Ablegrange (Lincoln) Limited

The Limes Care Home

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Inadequate**
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**

Overall summary

This inspection took place on 16 April 2015 and was unannounced.

The Limes provides care for older people who have mental and physical health needs including people living with dementia. It provides accommodation for up to 30 people who require personal and nursing care. At the time of our inspection there were 26 people living at the home.

At the time of our inspection 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.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

People told us that they felt safe and well cared for. When we spoke with staff they were able to tell us about how to

Summary of findings

keep people safe. However, medicines were not administered correctly and infection control risks were not consistently managed. People were at risk of cross infection.

We saw that staff obtained people's consent before providing care to them. However, the provider did not act in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). If the location is a care home the Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find.

We found that people's health care needs were assessed, and care planned to meet those needs. However, we identified concerns about how care was delivered to maintain people's health. People had access to other healthcare professionals such as a dietician and GP however on some occasions we found that appropriate referrals had not been made.

Staff were kind to people when they were providing support, however, we observed some occasions when people were not treated appropriately. Staff had a good understanding of people's needs. People had access to activities and excursions to local facilities however there was little opportunity for them to pursue personal interests.

People were not always supported to eat enough to keep them healthy. People were offered drinks throughout the day but did not have open access to drinks during the day. People did not have choices at mealtimes. Where people had special dietary requirements we saw that these were provided for.

Staff were provided with training on a variety of subjects to ensure that they had the skills to meet people's needs. Staff told us that they felt able to raise concerns and issues with management. We found relatives were clear about the process for raising concerns and were confident that they would be listened to. They said they would feel comfortable raising issues with the registered manager. The complaints process was openly in view however, it was only available in written format, therefore not everyone was able to access this.

Audits were carried out on a regular basis, however they were not always effective and did not consistently address the issues which were identified . Accidents and incidents were recorded and reviewed to ensure trends and patterns were identified, however, actions were not always in place to limit the reoccurrence of these.

Summary of findings

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.

Staff were aware of arrangements for keeping people safe. However, there were insufficient suitably skilled staff.

Medicines were not administered as prescribed.

Risk assessments were completed but actions had not been taken to manage the risk. There was a risk of cross infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People had access to healthcare. However, ongoing monitoring was not always in place.

People had had their nutritional needs assessed.

The provider did not act in accordance with the Mental Capacity Act 2005 (MCA).

Is the service caring?

Requires Improvement

The service was not consistently caring.

Interactions and communication between staff and people were not always positive.

Staff understood the relevance of privacy and dignity however they did not always ensure it.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Group activities were available and the home had links with the local community.

People were aware of their care plans. However, people's care plans had not been consistently updated. People were not always offered choices about their care

A complaints process was in place.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

A quality monitoring system was in place. However, this had not resulted in improvements in care.

Staff were supported in their role.

The Limes 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 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 16 April 2015 and was unannounced.

The inspection team consisted of an inspector, an expert by experience and a specialist advisor. An expert by experience is a person who has experience of relevant care, for example, dementia care. A specialist advisor is a person who has particular expertise in specific areas for example, physical health.

Before our inspection we contacted the local authority commissioners for information in order to get their view on the quality of care provided by the service. We also looked at notifications which we held about the organisation and information that had been sent to us by other agencies. Notifications are events which have happened in the service that the provider is required to tell us about.

During our inspection we observed care and spoke with the registered manager, five members of care staff, and a member of housekeeping, six relatives and six people who used the service. We also looked at seven people's care plans and records of medicines and audits.

We used the short observational framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk to us. We observed four people for a one hour period.

Inadequate

Is the service safe?

Our findings

We observed a medicine round and saw people were asked if they required their medicines. We observed medicines being administered to people and noted that appropriate checks were not carried out. Staff addressed people by their name to ensure they were administering to the correct person. However, they gave people their medicines and did not observe to ensure that people had taken them.

However, we found that there were a number of occasions when people had been recorded as refusing their medicines on a consecutive basis over a period of eleven days. Risk assessments had not been completed to indicate whether or not people regularly refused their medicines and we could find no record of the GP being informed of this. We spoke with the registered manager and their deputy who told us that in some instances they did not consider that people required the medicines. This was despite them being prescribed for them and that these may have been recorded as refused. They told us that they had not raised this or informed the GP of the refusal of medicines. We looked at the provider's policy for medicine administration which stated that the GP should be informed of persistent refusal. People were at risk of not receiving appropriate treatment.

