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The Limes Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Limes Care Home is a residential care home providing personal care to 10 people aged 65 and over some of whom were living with dementia at the time of our inspection. The Limes Care Home can support up to 40 people across two floors, due to the number of people using the service only the ground floor was in use.

People's experience of using this service and what we found

Medicines were not managed safely, and people were at risk of receiving their prescribed medicines unsafely. Risk management was poor and there were insufficient risk reduction measures in place in order to protect people from risk of harm. Infection control measures were ineffective and government guidance was not followed or adhered too in order to reduce the risk of possible transmission of COVID-19. Staff were not recruited safely, and staff training was not always completed in order to care for people safely.

Management of the service remained poor and insufficient improvement had been made in order to improve the quality and safety of care provided. Issues found during our last inspection had not been effectively addressed and people remained at risk of receiving unsafe care. Governance systems were not effective, and action was not taken to address areas of concern. Provider oversight was poor, and they failed to take timely action on known issues.

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 policies and systems in the service did not support this practice.

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 inadequate (published 3 September 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to infection control and management of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained as inadequate, this is based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Limes Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding people from the risk of abuse, staffing, recruitment and management of the service 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

The Limes Care Home

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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
The inspection was carried out by two inspectors 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

Service and service type
The Limes Care Home 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 did not have a manager registered with the Care Quality Commission; however an interim manager had been recently recruited. A registered manager 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
The Inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service,

what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with two people who used the service about their experience of the care provided and four of their relatives. We spoke with eight members of staff including the interim manager, provider representative, deputy manager, senior care worker, care workers and cook.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We reviewed training data and further records relating to the management of 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 our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people, manage medicines safely and ensure infection prevention control measures were effective. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management

- Risks were not effectively assessed, managed or monitored in order to keep people safe from harm.
- Risk associated with pressure area care were poorly managed. There was a delay in seeking professional advice when issues were found which placed people at risk of further damage to their pressure areas.
- Management of risk to people's safety from falls were not effectively managed. For example, one person had sustained several falls, the care plan and risk assessment did not reflect the persons current needs and did not direct staff in how to safely care for them.
- Water temperature monitoring had not been completed consistently. Some temperatures were recorded at very high temperatures with no action taken. Rooms which contained those water outlets were accessible for all people using the service and placed them at risk of scalding.
- Gas safety monitoring had not been effectively managed, and the gas safety inspection was more than 6 months overdue. Electrical equipment had not been effectively monitored which meant some equipment which we observed to be in use had not been safety tested in years. Failure to manage and monitor equipment placed people at risk of harm.

Using medicines safely

- Medicines were not managed safely which placed people at risk of not receiving their prescribed medicines.
- People did not always receive their prescribed medicines at the correct time. We found several medicine errors which had not been picked up or acted upon in a timely manner. This placed people at risk of harm.
- Prescribed creams were not managed safely. Prescribed creams were found in communal bathrooms and in people's bedrooms without an opening date, this was not in line with storage guidance. Records relating to the administration of prescribed creams were either missing or inconsistently completed.
- There were no records relating to medicines which were required 'as needed' in place. This meant staff had no instructions how to safely give these types of medicines which placed people at risk of harm. This was fed back during our inspection and the providers representative advised they would put these records in place.

Preventing and controlling infection

● People were at risk of infection due to poor infection prevention and control practices.

● Best practice guidance was not consistently followed to help reduced the risk of COVID-19. For example, staff did practice effective hand hygiene. We observed multiple staff supporting different people throughout both days of our inspection, without sanitising or washing their hands. This placed people at risk of harm.

● There was not a system in place to ensure visitors had tested negative for COVID-19 prior to being allowed entry to the home. It was unclear whether staff were undertaking regular testing and how this was being monitored in order to prevent the possible spread of COVID-19. We requested records to evidence that staff had undertaken testing for COVID-19 as directed by government guidance, but these were not supplied.

● There were no records in place to evidence that visiting professionals had provided evidence that they had received their vaccination for COVID-19. Not all staff had provided evidence they had been doubly vaccinated against COVID-19. This was fed back, and the providers representative advised they would address this immediately.

● Cleaning records had not been completed to ensure the home had been cleaned effectively and there were many areas which required cleaning. For example, bathrooms had visible dust and stains around the bath. Bars of soap were also found in communal bathrooms and staff did not know who these belonged to, this placed people at risk of possible cross infection.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service did not have effective measures in place to make sure this requirement was being met.

Systems had not been established to robustly assess the risks relating to the health safety and welfare of people, manage medicines safely and ensure infection prevention control measures were effective. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's representative responded during the inspection and they provided assurances that immediate risks had been addressed, however the provider failed to respond to further feedback given after the inspection.

