Anchor Trust

Limegrove

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Limegrove provides care and accommodation for a maximum of 55 older people, some who may be living with dementia and or have physical health needs. The accommodation for people is provided in five units and spread across three floors. At the time of this inspection there were 51 people living at the home.

This was an unannounced inspection which took place on 22 March 2016.

During our inspection the registered manager was present. 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.

Safe medicines management procedures were not always followed by staff. Although risk assessments were in place for people, those suffering from particular medical conditions did not have risk assessments in relation to this. Care records held for people were not always completed fully and did not reflect their current level of needs.

Although staff knew people well and were able to describe to us people's individual characteristics and routines, they did not always treat people in a thoughtful way. People may not always receive responsive care because staff did not always follow guidance included in care plans.

Although staff understood the Mental Capacity Act they had not always completed mental capacity assessments with people before making decisions on their behalf. However, where people did not have the capacity and were being restricted, staff had followed the legal requirements in relation to this.

People were cared for by a sufficient number of staff which meant they did not have to wait to be assisted. Staff understood their responsibility in relation to safeguarding people from abuse. When people had an accident this was recorded and accidents and incidents monitored to help prevent reoccurrence.

Staff had guidelines in place to help ensure people's care and treatment continued with the least interruption possible, should the home have to be evacuated or an emergency stopped the service running.

Recruitment checks were completed to ensure permanent staff were safe and skilled to support people. Staff received an induction and on-going training to help ensure they were competent in their role. Staff supervision and appraisal took place in order to provide support to staff and they worked to best practice guidelines.

People had access to a range of meals as well as snacks throughout the day. People's health was monitored and staff referred people to external health care professionals when needed.

People's privacy was respected by staff and staff welcomed relatives into the home. There was a range of activities available to people which we observed people taking part in.

People were made aware of how to make a complaint should they feel the need to. People and their representatives were encouraged to give their feedback and feel involved in the running of the home.

Quality assurance checks were carried out in order to improve the service and actions identified were addressed by staff. Staff felt supported by the registered manager and were included in the running of the home through regular staff meetings.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Safe medicines management procedures were not always followed by staff and people may not always have received the medicinal creams they required.

Risks had been identified for people in most cases, however risks for people with particular medical conditions had not been considered.

There were enough staff on duty to support people and to meet their needs.

Staff employed by the provider underwent recruitment checks to make sure that they were suitable before they started work.

Staff understood the importance of protecting people from harm and abuse. Accidents and incidents were recorded and monitored and there was a contingency plan in place should the home need to be evacuated.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Although staff had a good understanding of the Mental Capacity Act, assessments in relation to people's capacity had not always been completed.

The registered manager was following the requirements of the Deprivation of Liberty Safeguards.

Staff were sufficiently skilled and experienced to care and support people to have a good quality of life.

People were supported to eat a variety of foods and could choose where they wished to eat their meals.

People's health and care needs were managed effectively and staff referred people to external health care professionals when appropriate.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated thoughtfully by staff.

People's privacy was respected by staff and they were cared for by staff who knew them as individuals.

Relatives were welcomed into the home.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were assessed however care and treatment may not be provided in response to their individual needs and preferences.

An activity programme was in place and we saw people participate in activities taking place.

There was a complaints procedure in place and complaints received by the registered manager were dealt with promptly.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Contemporaneous records were not always completed by staff in relation to people's care.

Quality monitoring systems were being used to monitor the quality of service people received.

People were involved in the running of the home and comments from them was used to drive improvement.

People and their representatives were encouraged to give their feedback.

Staff felt supported by the registered manager.

Limegrove

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 22 March 2016 and was unannounced. The inspection team consisted of three 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.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The completed PIR was not available to us prior to the inspection as we had brought the inspection date forward.

We checked information that we held about the home and the provider before the inspection. This included information from other agencies and statutory notifications sent to us by the provider about incidents and events that had occurred at the home. A notification is information about important events which the provider is required to tell us about by law. We used all of this information to decide which areas to focus on during our inspection.

During the inspection we spoke with nine people and two relatives. We also spoke with five staff, the registered manager and the provider's area manager. Prior to the inspection we made contact with three external health and social care professionals, who agreed for their views to be included in this report.

Some people at the home were living with dementia and we were unable to hold detailed conversations with them. Therefore, we spent time observing the care and support that people received in the lounges and communal areas of the home during the morning, at lunchtime and during the afternoon. We also observed part of the medicines round that was being completed.

