MAPS Properties Limited

The Limes

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Limes is a residential care home. At the time of this inspection, 38 older people living with dementia were residing there. The service can support up to 46 people. The home is on one level and there are gardens attached; some rooms benefited from en-suite facilities.

People's experience of using this service and what we found
People had been placed at risk of avoidable harm due to poor risk assessing and management. This included around COVID-19, falls, pressure care, food and fluid intake, diabetes management and continence. The governance systems in place had failed to identify and rectify this. This was the eighth consecutive inspection where the service has been rated as either requires improvement or inadequate. Therefore, we do not have confidence the leaders for the service have the skills and abilities to make and sustain improvements.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the systems in the service did not support this practice. Consent to care and support was not consistently in place.

Local safeguarding policies had not been consistently adhered to and we found two examples of where incidents should have been referred to give the best opportunity for further protection. We could not be assured that people received enough to eat and drink and the service could have done more to ensure those living with diabetes remained healthy. One person had sustained a serious injury where the risks had not been fully mitigated.

The service could not fully demonstrate what care and support was being delivered to people and accurate records had not been maintained as required. The provider's quality assurance system had failed to identify and rectify concerns and the provider did not demonstrate they had oversight of the service.

The people who used the service were unable to tell us their experiences of using the service due to their level of dementia however we consulted with 11 relatives on their behalf as well as staff. Relatives told us they were kept up to date with their family member's care and staff told us they felt involved, listened to and valued. However, some relatives did raise concerns regarding risk management and told us they had not recently been involved in their family member's care plan.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 16 October 2020) and a recommendation was made regarding COVID-19 management. At this inspection we found the service had deteriorated and multiple breaches were identified.

Why we inspected
The inspection was prompted in part due to concerns received about risk management. We had also received a notification of a specific incident, following which a person died after sustaining a serious injury. We therefore examined the circumstances of that incident at this inspection. The inspection was initially a focussed on the key questions of Safe and Well-led however due to concerns found, this was opened up to include the key question of Effective.

We also looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk management, staff recruitment, safeguarding, meeting food and fluid needs, consent and governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

The Limes

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors, one medicines inspector and an Expert by Experience completed 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.

Service and service type
The Limes is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included information on safety incidents that the provider is required to notify us of by law. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and

represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
The people who used the service were unable to tell us about their experience of living at The Limes, however the care and support they received was observed. We spoke with four members of staff including the registered manager, regional manager, deputy manager and a senior care assistant. Eleven relatives also provided feedback on the service.

We reviewed a range of records. This included the medication records for 17 people. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service were also viewed, including maintenance checks, meeting minutes, audits and safety certificates.

After the inspection
We continued to seek clarification from the provider to validate evidence found and we met remotely with the registered manager to test their knowledge and seek further information. We spoke with an additional six staff including a domestic, senior care assistants and care assistants. We looked at training data, quality assurance records and we remotely accessed the care records for 12 people who used the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The service had failed to accurately assess risk and do all that was reasonably practicable to minimise it; people were at risk of harm as a result.
- One person had sustained serious harm following a fall that had not been adequately risk assessed or managed.
- For another person who had a pressure area, the service had failed to ensure equipment was in place to reduce pressure and assist healing.
- More could have been done to ensure people living with diabetes remained healthy. For one person, the service had failed to seek advice as recommended by a health professional regarding their diabetes. Additionally, the service had failed to consider the impact infections and poor fluid intake can have on people living with diabetes. Furthermore, the service had failed to individually assess the needs of people where their blood glucose levels fell below the lower recommended level.
- A person who was at risk of seizures had no care plan or risk assessment in place to address this. Furthermore, the provider had failed to identify and investigate an incident where the service user had potentially experienced a seizure.
- Continence care was poor, and the service had failed to consider its impact on those that were at risk of pressure areas. We saw that the care plans for three service users failed to provide staff with accurate information in relation to their continence needs.
- The service had failed to fully assess and mitigate environmental risks. This included the risks associated with people entering empty and unsecure rooms and accessible items such as denture cleaning tablets and razors. We saw that the service had failed to secure one room where a cleaning product had substantially leaked from the toilet over the floor.