At our last inspection the provider had failed to safely recruit suitably qualified and competent staff. This was a breach of both regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 and regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18 and regulation 19.

Staffing and recruitment

● Staff were not recruited safely.

● Staff files we reviewed did not all contain information to ensure staff were recruited safely. One staff file we reviewed did not contain information such as references and a disclosure and barring service check to ensure they were suitable to work at the service. There were no interview notes for three staff members current roles at the service. This placed people at risk of receiving care from unsuitable people.

● Management at the service had been recruited unsafely. The provider had appointed people to roles without any assurance checks taking place. We fed this back during our inspection and the providers

representative advised they would act.
● Not all staff had received training in key areas such as moving and handling, fire safety and infection control. Our observations supported that staff required further training in these areas in order to support people safely. For example, one person was repositioned unsafely placing them at risk of harm.
● During our inspection the home was in an outbreak of COVID-19, there were no trained staff available to clean the home effectively in order to protect people from risk of cross infection. The provider was aware there was no domestic staff available for an extended period and had taken insufficient action.

The provider had failed to safely recruit staff and ensure they were trained and competent. This was a continued breach of both regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 and regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The provider's representative responded during the inspection and they provided assurances that some of the issues had been addressed, however the provider failed to respond to further feedback given after the inspection.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Systems and process in place did not protect people from the risk of abuse.
● Training data we reviewed evidenced that staff had not received training in safeguarding. Incidents and records we reviewed detailed that staff failed to recognise incidents and some care provided as safeguarding concerns. For example, one care plan we reviewed provided staff with instructions in how to care for a person at risk of choking, these instructions placed this person at risk of abuse and neglect.
● The provider did not ensure safeguarding concerns were always recognised, recorded or reported on appropriately to the local authority safeguarding team. This placed people at risk of abuse.
● Incidents were not learnt from and little or no action was taken following incidents occurring. For example, one person fell regularly, and insufficient action had been taken in order to prevent further falls.

The provider failed to ensure that people were protected from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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 our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to monitor and drive service improvement in order to provide safe care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had not been made at this inspection and the provider was still in breach of regulation 17.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Failings found at our previous inspections had seen limited improvements, we received a short action plan following our last inspection which had dates in which the home would improve by. This action plan had not been completed and little improvement had been made.
- The provider had failed to learn from previous issues raised, there had been limited input or oversight from the provider. Action was only taken by the provider when serious issues were raised.
- Audits were not completed in order to drive service improvement. For example, medicine audits had not been completed therefore issues we found were not highlighted so improvements could not be made. This placed people at risk of harm.
- Lack of managerial oversight of care records meant these were not consistent. Care plans did not provide staff with accurate information in order to support people safely. This placed people at risk of harm.
- We found several incidents which should have been reported to both safeguarding teams and CQC but had not. The provider had failed to ensure the management team within the home were aware of their legal responsibility to report incidents which impact people.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was not an open and inclusive culture at the home which placed people at risk of harm.
- People and their relatives told us they had not been involved in creating their care plans. Relatives told us, "I have not been involved in anything, not even a basic assessment, it's not good there is no way of giving any kind of feedback".
- Relatives told us, "I am concerned about the management of the home, there is no consistency". Another relative we spoke with advised they had spoken with a social worker due to poor communication at the home and concerns they had about their loved one's care.

● Staff were not supported in their roles; we found little evidence that staff had received adequate support. Staff raised serious concerns with us during our inspection around the culture at the home. Multiple staff told us that it had become normal to work in an uncomfortable environment for a number of months. The provider had not had adequately supported staff for them to raise concerns.
● The home at recently appointed an interim manager and staff told us they felt a positive change in the culture at the home in the short time they had been there.

Working in partnership with others
● The service did not always refer to healthcare professional in order to seek specialist advice. We found a delay in referring to multiple specialist teams such as district Nurses and the falls team. This placed people at risk of harm.
● One professional we spoke with told us, "Communication is poor at the home which effects people living at the service".
● The providers representative and interim manager had recently made a number of referrals to specialist teams to seek professional advice.

The provider had continued to fail to monitor and drive service improvement in order to provide safe care. They had also failed to seek and act on feedback in order to improve care. This was a continued breach of regulation 17(Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● We received mixed feedback from relatives about how the service communicated when things went wrong. For example, one relative told us, "They tell me when things go wrong", however another relative we spoke with told us, "You have to ask to find anything out, it needs improving".
● The lack of investigation, poor oversight and failure to report safeguarding concerns indicated that the provider was not fully aware of their legal responsibility to be open and honest with people.

We fed back our concerns relating to investigations and the service being open and honest with people during our inspection. The providers representative advised they would take action to address these issues.