wardrobe one week prior. The wardrobe had not been secured to the wall. The person had sustained significant bruising as a result. However, medical attention was not sought for the person, nor was the incident notified to the local safeguarding authority. Following the incident, other people had not been safeguarded from the risk of injury as a result of the unsecured wardrobes, until we raised concerns. Following this, the provider had arranged for wardrobes to be secured to bedroom walls.

The provider had failed to safeguard people from abuse and improper treatment. This meant that people had been subject to degrading treatment and placed at risk of harm. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified significant concerns with the overall maintenance and cleanliness of bathrooms, toilets, bedrooms and communal areas.

In addition the concerns highlighted above, bedding, which included pillows and duvets were worn and thin. Wardrobes had not been secured to the walls in all bedrooms and were generally flimsy and in poor condition. This resulted in the incident, as described above.

Very strong odours were detected throughout the home during the inspection especially in people's bedrooms where soiled bedding was found. The lift which people used to access the ground floor and communal areas was extremely odorous of urine on 13 and 15 March 2018. The space behind people's beds was cluttered, dusty and had fallen debris. In two bedrooms we found broken and dirty commodes. We were told these were not being used; however, there was a risk of harm to people should they sit on the commodes and fall.

A fridge which was being used to store surplus food supplies was malfunctioning and had a very large lump of ice at the back of it. The casing of the fridge light appeared burnt and melted. The freezer part of the fridge was over frozen and covered in ice. This contained a bag of chicken thighs and bags of samosas, some of which had come loose. We were advised by the registered manager that daily temperatures for this fridge had not been completed to ensure that food was stored at a safe temperature.

On the ground floor of the home there was a walk-in shower room. This was not clean and not fit for purpose as it was located in a position which afforded people little or no privacy when using the shower. The room was too small for people to dry and change in privacy. A shower curtain had been installed around the outside of the shower room door which had fallen down in places. This meant that people were showering or being showered by care staff with no privacy in view of passing people, staff and visitors.

Following initial feedback on 13 and 15 March 2018 some improvements were made to the environmental concerns outlined above. Some mattresses and bedding had been replaced, wardrobes had been secured to walls and carpet had been removed from the lift. However, these were reactive actions taken as a result of the CQC's concerns.

The provider had failed to ensure that the premises and equipment used in delivering care to people was fit for purpose and maintained to a safe standard. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks associated with people's care and treatment were not being identified or where identified had not been mitigated. The service had not assessed risks for four people living at the home and guidance had not been provided to care staff on how to keep the person safe. One person had been living at the home for more than one month prior to the inspection. Information contained in people's referral documents indicated risks such as falls, pressure ulcers and incontinence. The registered manager told us that they were in the process of preparing their care records at the time of the inspection.

Risk assessments were not completed to demonstrate the appropriate management of these risks in order to minimise them leading to serious health complications. Risk assessments had been completed for other people living at the home, however, some identified risks associated with their care and treatment had not been assessed, for example, seizures, chronic respiratory illness and self-harm. This placed people at risk of harm as risk assessments failed to provide enough information for staff to adequately understand or mitigate risks posed to people they cared for.

People's medicines were not consistently safely managed. PRN or 'As needed' medicines are medicines that are prescribed to people and given when required. This can include medicines that help people when they experience pain. We found that quantities of PRN medicines were unaccounted for and staff did not clearly record when PRN medicines were administered or maintain accurate stock records. For one person, we found that their MAR had not been completed to indicate that their pain medicine had been administered. However, there was a shortfall of 11 tablets when we counted the stock. For another person, they had been prescribed strong pain-killers. 28 tablets had been prescribed for the person, however, staff had signed the person's MAR 34 times which was not accurate.

We observed poor infection control practices at the service. Areas of the home including bedrooms, bathrooms and toilets were unclean. During the inspection, we found that soiled incontinence pads were stored in bins in bathrooms. We observed on two occasions, staff not remove their gloves following supporting people with personal care and carried out other tasks wearing the gloves. People were not always protected from the risks of unsafe care as staff did not adhere to basic infection control measures.