The above concerns constituted a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- Although the service had not experienced a COVID-19 outbreak, we found concerns regarding the policies and procedures in place to ensure infection was prevented and controlled. This had been raised at our previous inspection in September 2020 and a recommendation made; this has not been acted on.
- The provider's COVID-19 policy had not been updated since October 2020 and contained information which was not in line with current government guidance.
- We observed staff wearing long sleeves and jewellery which did not adhere to the provider's infection control policy. Wearing such items makes effective handwashing difficult and jewellery, other than plain

bands, can be a source of contamination.
● A generic risk assessment was in place for admissions from other care settings however this had not considered current government guidance and had not been reviewed since new guidance was published.
● The provider had failed to follow government recommendations regarding testing for a person newly admitted into the home from another care setting.
● The service had a dedicated room for visiting however this had not been cleaned as specified by the provider's cleaning schedule. We saw that the room was cluttered making effective cleaning difficult.
● Care plans had not considered the impact staff wearing face masks could have on those people who used the service who lived with dementia or a hearing impairment. We saw one staff member pull down their mask to speak with a person with a hearing impairment which put them at risk.
● During our inspection we observed a heavily stained carpet in a communal area and a poorly maintained pressure cushion without a cover risking contamination.

We have signposted the provider to resources to develop their approach.

The above concerns constituted a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The provider had failed to protect people from the risk of abuse as the systems they had in place had been ineffective.
● We identified two safeguarding incidents that the provider had failed to report to the local authority as required. This meant opportunities to further protect people had been missed. These were reported to the local authority, by CQC, following the inspection.
● A person was being deprived of their liberty for the purpose of receiving care without lawful authority in place.

The above concerns constituted a breach of regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider had failed to have effective systems in place to ensure fit and proper staff were employed.
● For an employed member of staff, the provider had failed to seek satisfactory evidence of the staff member's conduct in previous employment where they worked with vulnerable people.
● For the same staff member, the provider had failed to make enough effort to seek the reasons why their employment in two previous roles had ended, both of which saw them working with vulnerable people.
● The provider had failed to assess and record the risks of employing the above staff member despite not having sufficient evidence they were of a fit and proper character.

The above concerns constituted a breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● We received mixed opinions on whether there were enough staff to meet people's needs in a person-centred and timely way. Our observations showed that while some people received assistance, we saw others needing support from staff that was not delivered in a timely manner.

Learning lessons when things go wrong
● Whilst there was some analysis in place regarding accidents and incidents, this was not consistent and had failed to capture all data meaning opportunities to mitigate risk and make improvements had been

missed.
● For example, one person was placing themselves on the floor, yet these incidents had not been reported as such events. We also found two safeguarding incidents that had not been recorded as such.
● Staff told us accidents and incidents were shared with them during handovers and that mitigating actions to prevent reoccurrence were discussed.

Using medicines safely
● Medicines management mostly followed good practice however some concerns were identified.
● There was written guidance to show staff how people preferred to have their medicines given to them. For some medicines prescribed on a when required basis (PRN) to be given at the discretion of staff, written guidance was not available to assist them to administer the medicines consistently and appropriately. In addition, when medicines were given to people in this way, additional records justifying their use were sometimes not completed.
● Staff carried out checks of people's medicines and their records. There was a system in place to report incidents and investigate errors relating to medicines. However, we identified some medicine discrepancies where people may not have received their medicines correctly as prescribed and that had not been identified and reported
● Medicines were stored securely and at appropriate temperatures.
● Members of staff handling and administering people's medicines had received training and had their competency to handle and give people their medicines safely assessed. We observed staff giving people their medicines by following safe procedures.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- The service could not demonstrate that people received enough to drink to sustain good health or that individual nutritional requirements had been met.
- For one person who was admitted to hospital with a urine infection, their average daily fluid consumption for the week leading up to the admission was recorded as just over a quarter of the lower recommended level as stated by the British Dietetic Association and the NHS.
- For another person where staff were required to monitor their food and fluid intake, the service could not demonstrate that their needs had been met as care planned. This was particularly concerning given that the service had linked the falls the person had experienced to urine infections meaning the need to ensure good fluid intake, to help prevent urine infections, was paramount.
- For two people living with diabetes whose care plans stated they needed to be offered regular snacks to help maintain blood glucose levels, the service could not demonstrate that this had been completed.
- One relative told us, "I am worried about [relative's] hydration as they have had urine infections. There is no water, no jug or glass available in their room."

The above concerns constituted a breach of regulation 14 (Meeting Nutritional and Hydration Needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- The provider had failed to work within the principles of the MCA.

