Limes Fenton 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 24 May and was unannounced. At our previous inspection in June 2015 we had concerns that the service was not consistently safe or well led as the systems the provider had in place were not ensuring that people's medicines were being managed safely. At this inspection we found that medicine management had improved however we found further concerns that meant that the service was not consistently safe, effective, caring, responsive and well led. We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Limes provides accommodation and personal care for up to 41 people. People who used the service may have physical disabilities and/or mental health needs such as dementia. At the time of the inspection 37 people used the service.

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 not being safeguarded from potential abuse as incidents of suspected abuse had not been referred to the local authority for investigation. We raised a safeguarding referral for two people following our inspection. Following the inspection the registered manager took action to prevent further incidents.

Risks of harm to people were not always assessed and minimised. Action was not taken to reduce the risk of harm following incidents that had put people at risk or resulted in harm. People's risk assessments were not consistently followed to keep people safe.

The principles of the Mental Capacity Act (MCA) 2005 were not consistently followed. People's mental capacity was assessed, however precautions were not being taken to ensure any restrictions in place for people were the least restrictive option.

Staff felt supported and received training to fulfil their roles. However the training available was not always sufficient for the provider to be sure that staff were fully competent in the care tasks they were required to undertake.

People were not always treated with dignity and respect and people's changing needs were not always responded to in a timely manner.

The systems the provide had in place to monitor and improve the service were not consistently effective in identifying concerns and making improvements to the quality of care for people.

There were sufficient numbers of staff to meet the needs of people who used the service. New staff were

recruited through robust recruitment procedures to ensure they were fit to work with people who used the service.

People's medicines were stored, managed and administered safely by trained staff.

People were encouraged to maintain a healthy diet and their nutritional needs were met. People were referred to health professionals if they experienced difficulties with eating and drinking. If people became unwell they were supported to access a range of health care services.

There was a range of hobbies and activities available to people if they chose to join in. People were involved in the planning of their care and activities through regular reviews and meetings and they were encouraged to be as independent as they were able.

People felt able to complain and confident that their concerns would be dealt with. The provider had a formal complaints procedure which was available for use.

People's feedback on the service was gained and action was taken to improve the quality of service where improvements were identified.

People who used the service and the staff felt the management were approachable and they were regularly asked their views on 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 consistently safe.

People were not always safeguarded from the risk of abuse.

Risks of harm to people were not always assessed, managed and reduced through the effective use of risk assessments.

There were sufficient numbers of staff to be able to meet people's needs safely. Staff had been employed through a robust recruitment process.

People's medicines were stored, managed and administered safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were not always assessed as being competent in their roles to maintain people's safety whilst supporting them with their mobility.

Practises in place were not always the least restrictive to ensure people were not being unlawfully restricted.

People's mental capacity had been assessed and staff knew the support people needed to make decisions.

People were supported maintain a healthy nutritional diet and had access to health care professionals if they became unwell or their needs changed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

People's right to privacy was upheld and they were encouraged to be as independent as they were able.

People were involved in their care and their friends and relatives were free to visit.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's changing needs were not always responded to in a timely manner.

People were offered opportunities to engage in hobbies and interests of their liking and which met their individual needs.

The provider had a complaints procedure and people knew who to complain to if they had any concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems the provider had in place were not always effective. Improvements were required to ensure people were receiving high quality and safe care.

People who used the service and the staff felt the management were approachable and they were regularly asked their views on the service.

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.

This inspection took place on 24 May 2017 and was unannounced. It was undertaken by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider had previously completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the home. We reviewed information that we held about the provider and the service which included notifications that we had received from the provider about events that had happened at the service. For example, serious injuries and safeguarding concerns.

We spoke with eight people who used the service and two relatives. We spoke with six members of staff, the registered manager, senior team leader and the area manager.

We used the 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 carried out a lunchtime observation to see how people were supported during meals in order to help us understand people's mealtime experiences.