The provider had failed to ensure that people received care in a safe manner. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked recruitment records for seven staff members. We found that for four staff members, no references were on file. For three staff members, an employment history had not been obtained and for two staff members, criminal records checks were from a different employer prior to them commencing employment. For one of these staff members, their criminal records check on file was one year prior to them commencing employment with the provider. It is best practice for services to apply for DBS checks on behalf of their own service to ensure that information is current. We were not satisfied that the registered manager was following safe recruitment practices and that all staff employed were suitable for the role they were engaged to perform, which placed people at risk of harm.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were insufficient staff employed at the service to ensure people's care needs could be met. Rotas confirmed that during the day, three care staff were on duty and two care staff were on duty at night. Staffing levels did not support the tasks assigned to care staff, which included providing or prompting personal care, meal preparation, administering medicines, cleaning, laundry, supervising mealtimes and accompanying service users to appointments. There was no designated cooking or cleaning staff employed at the service. It was observed that throughout the inspection that there was little interaction between staff and service users, particularly in the morning time as care staff were preparing lunch, administering medicines, providing personal care, cleaning and doing laundry. This meant that staff were not always readily available to provide people with assistance when needed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Routine health and safety check of the service were undertaken, such as Legionella, fire safety, electrical safety and gas safety. In October 2017, a health and safety audit was completed by an external company and one of the actions for completion was for Legionella testing. We saw that this had been done in

February 2018. Weekly tests of fire alarms were taking place and emergency lights were checked, however, these tests were taking place at periodic intervals and not on a regular basis.

Inadequate

Is the service effective?

Our findings

The service failed to ensure that The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were being followed and people's right to liberty was not always promoted. 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.

On commencement of the inspection, we noted that the front door to the service was kept locked at all times and only staff had access to keys. Two people who had been admitted to the service approximately one week prior to the inspection told us of their unhappiness at living at the service and their anxiety at not being allowed to leave the property. One person told us, "The manager told me I am not able to go out unless a member of staff accompanies me." This person told us that their requests to go out to purchase essential items had been on a number of occasions refused. They told us, "Not allowed to go out and buy pants. I am treated as totally incompetent mentally." Another person told us, "I was assured that I could leave when I wish but I have been told that I cannot unless given permission by management." The service had not documented that this decision was in the people's best interests, nor had they applied to the local authority for a DoLS authorisation. This meant that people had been deprived of their liberty without legal authorisation.

For two other people, who had lived at the service for a longer period of time, their care records stated that they were not allowed to leave the home due to their dementia and were at risk of absconding. One person's care record stated 'Staff should not disclose to [person] where the key to the front door is kept because [person] will abscond out of the building.' Neither of these people had a DoLS in place to ensure that their liberty was lawfully deprived.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records seen on inspection did not evidence that people had consented to their care. There were no records of any capacity assessment carried out by the service to assess if people had capacity to consent to their care. There was no information that any of these people had been consulted on the development of their care plan. Their care plans had not been signed to indicate that people had consented to their care and treatment.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Not all staff had received training to enable to enable them to provide effective care. The providers training matrix provided to the inspection team indicated that training available for staff included basic life support, care planning and record keeping, dementia, fire safety, first aid, medicines, safeguarding of vulnerable adults and infection control. The training matrix listed training records for nine care staff. However, a staff list provided to the inspection team after the inspection stated that there were 12 care staff employed. Therefore, there were three care staff without an overview whether they had completed any training. On review of training records we established that eight care staff had not completed first aid training and three care staff had not completed Basic Life Support training. We asked the Nominated Individual about this and were advised that the three care staff had offered to take their training certificates from their previous employer with them; however, they have been employed since 2016. Records also showed that seven care staff had not completed Fire Safety training. This placed service users at risk in an emergency situation as not all staff had completed basic life support, first aid or fire safety training.

The registered manager told us that no annual appraisals had been completed with staff members since he commenced employment in June 2017.

