Sanctuary Care Limited

Lime Tree Court Residential Care Home

Inspection report

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Date of inspection visit:
19 October 2017

Date of publication:
29 December 2017

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 19 October 2017 and was an unannounced inspection. At the last inspection of the service in April 2016, the provider was rated as Good.

Lime Tree Court Residential Care Home provides accommodation and personal care for up to 60 older people. At the time of our inspection, there were 56 people living at the home.

There was a manager registered with us. 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. However we were informed prior to the inspection that the registered manager was no longer working at the location and that a new manager had been recruited. The new manager was present during this inspection.

People felt safe living at the home and were supported by staff who knew how to recognise and report any signs of abuse.Risks to people were assessed and managed to ensure risks were reduced where possible. Medication was administered safely and accurate records of medication given was kept. There were sufficient numbers of staff for people throughout the day although people reported longer waits for support during the night.

People were supported by staff who had received training and had the skills and knowledge required to support people effectively. There were effective communication systems in place to ensure that staff had the information they required to support people. The oversight and application of the Mental Capacity Act [MCA] and Deprivation of Liberties Safeguards [DoLS] was in need of review at the home. Staff understanding of DoLS was variable. Staff established consent from people before providing care. People had their dietary needs met and were supported during mealtimes as required. People had access to healthcare services when this was needed.

People felt that although staff were caring, they did not spend enough time with them in order to build a caring relationship. Staff ensured that people were treated with dignity and respect and that people's independence was encouraged where possible. People had been encouraged to maintain relationships with people close to them and had access to advocacy services should they require this.

People's care needs had been assessed prior to them moving into the home and these needs were reviewed regularly. People did not feel there were sufficient activities available to them to keep them occupied during the day. People knew how to make complaints and there was a system in place to ensure complaints made were investigated.

A new manager had been recruited and people reported that this has had a positive effect on the service. Audits had not been completed consistently and had not identified some of the issues we found during the

inspection. Notifications about people who were subject to a Deprivation of liberty safeguard had not been sent to us as required by law. Feedback was gathered from people through resident, relative and staff meetings.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were supported by staff who knew how to manage risks to keep them safe and how to report concerns.

There were sufficient numbers of staff available for people throughout the day but people experienced longer waits for support at night.

Medication was administered as prescribed and accurate records were kept in relation to this.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received appropriate training and support in order to provide care for people effectively.

The oversight and application of the Mental Capacity Act [MCA] and Deprivation of Liberties Safeguards [DoLS] was in need of review at the home.

People were supported to have sufficient amounts to eat and drink and had access to healthcare services where required.

Is the service caring?

Requires Improvement

The service was not always caring.

People felt that staff did not spend time with them when able too.

Staff ensured they respected people's privacy and dignity.

People had access to advocacy services where required.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always have access to activities that met their hobbies and interests.

People were involved in the assessment and review of their care.

Complaints made were investigated and responded too.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits completed were ineffective and had not identified the issues we found during the inspection.

People did not feel the home was well led and were not always sure who the manager was.

People were given opportunity to provide feedback on the service they were provided with.

Lime Tree Court Residential Care Home

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 checked 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 19 October 2017 and was unannounced. The inspection was carried out as we had received concerns from members of the public about low staffing levels at the home, concerns around poor personal care being provided to people and a lack of support at mealtimes.

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.

We reviewed the information we held about the service. Providers are required by law to notify us of events and incidents that occur at the service; we call these 'notifications'. We looked at the notifications the provider had sent to us. We contacted the local authority who monitor and commission services, for information they held about the service. We used the information gathered to plan what areas we would focus on during the inspection.

We spoke with eight people who lived at the home and two relatives. As some people were unable to share their views, we completed a Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk to us. We also spoke with four members of care staff, the head chef, the covering care manager, the newly recruited home manager and the regional manager.

We looked at a sample of records including five people's care records, five staff recruitment files, records kept in relation to medicines, accidents and incidents and audits completed to monitor the quality of the

service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt there were enough staff to meet their needs during the day. One person told us, "I would say there are adequate staff numbers". Another person said, "Yes, there is enough staff". Our observations reflected this. We saw that where people had called for support, this was provided in a timely way. We also found that staff were always available in communal areas to support people if needed.