We looked at the care records for five people who used the service. We looked at the medication records, staff support and training records and two staff recruitment files. We looked at the systems the provider had in place to monitor and improve the service for people.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we had concerns that people's medicines were not always managed safely. At this inspection we found that improvements had been made in this area however, we had concerns that people were not always being safeguarded from the risk of potential abuse. We saw two people's care records stated that they had been the subject of potential abuse from another person who used the service. Although health professional advice had been sought for the alleged perpetrator of the abuse the incidents had not been referred to the local authority for a safeguarding investigation. The registered manager had not recognised the incidents as potential abuse. We asked them what had been put in place to prevent similar incidents occurring and they confirmed that a risk assessment had not been put in place to minimise the risk of a further incident. This meant there was a risk of further incidents occurring as appropriate measures had not been put in place

We saw on three occasions that one person had alleged abuse from staff. A member of staff confirmed that this person often accused staff of hurting them. The registered manager told us that the person had made false allegations against staff prior to admission into the service. There was no risk assessment in place to ensure that the person's allegations were taken seriously and no action was being taken to prevent the person from an actual incident of abuse having taken place.

These issues constitute a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's individual risk assessments were not always followed by staff to ensure that people's safety was maintained. We saw one person had been assessed by a speech and language therapist (SALT) as being at risk of choking when eating and drinking. The SALT had clearly advised that the person should not be left alone when eating and drinking. We observed the person eating and drinking their breakfast alone in the lounge. The person told us: "The staff have let me have my breakfast in the lounge this morning". We later observed on a further two occasions that this person was left unsupervised with drinks. We discussed this with the registered manager who informed us that the person was often none compliant with staff's request to eat and drink in the dining room where staff were allocated. However, precautions had not been taken for when the person did refuse to access the dining room. This meant that this person was at risk of choking as action had not been taken to minimise the risk.

We saw another person who was being cared for in bed and at high risk of sore skin had been assessed by the district nurses as requiring pressure relief to their feet at all times. We saw that the person did not have the pressure relief they required when we checked. We informed a senior member of staff who told us that care staff had just attended to the person and had forgotten to put the pillow back in place. They instructed a member of staff to ensure that pressure relief was put in place. This meant that this person was at risk of sore skin as their assessed needs were not being consistently met to keep them safe.

Another person had regularly been found wandering in and out of other people's rooms at night. We saw some other people who used the service had taken to locking their bedroom door at night to prevent them

from entering. We saw the person's risk assessment stated that they were at risk of falling. No action had been taken to minimise the risk of harm to this person when getting up in the night and to reduce the impact on other people who used the service. This meant that this person was at risk of harm as the risk of them getting up and walking around the service in the night had not been reduced.

People gave us mixed views on whether they thought there were enough staff. One person who used the service told us: "They could do with more staff when staff go on holiday", and a visitor reinforced this by saying: "They are always short of staff. They blame it on holidays". Another person told us: "Occasionally when staff are on holiday there is a shortage. But usually there is a full complement." Staff told us they felt there was enough staff to be able to meet people's needs in a timely manner and we did not see that people had to wait for long periods of time for support when they needed it. One staff member told us: "It was hard work recently when two people were poorly and in bed but the manager tried to increase the staff but couldn't always get the cover required, it's easier again now". The registered manager told us they had recently recruited two new members of staff and were awaiting their recruitment checks to be completed.

New staff who were being recruited by the provider were employed through safe recruitment procedures to ensure they were fit and of good character to work with people who used the service. Pre- employment checks included disclosure and barring service (DBS) checks for staff. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant.

At our previous inspection we had concerns that people's medicines were not always being managed safely. At this inspection we found that improvements had been made. Previously not all medication stock would balance and this meant that staff could not be sure that people had their medicine as prescribed. We found that a new system had been implemented which meant there was a running total of medicines. This meant that staff could see if a person had their medicine or not. One person told us: "I get tablets for my arthritis. If I want paracetamol then I just ask for it," another person said: "I get painkillers and vitamins. The staff bring them to me and I take them". We saw that medicines were stored safely in a trolley and locked clinical room. Staff administering medicines had all received training to do so and we observed that this was completed in a safe way. This meant that people's medicines were being stored and administered safely.

Requires Improvement

Is the service effective?

Our findings

People told us that staff were competent and effective in their roles. One person told us: "Staff know their job. If I had any problems, I'd ask for help and they would do their best". Another person told us: "The carers are very good. Two of them give me a shower." Staff we spoke with told us they received training and support to fulfil their roles. However, staff told us that the training they received was now all online and there was no practical training. We discussed with the registered manager about the moving and handling training and they told us that this too was completed on line. The registered manager and provider could not be sure that staff were competently moving and handling people as there was no practical training for staff in the use of any mobility equipment. The area manager told us that they would be arranging to train a member of staff to be a trainer in the safe moving and handling of people and until then they would ensure that a trainer from another service would assess staff competence in this area.