One staff member told us that they had completed an induction when they commenced employment. They told us, "I was shown the residents, alarms etc. They taught me how to do personal care and observed me." However, not all staff files contained a record of the staff member having completed an induction.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff files contained records of supervision. One staff member told us, "[Supervisions] not really regular." We saw that recent supervisions had been completed by the registered manager. Supervisions were generally person centred to the staff member and topics such as timekeeping and medicines administration were discussed.

We received a mixed response when we asked people about their dining experiences at The Lime Trees. Some people told us they had a choice of food; however, other people told us they had little choice. Feedback from people included, "[Food] not great and there is not a lot of it", "We are spoilt for choice, I do not like mashed potato so they asked me if I wanted an omelette and they gave me that", "There is plenty of food. I don't think we get a choice, [staff] just brings it out" and "We can't choose what we eat. We just get given." We saw that from the menu on display, people were offered two choices of main meal. The evening meal mainly consisted of sandwiches. We saw that people were offered a cereal or porridge option for breakfast. People were offered drinks throughout the days of the inspection and people told us that drinks were readily available. However, on one of the days of the inspection, we observed a person who had been sitting in the same chair all morning with very little staff interaction, repeatedly ask care staff for dessert, which was subsequently provided by a staff member.

Most people living at the service were independently able to eat their meals. We saw that one person was patiently assisted by a staff member to eat their lunch. We observed that there was a fruit bowl available for people and we observed people help themselves to fruit.

The service had a pre-assessment procedure in place which was done by the registered manager. Areas for care such as personal care, moving and handling and nutrition was assessed. However, the information obtained by the registered manager in the assessment process did not always result in a detailed, person

centred care plan.

People told us that they could access healthcare services if needed. One person told us, "Oh yeah, but I do not bother, GP comes in once a week every week." A second person told us, "Yeah, when I hurt my back three paramedics came here and said I trapped a nerve, could not get out of bed, put me in a chair and told me to take painkillers and take it easy for three or four days, no sudden movements, really supported by medical staff and staff here, cannot fault this place." One person, who was prescribed medicines which required monthly blood tests attended their appointments on a regular basis. However, some care files did not contain evidence that routine medical appointments such as cervical smear or opticians took place, despite these being noted in their care plans.

The home was comprised of an older Victorian building across three floors accessed by a lift. The third floor was not used for accommodation purposes. There was also a newer wing built which was on the ground floor. One person told us they would access the areas of the building they needed to. Some bedrooms contained some personal items and momentos such as photos and drawings. However, many rooms were sparsely decorated and not dementia friendly. Not all bedrooms had a photo of the person or name on the door and there were no memory boxes to promote conversation or assist people with recollecting their past. Some bedrooms had very little natural light due to the proximity of the neighbouring building.

Inadequate

Is the service caring?

Our findings

People were not always treated with dignity and respect. Some people told us of their poor experiences of care at the service and the inspection team observed poor care practices throughout the inspection. We received a mixed response from people when we asked if they thought staff were caring. One person told us, "I think so, they treat me very well, they are caring." A second person told us, "I like it. I have been here [number] of years now." A third person told us, "We are treated as if we are totally helpless. I am talked to as if I am a two year old, am stupid or don't understand anything." A fourth person told us, "There should be more kindness. There is mistreatment, abusive words and comments." A fifth person told us, "Nice to us? They can't even be nice to themselves."

On all three days of the inspection, we observed staff routinely showed a lack of respect for people who used the service. On one occasion, we saw a staff member when asked by a person if they could go outside, tell them in an abrupt manner that they could not go outside as they needed to wash first.

During our early morning visit, we observed a staff member opened the back door to the garden to let a person out to have a cigarette. The staff member locked the door and drew the curtain across and left the room. It was raining heavily and the person was outside wearing pyjamas. After five minutes we let the person back into the home. Prior to this, the person had asked for a cigarette and was initially refused their request by the staff member in an abrupt manner.

We observed another person come into the lounge early in the morning and was told in an abrupt manner by the staff member present to go back to bed.