One person who was prescribed medicines on a regular basis had had their care plan updated to state that staff should ask them if they required the medicine. However, their medicine was not prescribed on an as required basis but should have been given regularly. There was no evidence in the person's care record that this change had been agreed with the GP. People were not receiving their prescribed medicines.

There was a breach of regulation 12(1) (2) (g) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Medicines were not administered safely.

People who used the service told us they felt safe living at the home. One person said, "Yes I feel safe here and people understand me."

Individual plans were in place for people in the event of an emergency. Individual risk assessments were completed for people who used the service. However, it was not clear what action had been taken when people were at risk. For example, a person had a total of 30 injuries detailed in the accident book, the majority relating to falls. However, we could find no evidence of referral for advice and support in order to prevent the person falling. During February and March there had been more than 10 falls each month. We observed that where people had records of continuous falls further investigation into the cause and possible reduction of falls with other professionals had not taken place.

There was a breach of regulation 12(1) (2) (B) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not provided in a manner which mitigated risks.

Staff that we spoke with were aware of what steps they would take internally and externally if they suspected that people were at risk of harm. Staff said that information about safeguarding concerns was fed back and that they were kept informed of safeguarding issues. The provider had safeguarding policies and procedures in place to guide practice and we had evidence from our records that issues had been appropriately reported.

One person told us. "They could do with more staff on I think…. Sometimes they are rushed off their feet"

One member of staff told us that they felt they were short of staff on occasions. On the day of our inspection the registered manager told us that they were one member of care staff short due to sickness and therefore had asked one of the housekeeping staff to cover. They told us that they had received the appropriate training in order to provide care. In addition, another member of care staff was working as bank staff. During our inspection we observed that they were unfamiliar with the home, for example, they were unable to tell us about the location of food and fluid charts or operate the keypad to the outside door. They were also unfamiliar with people who lived at the home. For example, a staff member was asked where they were taking a piece of equipment to assist a person with care and when they answered they were told that this equipment was not relevant to this person. People were at risk of receiving unsafe and inappropriate care. The registered manager told us that they had recently recruited to additional posts and were in the process of carrying out recruitment checks. The provider had a recruitment process in place which included carrying out checks and obtaining references before staff commenced employment. Staff told us that they had had checks carried out before they started employment with the provider.

Inadequate

Is the service safe?

During our inspection we found that there was an unpleasant odour in some parts of the home. We saw that there were clean towels left uncovered in a communal bathroom where people could touch them which would be a cross infection risk. We also saw that equipment such as commodes and a toilet seat were dirty. We saw a number of open bins throughout the home which would present a cross infection risk.

Hand gel and soap dispensers were available throughout the home. Hand gel is important for staff to use in order to reduce the risk of cross infection. Staff had received training on infection control and we observed staff washing their hands to prevent cross infection. During the lunchtime period we observed staff wore protective clothing to prevent cross infection, however, staff did not wear protective clothing when serving the afternoon tea.

Requires Improvement

Is the service effective?

Our findings

People received care from staff who had the knowledge and skills to carry out their roles and responsibilities effectively. One person told us, "The staff seem well trained and competent."

A member of staff told us they had received an induction when they started with the provider. Staff told us they were happy with the training that they had received and that it ensured that they could provide appropriate care to people. They said that they had received recent training in areas such as moving and handling, food hygiene and infection control. One member of staff also told us about their recent training on dementia care which had helped them to provide appropriate care to people.

Staff were also satisfied with the support they received from the registered manager of the home and told us that they felt supported in their role. They told us that they received regular supervision sessions which included an annual appraisal of their performance.

People who used the service told us that they enjoyed the food at the home, however, during our inspection we observed lunchtime and saw that people struggled to eat the meat. One person commented, "It could have been a bit more tender," and another person said, "Tough as old boots."

People had been assessed with regard to their nutritional needs and where appropriate, plans of care had been put in place. Where people had specific nutritional needs referrals had been made to speech and language therapists and dieticians to assist staff in meeting their needs. However, two people who were nutritionally compromised did not have their diet monitored. We observed one of these people leave the dining table without finishing their meal and staff did not try to encourage them to eat more. Recommendations had been made for monitoring and a fortified diet by the dietician but staff seemed unaware of this. The registered manager told us that they had recently had training about supplementary foods for people who were nutritionally compromised. Allergies or particular dislikes were highlighted in the care plans to ensure that staff were aware of these. We observed people were offered drinks at various times during the day, however, drinks were not available for people to help themselves throughout the day.