The Mental Capacity Act (MCA) 2005 sets out the requirements that ensure, where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. We saw that people's mental capacity to consent to their care had been assessed and staff knew who was able to make informed decisions for themselves and who required more support.

The Deprivation of Liberty Safeguards (DoLS) are for people who cannot make a decision about the way they are being treated or cared for and where other people may need to make this decision for them. We saw one person was being cared for in bed and had bed rails in place. We looked at the person's risk assessment and could not see why the person had these in place and that it had not been agreed following the principles of the MCA as being in the person's best interests. Staff we spoke with told us that the person was not at risk of falling from their bed and that they had a bed which could be lowered to the floor if the person's needs changed and they became more at risk. This meant that this person was not being cared for in the least restrictive was and the person was at risk of being unlawfully restricted.

We saw that other people who had been assessed as lacking the mental capacity to agree to their care and support at the service had been referred for a DoLS authorisation by the registered manager. This meant that these people were being protected from being unlawfully restricted by being at the service.

People told us that the food was good. One person told us: "The food is good, I would say so. If I don't like it they give me something else. There is always plenty to drink," another person told us: "I eat in my room. Dinners are very good. I get more than enough. I like my tea. The water jug in my room is always topped up." Some people required a special diet such as a pureed meal and we saw that this was available to them. If people were prescribed food supplements we saw that these were given to people at the times they required them. People were regularly weighed and referrals to their GP were made if weight loss or difficulty in eating was noted.

People had access to a range of health care professionals when they became ill or their health needs changed. One person told us: "I had a rash and they called the doctor straight away. I also had a slight infection and the nurse treated it and it is healing up now." Another person told us: "If I needed a doctor to

visit the staff would get them. I make my own arrangements for dentists but staff make my chiropodist appointments and appointments for my nails and corns." We saw that people had been referred to other professionals where concerns had been identified, such as dieticians, tissue viability nurses and consultants. This meant that people's health care needs were being met as staff and the management had acted to ensure people remained healthy.

Requires Improvement

Is the service caring?

Our findings

In the majority of instances, interactions between staff and people were caring and considerate, however on two occasions, respect was not demonstrated.There were two dining rooms and only one food trolley which meant at lunchtime people in one dining room had to wait for between 30 and 45 minutes for their meal after being encouraged to sit at the dining tables. Staff told us that they alternated which dining room was served first every day to try and be fair but one dining room had a long wait every other day. We saw that people were offered choices of meals, however on the day of the inspection one of the choices ran out and there was still two people who had requested that meal. We saw that staff gave the people the alternative with no explanation as to the fact that their chosen meal had ran out or an explanation on what they were being given. They were not offered a choice of meal if they did not like what they were being given. This did not demonstrate respect for these people and they were not offered an alternative to what was on offer.

Two people shared a room; it was unclear if these people were able to agree to this decision and why they were sharing a room as there were vacant bedrooms. We saw records that confirmed that one of the people regularly disturbed the others person's sleep as they often got up in the night. A member of staff told us: " [Person's name] will ring the call bell and tell us that the other person is up and about ". No consideration had been taken to the person's sleep being regularly disturbed and no action had been taken to minimise the risk of this occurring. This did not demonstrate a respect and understanding for the person whose sleep was being disturbed.

People we spoke to told us that staff were kind and caring towards them. One person told us: "The staff are lovely duck. They're carers but I call them friends as well, they know what I like. I can always share a problem with them." Another person told us: "Since I've been here the staff and I are on good terms. In the circumstances this is the best place I could be. I am happy here." We saw and people told us that their friends and relatives were free to visit and were kept informed of their well-being. One person told us: "Relatives can come anytime. My child works and so they come on a Sunday with my grandchildren. The home phones my family if I am sick." Another person told us: "My relatives' visit four times a week but can come at any time. They just telephone me to let me know."

People were encouraged to be as independent as they were able to be. One person told us: "I get a lot of help but I can wash myself and dress myself and join in the activities that I enjoy. "Another person told us: "I just act normal and am independent. I wouldn't have it any other way". We observed that people freely moved around the home and did what they could to maintain their independence.

People's right to privacy was respected. One person told us: "Yes the staff respect my dignity and always knock on the door." Another person said: "Without a doubt I have privacy in my bedroom. The staff help me to choose the clothes and get me dressed.The carers bathe me and they always close the door". We observed that staff knocked on people's doors before entering and we saw nothing that compromised a person's dignity on the day of the inspection.