We observed one person being dressed in torn clothing following their shower. Despite having just been showered, there remained a strong odour of urine from the person. Following their shower, the staff member escorted them to the living room and patted their head roughly calling the person "Good Boy."

Staff spoke about people when they were present rather than including the person in the conversation. For example, one person who had been incontinent told the registered manager that they did not feel well. The registered manager did not acknowledge what the person had said and told a staff member to change the person without any compassion or kindness. On another occasion, the registered manage told us that one person who had sustained an injury, "Wanted to prove a point."

People were not supported with maintaining their dignity. We observed four people being exposed naked to communal areas as a result of the inadequate showering arrangements in place at the service. We observed a staff member take a phone call whilst showering a person. We observed people being told to 'sit down, sit down' in an abrupt manner by the staff member showering them.

We concluded that people were not treated with dignity and respect and staff demonstrated a lack of compassion towards the vulnerable people in their care.

Care plans were written in a manner which focused on the potential behaviours the person may display as a result of their health condition. However, little recognition was given to supporting the person to manage their health condition. There were examples of insensitive language used. For example, one person's care plan stated, "Staff to regularly check to ensure [Person] does not mess himself up." For another person, we saw an email sent to an external health professional by the registered manager in August 2017 refer to a person with dementia as, 'I will appreciate it if [Person] could be moved immediately before I lose all my service users as none is happy with [person's] behaviour and the way [person] manipulates and instigates." These comments observed in the written form, were reflective of insensitive interactions we observed throughout the inspection.
Information such as people's likes, dislikes, food preferences, favourite activities or past times was not detailed in service users care plans. Care plan reviews were completed on a regular basis by the registered manager; however, there was no evidence of the person having been involved in their care review. Care plans and reviews were not signed by people to indicate that they had been involved in any of the care planning or subsequent review process. One person told us, "I have not had my personal plan discussed. There is no conversation and no knowledge of my life on the outside. I used to be a [name of profession]."

People were not supported to be independent and exercise choice or control of their daily routines. Most people did not have televisions in their bedrooms. There was one television in the lounge which was generally on all day. Three people told us that they were unable to remain in the communal areas after a certain time in the evening. One person told us, "Too many rules. No television after 11:00pm." A second person told us, "We are asked by evening/night staff to leave the main lounge at night sometimes because us talking or watching loud TV, but the TV can be turned down." They further stated, "It can be easier to sit and chat in the evening." A third person told us, "I only wanted to go to the paper shop. They said I was prohibited. The manager won't answer any questions I have in that respect." A fourth person told us, "Ask them for something they just say no." A fifth person told us, "I can't step into the kitchen and I live here." A sixth person told us, "We're not being given the help to do what we could do."

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see some instances of kind and caring interactions from some staff, and in particular the director and nominated individual who greeted people when they entered the living room and engaged people in conversation. We also observed people engage with each other in conversation and camaraderie. One person regularly asked other people if they were okay and if they needed drinks.

Care plans were reflective of people's cultural and religious and personal diversity. One person's care plan noted that they had a religious dietary requirement. We saw this being followed by care staff at mealtimes.

Inadequate

Is the service responsive?

Our findings

People were not receiving care that met their needs or preferences. Four people admitted to the service in the weeks prior to the inspection had not had any care plans or risk assessments completed, despite these people having health conditions such as pressure and skin ulcers, incontinence and dementia. This meant that not all people had a care plan in place to provide guidance for staff to support the person according to their needs and requirements and in a person centred way.

We saw evidence in numerous bedrooms of urine soiled and soaked bedding and very strong odours of urine and faeces. Some people told us that they were not being supported to manage their continence needs. One person told us, "Run out of pads not got the right ones." A second person told us, "Not allowed to go out and buy pants." The evidence of urinary incontinence, combined with the feedback received and lack of detail in people's care records regarding the support people needed indicated that people were not receiving care that met their needs or preferences.