However people did not feel there were enough staff to support them at night. One person said, "They could probably do with some more at night time". Another person explained, "At night they are short staffed and could do with another on". People told us that if they required support at night, they had to wait for staff to come to them. One person said, "I have had to press my alarm but the response was not too quick but they did come". We looked at staff rotas completed and saw that the provider had ensured the number of night staff were available that they had assessed the home as needing, however people continued to feel that staffing levels at night were not sufficient. We spoke with staff who informed us they also felt more staff were needed on duty to support people safely. One member of staff told us, "Personally, no I do not think there is enough staff. We have people who are highly dependent and need two staff to support them and it can be hard". Staff informed us that they had fed this back to management in the past, but were informed that it was provider policy that the staffing levels remained at what was currently set. We spoke with the newly appointed manager and the regional manager about the feedback we had received. The regional manager explained that there were no systems to formally assess staffing levels but that they had assessed the needs of each person living at the home and if those needs changed, they would then firstly assess whether they could still meet those people's needs and if so, recommend increasing the staffing levels. However, we saw no examples of staffing levels being amended to reflect changes in people's needs.

We saw that safe recruitment practices had been followed to ensure that only people considered safe to work were employed by the service. This included requiring staff to provide a full work history, references from previous employers and complete a check with the Disclosure and Barring Service (DBS). The DBS would show if an employee had a criminal conviction or had been barred from working with adults. Staff confirmed that these checks took place. However, we saw that the provider had no systems in place to re-check employee's DBS certificate where the employee had worked at the home for a number of years. We asked the provider how they ensured that staff they employed continued to be safe to work with people. The regional manager explained that while systems to check this were not currently in place, they would commence a scheme where staff have to declare that they have no criminal convictions on an annual basis to ensure they remain safe to work.

People we spoke with told us they felt safe at the home. One person told us, "It appears to be very safe here with plenty of company to look after you". Another person said, "Of course it is safe. Staff are around and the front door is always locked with a keypad for entry". This view was shared by relatives with spoke with. One relative explained, "Yes [Person] is safe here, I have no concerns surrounding her safety here".

Staff we spoke with confirmed they had received training in how to keep people safe from harm and could explain what abuse is and what action they should take if they were concerned about someone being at risk

of harm. One member of staff told us, "If someone was at risk, we would make sure a safeguarding was put into place. I would report any concerns to the manager". We saw that where concerns had been identified, appropriate referrals had been made to ensure that action was taken to keep people safe.

People told us that staff ensured that risks to their safety had been reduced where possible. One person told us, "I do suffer with a lot of falls but the carers are always on hand to get to me and help me so that's a comfort". A relative we spoke with said, "[Person] cannot walk unaided and they [care staff] support her well". We saw that where people were at risk of falls, risk assessments had been completed to ensure that the appropriate support was given and staff we spoke with were aware of how this support should be provided. One member of staff told us how they support one person who was identified as being high risk of falls. The staff member said, "[Person] does walk independently so we just keep an eye on them, make sure they are checked regularly throughout the night and put equipment like bed sensors in place". We observed staff supporting people with their mobility needs and saw that staff did this in a safe way, explaining to the person what was happening and providing encouragement throughout.

We saw that systems were in place to ensure that people were kept safe in case of emergencies such as a fire. We saw that each person had a Personal Emergency Evacuation Plan in place that detailed how they should be supported out of the home in case of a fire. Staff we spoke with knew about these plans and could explain what action they should take in case of a fire. One member of staff told us, "We will check the fire panel, two staff will go to where the fire is to check there is a fire and if so, we start the evacuation and call the fire brigade".

We saw that a record was kept of accidents and incidents that had occurred at the home. We saw that following each incident, actions were taken to reduce the risk of reoccurrence. For example, where people had fallen, referrals had been made to the 'Falls Prevention Team' and extra checks had been put into place to ensure the person was safe.

People were happy with the medicines support they received. One person told us, "The staff are good with medicines. They are very careful with me. I have them at certain times and they [care staff] come around on a regular timed round". Another person said, "Oh yes, the staff are very good with my medicines". We observed staff supporting a person with their medicines and saw that they did this safely. The staff member informed the person that it was time for their medicine and then stayed with them while they took this. We checked eight medicines records and found that these had been given as prescribed. We saw signatures on Medication Administration Records (MAR) to evidence that medication had been given and found that the amount of medicine available matched what had been recorded on the MAR. Where people had medicine on an 'as and when required' basis, there were protocols in place informing staff when these medicines should be given. This ensured that these medicines would be given in a consistent way. Where people required controlled medicines, these had been stored correctly and given as prescribed.