We found that people who used the service had access to local healthcare services. For example, people were able to access the GP for regular check-ups. However, people did not always receive appropriate monitoring for their health needs. For example, the provider was not currently providing regular blood sugar checks for people with diabetes. The registered manager told us that they had been advised that they were unable to do these, however they did not liaise with community services colleagues to find a resolution to this. People were at risk of being unwell and staff not being aware of this.

A relative told us, "They always get the GP or nurse if [my relative] needs any medical attention…. And then inform us…... they are very good like that." The provider made referrals when required for advice and support for example, to the optician and specialist services such as the mental health services. We saw where people had physical health problems they had been referred in a timely manner to the GP and treatment provided.

We saw that staff always asked people if they wanted support and waited for their consent before providing it. Where people did not have the capacity to consent, the provider did not act in accordance with the Mental Capacity Act 2005 (MCA). The MCA protects people who might not be able to make informed decisions on their own about their care or treatment. Where it is judged that a person lacks capacity, a person making a decision on their behalf must do this in their best interests. Out of the care plans we looked at we found only one had a best interest decision recorded. We saw where other people had restrictions to their care to keep them safe but were unable to consent to these measures, there was no evidence of best interest decisions having been made. When we spoke with staff we found they were unclear about the Mental Capacity Act 2005 however, we observed that they gained consent from people before delivering care.

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of people using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are

Requires Improvement

Is the service effective?

trained to assess whether the restriction is needed. If the location is a care home, the Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find. At the time of our inspection there was no one subject to a DoLS.

Requires Improvement

Is the service caring?

Our findings

People who used the service and their families told us they were happy with the care and support they received. A relative said, "The staff are brilliant, they know everything about [my relative] (who has vascular dementia)… we can have anything we want… We have had Mother's Day here – Christmas Day is brilliant … one member of staff even brought [my relative] a McDonalds in the other day… in her own time as well!"

One person who had recently moved into The Limes for respite care said they had been made to feel very welcome, though wished there was someone they could communicate with more.

We saw that some staff interacted in a kind manner with people, for example, staff checked that people had finished their drinks before removing their cups and chatted with them about the morning. However, we also observed examples of care when interactions were poor. For example, at lunchtime a member of staff was supporting a person and did not interact with them at all whilst carrying out the care. We observed two other members of staff within the dining room area who did not interact with people during lunchtime.

Staff were able to tell us about people's needs and how they supported them to meet their needs. For example, people who required support with mobility and people who preferred to get up early in the morning. Staff usually provided support and assistance to people in a respectful manner. For example, asking people if they required assistance and sitting with people when they were providing assistance with their meal and drink. We observed that staff used equipment to support people to move safely and confidently. Staff explained to people what they were going to do and what they needed to do. For example, "Sit forward," "Can you lift your feet up?" However, we observed during this manoeuvre the staff were disturbed from their task by another member of staff to exchange in a conversation that was not relevant to the person being supported or involved them.

We observed an occasion when a member of staff supported a person to move inappropriately and did not walk with them at their pace but walked ahead of them at a quicker pace. The person was not supported and was at risk of falling as they could not keep up with the member of staff.

We also observed one occasion during our inspection when a member of staff spoke indiscreetly to people when they were asking them if they could assist them with their care. The member of staff spoke loudly to a person so that other people in the room overheard the question.

People told us that staff treated them well and respected their privacy. People told us and we observed that staff knocked on bedroom doors. Staff understood what privacy and dignity meant in relation to supporting people with personal care. People's bedrooms had been personalised with their belongings, to assist people to feel at home. The home was spacious and there were areas for people to spend time with their families if they wanted to, including the main lounges. All the rooms at the home were used as single rooms.

Requires Improvement

Is the service responsive?

Our findings

Relatives were encouraged to visit and support people. Relatives confirmed activities were available and told us, “Yesterday we had a 40`s Sing-a-long and everyone was waving flags,” and “Sometimes they have an evening bingo session.”

A member of staff told us that most of the activities were group activities rather than one to one. We did not see any evidence of people being encouraged to follow leisure pursuits on an individual basis. We observed an activity being carried out with people in the lounge during the morning and the afternoon. People were encouraged to engage in the activity and staff explained what they had to do. However, the morning activity was interrupted because the member of staff who was leading the activity had to leave to escort a person to a hospital appointment. Although another member of staff was asked to take over the lead of the activity, they kept being disturbed and asked to provide support to other people. Consequently the activity did not continue in a positive manner for people.