Requires Improvement

Is the service responsive?

Our findings

People had individual care plans which documented their personal history, likes, dislikes and preferences. People's care and care plans were regularly reviewed however the reviews did not always identify changes in people's needs. The staff were not always responsive in making changes to people's care when their needs changed. For example, we saw that one person's records noted concerns with one person whose mental health had deteriorated. They had become more unsettled at night and this had not been addressed, medical advice sought or their care plan up dated. Issues around the safety of people had not been responded to in relation to potential incidents of abuse. This showed that the registered manager and staff were not always responsive to people's changing needs and this put people were at risk of harm.

We saw that staff knew people well, one person told us: "Of course the staff know me! They say "hey up, here she is again in a jokey manner." Another person told us: "They know what I like". The activity coordinator told us how they used a white board to write and communicate with one person who was hard of hearing. The registered manager told us that they had recently arranged for an interpreter as one person had reverted to their language of heritage as a symptom of their progressive dementia.

There were meetings for people who used the service and their relatives to have a say in how the service was run and people were involved in their own care planning. We saw that an advocacy service was available for people who needed extra support to have a say in their care planning. One person who used the service told us: "I have a care plan. They went through it with my son two weeks ago." This meant that people were involved in their care as views on the service they received were being sought.

People told us and we saw that they were offered hobbies and interests of their liking. One person told us: "I join in lots of things. I enjoy knitting, quizzes, games and dominoes. You can do all those here." Another person told us: "I'm social and join in lots of things. We've a good life here." The activity coordinator told us they had obtained a qualification in activity work and for work with people with dementia. They produced a weekly plan for activities and asked people what they enjoyed and would like to do. They told us: "The activities are not a set menu and vary depending on people's interest". They went onto tell us: "Those people who do not like group work or who are in bed I carry out one to one activities that can include music, memory work and doing people's nails".

People told us that they felt they could complain if they needed to. One person told us: "I'd talk to the owners but the staff also listen. I have no complaints." Another person told us: "I would see the manager. I have raised niggly things but they soon sort it out. They sorted out my bed linen." The provider had a formal complaints procedure and this was visible in the reception area. The registered manager told us there had been no recent formal complaints to investigate.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we had concerns that the systems the provider had in place to monitor and improve the service were not always effective. At this inspection although we found improvement in the system to monitor and manage people's medicines we had further concerns.

We saw that people's care plans were reviewed on a monthly basis but these reviews were not always effective. For example, we saw one person's daily care notes stated that they had refused their medication on several occasions during May. However, the care plan had been audited in May and it stated that there were no issues with medication this month. This meant that the review of this care plan was ineffective as the plan for the management of this person's medication had not been updated to reflect the concerns.

Incidents of suspected abuse were not always been investigated to ensure that changes could be made to people's plan of care. The registered manager and staff had not recognised incidents of potential abuse and acted upon them. This meant that necessary improvements to people's experiences at the service were not being made to ensure they were receiving high quality safe care.

Staff we spoke with told us that the registered manager was supportive. They told us they had one to one time with either the registered manager or deputy manager and there were staff meetings. The registered manager told us they conducted observations of staff performance including the administration of medicines. However, they had not identified that they could not be sure that staff were competent in the moving and handling of people as they had not refreshed their practical training since the new online training had come into place and they were not completing competence checks.

People who used the service told us that the registered manager was approachable and that they were asked their views on the service they received. One person told us: "The manager will ask you how you are." Another person told us: "Staff do come around and ask if you have any complaint and put things right." There were annual quality survey and we saw these were analysed and action taken if there were any areas that required improvement. For example, in the last survey people had said they did not know the complaints procedure so the procedure was refreshed with everyone.

The registered manager told us that they were fully supported by the provider and we were told that the regional manager regularly visited the service and gave support to the registered manager when required. The provider was sent information of incidents, accidents and issues such as weight loss in people so they were kept aware of the events in the service.

The service was being extended and we saw that there had been a clear plan of action whilst building work was on going. This included a revised fire risk assessment as some fire exits were blocked due to the on-going building work.

The registered manager knew their requirements in relation to their registration with us and sent us notifications of significant incidents as they are required to do so by law.

Following the inspections the registered manager sent us evidence of actions they had taken to improve since the inspection. This showed that they were committed to improving the quality of service for people who used the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

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 People were not always being protected from the risk of abuse as action was not always taken following potential incidents of abuse.