Requires Improvement

Is the service effective?

Our findings

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.

People told us that staff sought their consent. One person told us, "They [staff] always ask if I would like a wash or a shower before doing it". Another person said, "Yes, they [staff] are good at that and won't do anything I don't want". Staff understood the importance of seeking consent and could explain how they support people to give consent where required. One member of staff explained, "We ask the person directly and then wait for their response, we allow people their choice. For people who cant verbally consent, we use other signs such as hand gestures, facial expressions or signs". We observed staff seeking people's consent prior to supporting them and saw that staff respected people's wishes where support was declined.

We found that staff knowledge of DoLS varied. Although a number of people living at the home had DoLS authorisations in place, staff were not always aware of these. Without the awareness of who requires a DoLS authorisation and why, it could not be ensured that staff were consistently acting in line with the authorisations. However we did not observe staff supporting people in a way that would not be in accordance with their DoLS authorisation. We spoke with the newly appointed manager about this who assured us that further work would be completed to ensure staff were given this information.

People told us they felt that the staff had the skills and knowledge required to support them effectively. One person told us, "Yes the staff here are well skilled in my opinion and are looking after me well". Another person said, "I think they are well trained and know me well and what I like and don't like".

Staff told us that before starting work, they completed an induction that included completing training and shadowing a more experienced member of staff. One member of staff told us, "My induction was two weeks of shadowing and then completing all of the training. It was good". All of the staff we spoke with felt that the induction prepared them for the role. Staff told us that their training was refreshed annually and we saw that this was the case. One member of staff said, "Our training updates every year, it is online with some group training too. I do think the training is good". The training covered areas relevant to people's care needs and included pressure area awareness, communication and falls prevention.

Staff had been supported through supervisions and were able to ask for extra support if needed. One member of said, "We always have opportunity to ask in supervision for extra training. I have asked to be a 'medication champion' and this is being arranged". Another staff member told us they had completed extra

training to become a trainer in Moving and Handling. This had meant they were able to support and train other care staff in this area of care.

We saw that there were effective communication systems in place to ensure that staff had the knowledge they required to support people. We saw that handovers took place between staff before they started work so that they were informed of any changes to people's needs. Staff felt this was effective and told us, "We have handovers to discuss any concerns or changes. I always get the information I need".

People spoke positively about the meals they were offered. One person told us, "I like the food here and always clear my plate. You get a choice as well". Another person said, "The food is perfectly acceptable and adequate with a good variety. It is well cooked and presented". We saw that people were given choices at mealtimes about where they would like to sit, what they would like to eat and what drinks they would like with their meal. The meals looked and smelt appealing and each dining area had a relaxed atmosphere while people eat. We saw that where people required support to eat, this was provided by staff in a caring way and staff spoke to the person kindly throughout the meal.

We spoke with the head chef about how they ensure people's dietary needs were met. The head chef informed us and we saw that there was a noticeboard in the kitchen that gave staff information on people's specific dietary needs and that this was used when preparing meals. The head chef informed us that alternative meals were available for people if they did not want what was on the day's menu and we saw that alternatives had been noted on the menu on display.

People felt supported to access healthcare services when needed. This included the opticians and GP. One person told us, "They [staff] do ask if I need to see anyone and will make an appointment for me if I ask them". Another person said, "They [staff] are very helpful in making appointments for me". We saw people being visited by district nurses throughout the day and were given privacy during these appointments. Records we looked at showed that people were supported where their health needs had changed and that referrals to other services such as dieticians had been made as appropriate.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that staff were kind and caring to them when they spent time together but that staff didn't often take time to sit and talk with them. One person told us, "The staff are nice but they could engage with us more, They leave us to sit around just with the television or music on". Another person said, "They don't sit and talk, they sit in a huddle doing paperwork in the corner". A relative we spoke with said, "I really do think [staff] could engage with people more. I know paperwork has to be done but surely they can sit and talk more".