One person told us that they had requested a writing pad when they were admitted to the home approximately one week prior to the inspection; however, their request had not been facilitated until they had raised their concerns with the inspection team. In one bedroom we saw dead flowers lying in a basin. The person told us that the flowers had been a gift from visiting friends and they had requested a vase for their flowers, however, this had not been facilitated. A person told us, "I want my newspapers. I said I'd pay but nobody took my money."

We asked people whether they were supported to engage in activities. Feedback in this regard was mainly negative. One person told us, "No bloody way, they say we are having games, but no games." A second person told us, "I get bored very easily. To re-echo my last thought to promote my artistic talent. I could draw staff and residents and teach people how to draw." A third person told us, "I am craving a [cigarette] because I am bored."

We observed that in general, there was little in the way of organised activities at the service. We saw that one person wanted to play games and some care staff tried to set up a game of chess but the chess pieces were not complete and the game was unable to be played. We did observe the person have a game of dominoes with a staff member who was encouraging and helping the person play, however, the game was left unattended. We observed another person who had eaten some biscuits; play with the crumbs for a prolonged period. We observed people sat at tables unattended other than when being served food or drinks or being assisted with personal care. On one of the days of inspection, we observed an external activities provider attend the home to engage people in exercise which was well received by the people in the room. We observed the director encourage people to move to the area of the room where the activity was taking place.

During the early morning visit to the service, we observed a staff member carry out a check on people. Some people's bedrooms did not have a name on the door nor a room number. We observed that the staff member did not know everybody's name. We also saw that the sheet which documented the night checks

did not contain the names of all people living at the service. On the night of 14 March 2018, the list stated 15 people which was incorrect as there were 17 people living the home on that date. No further names had been added. This meant that staff did not have all sufficient information to ensure that they were aware of all people living at the service and their care needs.

Care plans were often written in a generic style and did not provide care staff with detailed guidance on how to support people with their care needs in a person centred way. For example, for one person their risk management plan stated, "[Person] gets distress and restless [person] tends to move around however, there is a potential risk that [person] could push and pull the door or sits in one corner. At all times staff needs to be vigilant, and comply with health and safety policy. All incidences to be recorded. This will help in the learning process." The person's care plan did not provide guidance on what techniques staff should use to de-escalate the situation in a person centred way.

One person's care plan advised what made a good day for them which was 'personal care in the morning including breakfast. Relax in the lounge with the newspapers and TV. Socialise with people around me.' Their care plan did not state what TV programmes they preferred to watch or any specific activities that may prefer to engage in.

We did see some instances of person centred care planning. For example, one person's care record stated that they needed help cutting their food as they had pain in their left shoulder and that people shouting loudly made then nervous. Overall there were inconsistencies with how care plans were developed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked complaint records and found that one complaint had been logged. This was a contact made by CQC to the registered manager following a complaint from a member of the public to CQC regarding the cleanliness at the home. No further complaints had been logged. From our conversations with people, whilst nobody told us that they had raised a complaint, we received a mixed response when we asked people if they felt they were listened to. One person said, "Nobody they do not want to know." A second person told us that staff did listen to them. They told us, "Yes of course they do, but they have to be aware of my condition." A third person told us, "I do not talk to them. I could not even tell you their [staff] names."

We asked the registered manager about how the service supported people at the end of their lives. The registered manager showed us that some staff had attended end of life care training. Care records contained a section regarding end of life care. Some of these were completed where people or their relatives had indicated that they were comfortable discussing their wishes. We saw that in February 2018, during a residents meeting, passing away and moving on was discussed.

Inadequate

Is the service well-led?

Our findings

We asked people if they were satisfied living at the Lime Trees. Seven out of ten people told us they were not. One person told us, "It is a very good home and I feel very well looked after." Other feedback included, "In general staff mean well. They don't realise that the patient has to be number one and they should come second. It is quite the opposite here. The staff come first and not the patient. Elderly people can be pushed aside", "If this place burnt down I would put petrol on it", "You work hard all your life and end up in a place like this" and "I wouldn't like to see my mum here."