We reviewed a range of records about people's care and how the home was managed. These included eight

people's care and medicine records, staff training, employment records, quality assurance audits, minutes of meetings with people and staff, menus, policies and procedures and accident and incident reports.

Limegrove was last inspected on 31 January 2014 when we found nothing of concern.

Requires Improvement

Is the service safe?

Our findings

People said that they felt safe and would talk to the manager if they had any concerns. We observed people appeared happy and at ease in the presence of staff. One person told us, "There is no question about it (that I feel safe)." Another person said, "I don't feel like I have a care in the world. I am a worrier and lived alone and that is why I came here." A third person commented, "Safe as houses I must say." A relative told us, "I feel she is safe because there is always someone (staff) around."

Good medicines management procedures were not always followed at Limegrove. We identified some poor medicines practices with one member of staff. For example, we saw the member of staff use a dessert spoon to dispense a liquid medicine to one person. The quantity held in the desert spoon was not in line with the instructions on the bottle and we had to stop this member of staff dispensing a second spoonful as this would have exceeded the correct dosage. This same member of staff left the medicines trolley open and unattended for several minutes which meant people may be able to access medicines not meant for them. Other staff followed good medicines management procedures therefore we were confident people received their medicines appropriately and safely by staff. At the end of our inspection the registered manager told us they had taken action to ensure the member of staff did not administer medicines until they had undergone re-training and competency assessments.

Where medicines had been prescribed on PRN 'as needed' basis people had PRN protocols in place. This contained information about each medicine prescribed, the reason for administration and the maximum dose allowed. However, PRN protocols were not consistently completed for people. For example, in the case of one person who had a PRN regularly throughout the day.

In addition records for people who required topical medicines (creams) were not completed fully by staff which meant it was not clear whether people had received the creams as prescribed. For example, one person required a gel to be applied three times a day to relieve pain, however on four occasions it was only applied once and on three occasions not at all. Other topical creams records stated, 'none available' or, 'finished bottle, not another in stock at the moment' which indicated some people had not received their creams for several days. The registered manager was unable to confirm with us whether or not this was a records issue or staff were not following prescribed instructions for people.

The lack of proper medicines management procedures was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicine administration records (MAR) contained people's photographs for staff identification as well as details of any allergies they had. Staff did not sign people's MAR charts until they were confident people had taken their medicines and we heard staff explain to people what their medicines were. There were no gaps in the MAR charts, which were clear and legible. Medicines were labelled with directions for use and contained both the expiry date and the date of opening. Medicines were safely stored in lockable cabinets and reconciliation of tablets as well as a record of returned/spoiled or destroyed medicines took place to ensure all medicines were accounted for. On the whole people told us they received their medicines on time

and staff knew which medicines they should be taking. One person who self-medicated told us, "They (staff) check my medication records that I keep."

In the main, potential risks to people were assessed and information was available for staff which helped keep people safe. This included assessments in relation to falls, pressure areas, malnutrition and moving and handling. One person who smoked had a risk assessment in place for this with guidance for staff which we saw staff followed. Other people had risk assessments in relation to diabetes and particular medicines. However, we did note that for one person the symptom's that related to a medical condition had not been considered and another person who was susceptible to pressure wounds had no risk assessment in relation to this.

It is recommended that the registered provider reviews its risk management systems in order that they ensure risk assessments relation to all aspects of a person's care is considered.

Recruitment checks were completed to ensure permanent staff were safe to support people. Permanent staff files confirmed that checks had been undertaken with regard to criminal records, obtaining references and proof of ID. They also included checks on staff's eligibility to work in the United Kingdom.

We asked people and their relatives if they felt there were enough staff. People told us on the whole that there were enough staff on duty to support them at the times they wanted or needed. We were told, "Yes, I should say so" and, "Yes, I think so." We observed this on the day of our inspection when we found sufficient staff on duty and that people received assistance and support when they needed it. We did observe a time when one person had to wait for a member of staff to assist them, however the staff member ensured the person knew they were waiting and assisted them as soon as they had finished what they were doing. Staff did not appear to be rushed or too busy to sit down with people and spend time talking with them.

The registered manager used a dependency tool to decide staffing levels. This considered people's individual needs and the layout of the building. The registered manager told us that staffing levels were reviewed regularly or if there were changes in a person's needs. She said they had recently increased from one care staff to two on each unit which had resulted in an increase in the use of agency staff throughout the home. However, the registered manager said she used regular agency staff who had got to know people well and we found this on the day. The registered manager said they encouraged permanent staff to treat agency staff as, "Their own" and they ensured they had, "Baseline" training and were invited to attend staff meetings.