We observed that staff were kind in their interactions with people when offering support but did not take time to sit and talk with them while they were together in communal areas. We observed that in all three living areas, people were sat in the living area, whilst staff sat together in the dining area of the same room. This meant that while staff were present for people if support was required, people were not having opportunity to develop relationships with staff as they were not spending time with them when able too.

People told us they felt valued by staff and involved in their care. One person told us, "It's quite good, they look after me ok and I do feel part of the home". Another person said, "I have nothing to worry about and do feel valued here". Relatives we spoke with also felt they could be involved in their loved ones care where necessary. One relative told us, "We are fully engaged with decisions in respect of [person's name] care. They let us know if she is not well or if they have concerns over anything". We observed that people were given choices throughout the day and were supported to make decisions over what they would like. For example, we saw people were given a choice of what time to get out of bed and what area of the home they would like to spend time in. Staff then supported people once they had made these decisions.

People's privacy was respected and people told us they were treated with dignity. One person told us, "My privacy is well respected, there are no issues with that when they wash or shower me. I am kept covered up, kept warm and the door is kept closed". Another person said, "They [staff] are very good at that [treating me with dignity]. Very respectful". Staff we spoke with told us how they ensured they provided people with dignified care and gave examples that included; knocking before entering people's bedrooms, and covering people during personal care so that they were not unnecessarily exposed. People confirmed that staff encouraged them to maintain their independence and we observed this. For example, we saw people being encouraged to mobilise independently where they were able and staff actively encouraged people to be active and walking around the home.

People were supported to maintain relationships with people who were important to them. We saw people had visitors throughout the day and people told us that there were no restrictions on when relatives could visit. One relative told us, "I can call in to visit at any time. I have even been here at 10pm".

For those people who did not have a family member to support them to make decisions, the manager knew how to access the support of advocacy services. An advocate can be used when people may have difficulty making decisions and require this support to voice their views and wishes.

Requires Improvement

Is the service responsive?

Our findings

People gave us varied feedback on the activities that were offered to them at the home. Some people were pleased with the activities and told us, "I'm happy with the activities they support me to do and join in". However other people told us there were not always activities available for them. One person told us, "I would like something more to do in the afternoon not just left in the chair with the television on. It is dead boring". Another person said, "We used to have lots of activities and things to do but not so much now. We used to have trips but that seems to have stopped and we don't get that now. They give me colouring and word searches a lot but don't give as much support now as they used too".

We saw that there was an activity coordinator in post who was responsible for supporting people with activities. However, this staff member was responsible for activities across three lounges in the home and so whilst activities were ongoing in the lounge the staff member was in, the other lounges were left without activities. We saw people in the other lounges had been provided with pencils and paper to colour with, however many people were not engaging with this and clearly had not wanted to do this activity. Care staff were in the communal areas with people but were occupied with other tasks and so were not supporting people to complete the activity. People in communal areas without the activity co-ordinator were seen spending a lot of time asleep and with little interaction with staff or other people. The rooms where the activity co-ordinator was based however, were a hub of activity with people singing, dancing and chatting with the activity staff. We spoke with the newly appointed manager about our observations and they informed us that the activities would be addressed to ensure these were available for everyone.

People told us that prior to people moving into the home, an assessment of their needs was carried out. These assessments ensured that staff would know people's individual needs and preferences with regards to their care. One person told us, "I was fully involved in my assessments and I chose to come here". Another person said, "Yes I was involved in my assessment with my family before coming here". Records we looked at confirmed that these assessments had taken place.

People's care and support needs were reviewed regularly to ensure that staff could continue to meet their needs. People had been involved in their care reviews through a system called 'Resident of the day'. Resident of the day supported the person to speak with staff about their care and raise any issues or changes they would like to make. However, some relatives had not always been involved in these reviews. One relative told us, "We have been verbally asked briefly about the care plan but there has been no regular sitting down and going through it".

People we spoke with told us staff understood their preferences with regards to their care. One person told us, "I have been here years now so yes they [staff] know me well". Another person said, "They [staff] know what I like and dislike". We saw that care plans held information relating to peoples life history, interests, likes and dislikes. For example, records indicated what hobbies or interests the person has. Staff we spoke with had a detailed knowledge of people's care needs and how they would like their support delivered. One staff member spoken with was able to explain about one person's preferences with regards to what time they got up each day, what time they liked to eat their meals and where they enjoyed spending their time.