● People's capacity to make decisions had not been consistently assessed by the provider even where they, and other stakeholders, had deemed people to lack capacity.
● Consent to care was not consistently in place and where it was, it was not always from the people who had legal authority to make such decisions.
● We saw for the one person where conditions were attached to a DoLS authorisation, the service could not demonstrate that all of them had been met.

The above concerns constituted a breach of regulation 11 (Need for Consent)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Nationally recognised risk assessment tools were in place however these had not been accurately used in all cases. This meant risks had not been correctly assessed and appropriate actions not always in place.
● Evidence-based guidance had not always been followed. For example, Diabetes UK's 'Good clinical practice guidelines for care home residents with diabetes'.
● The provider used an electronic care planning system that meant people's physical, emotional and social needs had been assessed. However, some of these contained generic information and reviews had not been consistently meaningful or identified inaccurate information.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● We found examples where the service had failed to contact health professionals in a timely manner, or at all, in order to ensure people received the best care possible.
● For example, some people were experiencing continence issues but had not been referred for a continence assessment. For another person, the service had not contacted a diabetes professional to review blood glucose levels that had been outside of the recommended levels.
● For another person whose health had deteriorated meaning meeting a condition on their DoLS had become more difficult, the service had failed to update the Supervisory Body as required.

Adapting service, design, decoration to meet people's needs
● The environment met people's needs, most of whom were living with dementia.
● For example, the home was all on one level making movement easy for those people that lived there.
● People's rooms were personalised, and they had access to both communal and private areas in order to spend time with their visitors. We did, however, note a heavily stained carpet in a communal area which needed urgent replacement; the registered manager told us this was planned.

Staff support: induction, training, skills and experience
● Staff told us they were well supported, that their induction prepared them for their role and that training was received.
● One staff member said of the management team. "They are really supportive, and I can go to them at any time. They are professional and polite and always willing to help.' Others agreed.
● In discussions with staff they mostly demonstrated good knowledge. However, during the site visit, we did see three staff crowd a person in distress and appear not to be able to calm them. In discussions, some staff did raise concerns about a few colleague's approach in such situations and felt they could have benefitted from more training.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service has consistently failed to achieve full compliance since 2014. This is the eighth consecutive inspection where well-led has been rated as either requires improvement or inadequate.
- The provider has failed to demonstrate that they can achieve and sustain improvement. Previously imposed conditions on the provider's registration obligated them to complete monthly audits of the service and showed they had driven some improvement. However, since these conditions have been removed, the provider has failed to continue to complete audits.
- Due to poor provider and registered manager oversight, care and support had not been provided in line with regulations, best practice and government guidance.
- The provider had failed to ensure accurate, complete and contemporaneous records had been maintained in relation to the care and support those people that used the service received.
- Despite the local authority's recent recommendation that the provider would benefit from the implementation of a service improvement plan, none was in place at the time of this inspection.

The above concerns constituted a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others

- The provider's quality assurance systems had failed to ensure people received consistently safe and effective care.
- Quality assurance audits had not been completed as per the provider's schedule and for those that had, they had failed to identify the issues found at this inspection.
- For example, audits on care plans had not been completed as per the provider's schedule and there was no system in place to ensure safe recruitment practices were in place. Fluid consumption was not audited and assessed.
- Some policies were out of date and the provider had failed to ensure staff were adhering to others, such as the falls and infection prevention and control policies.
- No audits were in place above home level meaning the provider could not demonstrate oversight of the service.
- The local authority had completed a quality assurance visit in September 2021 and made recommendations for improvement. At the time of this inspection, those recommendations had not been fully acted upon.

The above concerns constituted a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- We found little evidence that the people who used the service were consulted in any meaningful way. However, relatives told us they were engaged on an informal basis although most said they had not been involved in any recent discussions about their family member's care plan.
- Staff told us they felt listened to and consulted, had regular staff meetings and opportunities to discuss their role and learning.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Teamwork was effective amongst staff however we could not be confident that leaders had the skills and knowledge they needed to lead effectively due to the consistent and long-standing non-compliance with regulations.
- The registered manager did not demonstrate that they had knowledge of what the key challenges were in the service or the associated risks; their oversight was not as expected.
- Staff told us the culture was open and supportive, and that they felt valued and informed.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager was able to explain their responsibility under this requirement and told us it was about being open and honest when things went wrong.
- The relatives we spoke with told us the service informed them of accidents and incidents.