Staffing levels consisted of two care staff in each unit, two team leaders who covered all units and one care manager. In addition to this, separate cleaning, kitchen and activity staff were allocated to undertake specific duties. Staff said that staffing levels were sufficient to provide safe care. One staff member said, "It's much better now we have two staff on each unit." Another member of staff told us, "It is much better for people being cared for as they are no longer unsupervised for any significant period of time." A relative told us, "There are enough staff. I never have to look for them."

Accidents and incidents that people had were managed appropriately. When incident and accidents occurred records evidenced that action was taken to minimise the chance of a re-occurrence. For example, one person had begun to fall on a regular basis. Staff had provided this person with a sensor mat to alert staff if they got out of bed during the night and had made a referral to the falls team (support team who give advice to help prevent further falls). In addition, a multi-disciplinary meeting had been convened to discuss other ways in which they could reduce this person's risk of falling. Where people had experienced a fall, there was a post-fall record in place. Staff understood risk management and keeping people safe whilst not

restricting freedom. Staff told us they could not stop people from moving around the home as this was their right, but they would always try to ensure that they used the correct equipment to support them to do so. For example, a walking aid.

Systems and processes were in place to safeguard people from harm. Staff had undertaken adult safeguarding training. They were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local authority safeguarding team should be made in line with the provider's policy. Staff told us the registered manager had an, 'open door' policy and that they felt able to share any concerns they may have in confidence. Staff told us people were vulnerable because of, "Their dependency on others, difficulty with communicating and general levels of frailty."

In the event of an emergency people's care would continue with the least disruption possible. Staff had access to a contingency plan which gave guidance and information should the home need to be evacuated or closed temporarily. Staff had undergone fire safety training which meant they would know what to do in the event of a fire. Each person had a personal evacuation plan which gave information to staff on how they should be evacuated from the building in the safest way possible.

Requires Improvement

Is the service effective?

Our findings

Staff had a good understanding of the Mental Capacity Act 2005 (MCA) but they did not always follow the full legal procedures in relation to it. The 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. Mental capacity assessments were completed in some cases and their capacity to make decisions had been assumed by staff unless there was an assessment to show otherwise, however we found inconsistency in whether people had been assessed under the MCA.

We discussed the MCA with the registered manager and Anchor area manager's at the end of our inspection. They explained there had been conflicting guidance and information circulating in relation to the MCA which had meant registered manager's in all of their homes had followed different processes. An Anchor wide initiative was taking place to address this shortfall and area managers were working with registered managers to ensure the necessary processes were followed and paperwork completed.

We recommend the registered provider reviews and implements the MCA code of practice to ensure legal requirements are followed.

Where people had capacity we saw in some care plans they had signed to consent to their care. People's PRN records stated whether or not a person had the capacity to decide when they needed their PRN medicine.

The registered manager was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). 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. The application procedures for this in care homes are called DoLS. The registered manager understood when an application should be made and how to submit one. Applications had been made for people who lived at the home as coded locks were in place and some people did not have the capacity to consent to their use. We read evidence that a relative had been involved in a best interest decision in relation to their family member who wished to leave the home, but it was unsafe for them to do so unaccompanied. A DoLS application had been submitted in this case. Another relative told us they had been invited to a best interest meeting in relation to their family member and an incident in the home.

People said that they were happy with the medical care and attention they received and we found that people's health and care needs were managed effectively. One person told us, "I had a pain in my knee but I couldn't wait for the doctor who is here twice a week, so I told a member of the team who contacted the doctor." They added, "I was visiting some friends across the road and they talked about not being able to get doctor's appointments and I thought how lucky I was." A relative said, "Staff will make a referral to the GP is needed." We noted staff had identified one person had become disorientated and had called in the GP who diagnosed an infection. Another person's medical condition and treatment was kept under review by the GP

and routine blood tests were arranged by staff.

Staff involved a range of external health and social care professionals in the care of people. These included a physiotherapist, diabetic nurse, district nurse and GP. A health care professional told us they felt people's care was well managed by staff.