A registered manager was in post. They commenced employment with the service in June 2017. They told us, "When I came, I started running around doing assessments. To bring people in and to develop the place as it should be." At this inspection we found significant shortfalls in the delivery of care as evidenced by the regulatory breaches cited in this report. Governance systems were not effective as issues had not been identified or addressed through quality audits. We concluded the service was not well-led and as a result, people were receiving an unacceptably poor standard of care.

The registered manager completed monthly audits for aspects of care delivery such as recruitment, housekeeping and medicines. The housekeeping audit was completed by the registered manager on a monthly basis which checked laundry, bedding, cleaning and a daily room check. On 1 February 2018, the Registered Manager identified that sheets on beds had not been spread properly and record keeping required improvement. These actions had been signed off as completed on 5 February 2018. On 10 October 2017, the Registered Manager carried out an audit of housekeeping and identified that daily room checks 'needs improvement'. No further information was documented to elaborate on the areas which required improvement, such as which bedrooms were audited or where the concerns noted referred to. On 9 September 2017, the Registered Manager documented 'remove stained linen' and 'more efforts needed' in daily room checks. The audits detailed actions to be taken and these had been signed off as completed by the registered manager. Despite some of the concerns being identified by the Registered Manager in the months preceding the inspection, improvement had not been made to the condition of people's bedrooms as observed throughout the inspection.

Checks to ensure safe recruitment practices did not identify the concerns identified on inspection. An audit completed by the Registered Manager on 20 February 2018, which checked recruitment practices including interviews, DBS, employment history and references. This check did not identify the concerns identified with the recruitment practices on inspection.

People had been deprived of their liberty without lawful authority. People were not safeguarded from abuse and neglect. One person told us following an instance of the inspection team observing poor staff interaction, "You can see now how rude [staff member] is and you're here. Imagine what [staff member's] like when you're not here." Incidents, which may have constituted a safeguarding concern were not appropriately escalated to the local safeguarding authority.

The provider was not ensuring that the principles of MCA were being followed and people were not involved

or consulted in planning their care.

Staff training was inconsistent and records were not kept up to date.

The provider and registered manager had failed to ensure that basic standards of cleanliness, hygiene and maintenance were maintained.

Risks associated with people's care and treatment had not been assessed to ensure that people were kept safe from the risk of harm. There was an inadequate oversight of how medicines were managed. There was insufficient number of staff deployed to ensure that people's care needs could be met.

Care plans were not completed for all people in a timely manner following receipt of a referral. There were incomplete records for people receiving care. A full and contemporaneous record for each individual service user and their care requirements was not held by the service.

We observed a mission statement on display on arrival at the service. It stated, "Dedicate our energies, skills and resources to provide all our service users with individual and sensitive care, in a safe, pleasant environment where they can enjoy their privacy, independence and exercise informal choice." We assessed that from our observations and feedback from people that the provider was not always adhering to the standards they had set themselves. We were horrified and appalled at the poor standard of care people were receiving at The Lime Trees. People consistently fed back to the inspection team that they were not treated with respect and exercised little choice in how they lived their lives.

People's care records were not kept securely. Throughout the days of the inspection, we saw that post addressed to people was left in a lounge. When we initially asked for access to people's care records, we were directed to a drawer in the manager's office. We found that some care files did not contain care plans and risk assessments. During the feedback at the end of the inspection, we were advised that care records were kept on a shelf in the living area which contained people's care records. These documents were not stored securely.

We communicated our urgent and significant concerns to the provider and registered manager throughout the inspection. Initial remedial actions had been taken to improve some of the concerns identified. However, these improvements were reactive as a result of the findings of the inspection team. The provider told us that they would carry out more robust audits in future. However, we found that the provider and registered manager failed to understand the significance of our concerns, particularly around our findings in relation to safeguarding people from abuse, maintaining people's dignity and treating people with respect.

Overall governance from both the provider and registered manager was ineffective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke to told us they found the management team in place supportive. One staff member told us, "The manager is a nice man. The director is a good woman." A second staff member told us, "The manager is very supportive. We can knock on his door, he is around every morning."