People told us they knew how to make complaints if required. One person told us, "I would speak to the carer when she comes around [if I needed to complain}". Another person said, "I would speak to the senior carer or the manager". Some relatives spoken with told us they had made complaints in the past but these had been resolved to their satisfaction. One relative told us, "I have complained in the past to the previous manager and things were handled quickly".

We saw that information was displayed around the home informing people how they could make a complaint if they wished. However, we did not see that this was available in other formats for people if they required this; for example, in large print. We looked at records held on complaints and saw that where complaints had been made, these had been investigated and a response provided to the complainant.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in post. However, we were informed prior to the inspection that the registered manager was no longer working for the provider and that a new manager had been recruited. The new manager had been in post for a number of weeks and was in the process of applying to become registered with us.

People we spoke with did not know who the new manager was. One person told us, "If you asked me who the manager was I wouldn't know". However, we saw that meetings had been arranged for the new manager to introduce herself to people and relatives and posters informing people of this meeting had been displayed around the home.

People did not feel that the home was well led. One person told us, "No, it's not really well led. They need to do more for you". Another person said, "It is not well led now as I have said, it has gone downhill". However other people spoke more positively and one person told us, "It is good for what it is and it achieves its purpose". We spoke with the regional manager and the newly appointed manager who advised that there had been a number of changes at the home following the departure of the previous registered manager and the deputy manager but that the new manager would bring some needed stability to the home.

We found records in relation to people's care needs were not always detailed. For people who were at risk of falls, there were risk assessments in place that scored the level of risk. For one person, the level of risk had fallen between the months of August and September, however there was no information available about why the risk had decreased or how this would impact on how staff should support the person. We saw one person who had their breakfast late on in the morning, they were then seen having their lunchtime meal only one hour after their breakfast. We spoke with staff and the manager about this and were informed that this person likes to get up late and so has breakfast late, and will often have their lunch at a later time or refuse lunch altogether. However, there was no mention of this in the person's care records to inform staff on what this person likes to do with regards to their meals. This meant that records had not always been maintained to ensure they included detailed, robust information about people's current care needs and preferences.

We saw that audits were completed to monitor the quality of the service. However, we found that in some cases, these had not been completed consistently. For example, we saw that medication audits were in place and that these should be completed daily, however these had not been completed at all throughout the month of September. Other medication audits had been completed within the identified timescales. We spoke with the newly appointed manager about this who advised that these may have been missed due to the transition between managers. The newly appointed manager informed us that these would now be re-implemented.

The audits completed had also failed to identify the issues we found during the inspection. For example, the audits had not identified that notifications had not been sent as required where DoLS authorisations had been issued and the provider was not aware of people's concerns regarding staffing levels at night or the

lack of activities. This meant that the provider's quality assurance processes were not robust in some areas of care provision.

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

We found that the provider had failed to notify us where people had Deprivation of Liberty Safeguards in place. It is a required by law that we are notified of any application made in relation to depriving a person of their liberty. The provider was not aware that these notifications had not been sent as required and provided assurance that these would be sent in retrospectively. We are considering what action to take in respect of this.

We found that the newly appointed manager was keen to promote an open and transparent culture within the home. One person spoken with told us, "Her [the new manager] door is always open and she is very approachable". This was confirmed by staff who also felt supported and able to approach the new manager. One member of staff told us, "I feel more supported since the new management came in. I do feel like if I had any concerns, [manager's name] would be helpful, act on it and support me". Staff we spoke with were aware of the provider's whistleblowing policy and knew who to contact if they needed to whistle blow.

People were actively encouraged to provide their thoughts on the service. We saw that meetings for people and their relatives were held for people to discuss the home and any changes they would like to see. Staff told they also were given opportunity to provide their opinions in staff meetings. One member of staff told us, "We have staff meetings, the last one was two weeks ago. We can discuss any problems, rotas and training". Records we looked at confirmed these meetings took place.

It is a requirement that providers ensure that their most recent rating is displayed within the home and on any websites ran by the provider in relation to this home. We saw that the provider had displayed their rating on both their website and in the reception area of the home and so had met this requirement.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that records completed were accurate and robust. Audits completed had failed to identify the areas for concern found at inspection.