The registered manager told us that they had links with the church and groups in the local community. For example, a local RAF group had been involved in decorating one of the areas in the home and had involved people in this. They said that they were in the process of trying to raise funds for a mini bus so that they could take people out more often as locally transport links were poor which meant it was difficult to take people out for the day.

We looked at people’s care records for seven people who used the home service. We saw that care records had been reviewed and updated. However, we observed inconsistencies within the care plans. For example, a person’s assessment stated that they required liquidised food however their nutritional care plan stated that they required a soft diet. Another person who was immobile had a mobility care plan which stated that they were able to walk with support. There was a risk that people would receive care which did not meet their needs as care plans had not been updated to reflect their needs.

People told us that they knew what was in their care plan. People and relatives told us that they had been involved in developing and reviewing their care plan. We saw in the records that people’s preferences were recorded, for example, one record said, “Please ask me when I would like to get up in the morning.” Care records included consent forms for issues such as photography and had been signed by people on admission. We observed people had limited choices with regard to the care they received for example people told us that they couldn't have a bath when they chose but they had one when they were told. Similarly people told us that they were not offered a choice of drink during the day or at mealtimes. One person said, “No I don’t think we are involved in choosing the menus." someone else must do that… we just get presented with the meal.” The registered manager told us that the issue of choices at mealtimes had been discussed at a residents meeting to identify people's preferences.

The complaints procedure was on display in the home. Relatives told us that they would know how to complain if they needed to as they had previously received information about how to complain and would be happy to raise issues with the staff and registered manager. We saw that a log was maintained of complaints and complaints had been managed according to the policy and procedure. There was currently one ongoing complaint which was being dealt with.

Requires Improvement

Is the service well-led?

Our findings

The registered manager told us that they had an audit programme in place. However the processes which were in place did not operate in an effective way which improved the quality of the service for people. For example, the falls audits were not used to reduce the number of falls which occurred. Similarly the medicines audit did not identify the frequent use of refusal in the medicine records.

The provider was in the process of introducing a new care record format. Checks had been carried out on some of the records that we looked at to ensure that all the relevant information was included. However, we found that although the records were complete and audits were carried out the findings did not reflect the issues which we found on the day of our inspection. Care records had not been consistently updated and people were at risk of receiving inappropriate care.

When we walked around the home we observed that there were areas which required refurbishment and presented a risk to people. For example, we saw in the bathroom area the floor was stained and paintwork was peeling, this would make it difficult to clean to prevent cross infection. Plasterwork was exposed in a bedroom area and revealed holes in the walls there was also mould around the window frame. We spoke with the registered manager about this who told us they did not have a refurbishment plan but that refurbishment was on-going. There was no record of the risk to people and the actions required to address these in a timely manner.

There was a breach of regulation 17(1) (2) (a) (b) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Systems were not in place to assess, monitor and improve the service to people.

The relatives told us that they felt they knew the manager very well, one relative said, “We would always go to the manager and she would sort things if we had a problem.” Another relative told us about a problem they had had with their family member’s bedroom environment and explained that the manager had resolved it promptly.

The relatives we spoke with told us that they would be happy to raise any concerns they had. They said that they would go to the registered manager and were confident that they would sort it out quickly. The registered manager told us that a survey had been carried out in January 2015 however, they had only received one response to this which was positive. They said that they were looking at developing a survey for people who used the home service. Meetings had been held with people who used the service and their relatives to discuss changes and issues within the service. The registered manager told us that they had arranged to frequency of meetings according to people’s request. The last meeting was held in November 2014. The home also provided a newsletter from people, relatives and visitors to keep people informed of what was happening in the home.

Staff said there were good communication arrangements in place which supported them in their role. Staff told us that they would feel comfortable raising issues. They said that they were aware of their roles and who to go to for assistance and support. One member of staff told us that the registered manager was ‘very’ approachable to both staff and people who lived at the home. A staff member told us that they had staff meetings.

We observed that the registered manager had a good knowledge of the people who used the service. We saw that people appeared very comfortable and relaxed with the registered manager. Throughout our inspection we observed the registered manager interacted with staff, relatives and people who lived at the home.

The service had a whistleblowing policy and contact numbers to report issues were displayed in communal areas. Staff told us they were confident about raising concerns about any poor practices witnessed. They told us they felt able to raise concerns and issues with the registered manager.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was a breach of regulation 12(1) (2) (B) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not provided in a manner which mitigated risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was a breach of regulation 12(1) (2) (g) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Medicines were not administered safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was a breach of regulation 17(1) (2) (a) (b) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Systems were not in place to assess, monitor and improve the service to people.