Staff told us they attended meetings. We saw that there were records of meetings from July, August and September 2017 and March 2018. The registered manager told us that he hadn't typed some minutes. Minutes of these meetings were brief and topics discussed at the meeting were around new admissions, timekeeping and training. On the second day of the inspection, we attended a daily handover meeting from the night staff member to day staff. People's general well-being and medical appointments were discussed.

We saw that a residents meeting had taken place on a regular basis. Minutes of meetings indicated that topics such as Easter and reminding people that suggestion were welcome.

A quality assurance survey was carried out in 2017. The date this was carried out was not clear. Feedback was mostly positive.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 The provider did not ensure care plans were in place for all people who used the service. The provider had not ensured all people were receiving care in line with their needs or preferences.

The enforcement action we took:

A Notice of Decision was issued on the registered provider on 23 March 2018 to impose a condition to restrict the admission of new service users without authorisation from CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 The provider did not ensure that people were treated with dignity and respect.

The enforcement action we took:

A Notice of Decision was issued on the registered provider on 23 March 2018 to impose a condition to restrict the admission of new service users without authorisation from CQC.

A Notice of Decision was issued on the registered provider and registered manager on 18 July 2018 to cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 Care and treatment was not always provided with the consent of the relevant person as the registered provider was not always acting in

accordance with the Mental Capacity Act 2005.

The enforcement action we took:

A Notice of Decision was issued on the registered provider on 23 March 2018 to impose a condition to restrict the admission of new service users without authorisation from CQC.

A Notice of Decision was issued on the registered provider and registered manager on 18 July 2018 to cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 The provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users. The provider did not ensure the safe management of medicines. The provider failed to assess the risk of, and preventing, detecting and controlling the spread of infections.

The enforcement action we took:

A Notice of Decision was issued on the registered provider on 23 March 2018 to impose a condition to restrict the admission of new service users without authorisation from CQC.

A Notice of Decision was issued on the registered provider and registered manager on 18 July 2018 to cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 The provider had not safeguarded people from abuse and improper treatment. People were subjected to degrading treatment. The provider had not appropriately reported safeguarding concerns to the local safeguarding authority.

The enforcement action we took:

A Notice of Decision was issued on the registered provider on 23 March 2018 to impose a condition to restrict the admission of new service users without authorisation from CQC.

A Notice of Decision was issued on the registered provider and registered manager on 18 July 2018 to

cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Regulation 15 The provider had failed to ensure that the premises and equipment used clean, secure and suitable for the purpose they were being used. The provider had not maintained appropriate standards of hygiene.

The enforcement action we took:

A Notice of Decision was issued on the registered provider on 23 March 2018 to impose a condition to restrict the admission of new service users without authorisation from CQC.

A Notice of Decision was issued on the registered provider and registered manager on 18 July 2018 to cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 The service did not have effective systems in place to record and monitor the quality and safety of service provision in order to improve, learn and develop.

The enforcement action we took:

A Notice of Decision was issued on the registered provider on 23 March 2018 to impose a condition to restrict the admission of new service users without authorisation from CQC.

A Notice of Decision was issued on the registered provider and registered manager on 18 July 2018 to cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 The provider did not ensure a robust recruitment procedure by ensuring staff employed were of good character and had the skills and experience which were necessary for the work to be performed by them.

The enforcement action we took:

A Notice of Decision was issued on the registered provider on 23 March 2018 to impose a condition to restrict the admission of new service users without authorisation from CQC.

A Notice of Decision was issued on the registered provider and registered manager on 18 July 2018 to cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 The provider did not ensure there were sufficient levels of staff were suitable deployed to ensure all other regulatory requirements were met. The provider did not ensure all staff received training.

The enforcement action we took:

A Notice of Decision was issued on the registered provider on 23 March 2018 to impose a condition to restrict the admission of new service users without authorisation from CQC.

A Notice of Decision was issued on the registered provider and registered manager on 18 July 2018 to cancel their registration.