We asked people if they liked the food. One person told us, "Yes, most of the time. There is a menu and I have a choice and I get that. We get a choice of fresh fruit." Another person said, "Yes, very much so. I get the opportunity to eat fresh fruit daily. It is all there for the taking." A third person said, "Yes, the food is very good." A relative told us their family member was putting on weight and they had, "No problem with the food."

People were provided with a wide range of foods. Staff had introduced 'nutrition' stations and trolleys for people which meant people could have a variety of snacks, fruits and drinks. Catering staff gave clear instructions to care staff as to the length of time it was safe to offer certain snacks before they should be disposed of. One person told us they really enjoyed this and it made a, "Change from always having a biscuit." Another person told us as they sat around a lot they did not want to eat too much and had asked staff to put their meals on a small plate which staff did not them.

There were separate dining rooms in each of the units of the home which helped promote a cosy dining experience for people. We observed that some people choose to eat in the dining rooms and others in their rooms. The meals in general looked appetising and pureed food was well-presented. There was a choice of two meals and we saw people who did not wish either meal were provided with a meal of their choice. Staff told us if people wished to eat outside of mealtimes there were always snacks available.

People's dietary requirements were identified. Staff had a list which they referred to for people's dietary needs. This gave information on who required a pureed meal or who was diabetic, for example. Where people were taking a particular medicine it was clear to staff which foods people should avoid. People were weighed regularly to help ensure they were not at risk of malnutrition which may in turn affect their health.

Staff were skilled and experienced to care and support people appropriately. New staff told us they completed an induction programme at the start of their employment. This included shadowing more experienced staff. They said the provider's mandatory training they undertook was good and helped ensure they felt competent in their role. One member of staff told us the induction had provided them with, "Good information about safe systems of work" and had, "Enabled them to fulfil their role safely and effectively."

Staff were trained in areas that included fire safety, first aid, food hygiene, infection control, moving and handling, safeguarding and health and safety. A training programme was in place that included courses that were relevant to the needs of people who lived at Limegrove. For example, dementia care.

Staff received support to understand their roles and responsibilities through supervision and an annual appraisal. Supervision consisted of individual one to one sessions and group staff meetings. Staff confirmed they had regular supervision.

Requires Improvement

Is the service caring?

Our findings

People said they were happy with the care they received. One person said, "I really quite like it here. I can't think of anything that would make it better." Another person told us, "The staff are all quite pleasant." A third person commented, "Oh my goodness yes, I have not had anyone who is not kind. When I first came here I found the dining room depressing and staff asked me if I wanted to eat in my room. I found that so kind." A fourth person said, "A few staff here are exceptional." A relative told us, "She is always happy, relaxed and content. Everyone is lovely."

However we found people sometimes received a lack of thought from staff. For example, one staff member gave some tea and biscuits to one person mashed up in a bowl. We saw them put a spoon of this into the person's mouth without first explaining what it was they were giving them. Another person asked staff to support them to go outside to have a cigarette. We heard the staff member say, "But you've just had a cigarette." When the person became agitated the staff just walked away. During the afternoon we were aware of one person getting upset. We alerted staff to the person who was in distress. Although they attended to them immediately they did not show much compassion to the person but just told them, "I will get a team leader for you." The team leader did come and assist this person in an extremely kind way.

Although the registered manager had introduced a 'show plate' system (where staff showed people two meals) during lunch time we did not see all staff follow this. For example, on one unit we observed people being given lunch without being offered a choice. We also saw a staff member stand over two people individually and put a spoonful of food into their mouths to encourage them to start eating themselves. They did this without telling the person what they were doing or taking the time to sit at their level. At lunchtime some glasses fell on to the dining room floor and smashed. Although staff very quickly swept this up, they did not check whether or not a person sitting nearby was okay, despite glass spreading out under their table. Instead we watch staff pull the person out in their chair sweep under the table and push them back in without speaking to them.

The homes aims philosophy of care included, 'Make a difference' which reminded staff of the need to, 'give a running commentary and when giving someone with dementia something – name it'. We did not see staff always follow this. At lunchtime staff did not always tell people what the food was and we saw staff put food into people's mouths without explaining what was on the spoon. We observed staff transfer one person from a chair to their wheelchair. This was done competently and efficiently by staff, however they did not talk to the person or explain what they were doing. Some care records written by staff included, 'was roaming around the units as usual' or, 'very disagreeing mood'. In addition we heard staff talk about people in front of them and we noted one person had expressed a desire to go swimming but no action had been taken to enable this to happen.

The lack of respect shown to people was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see some lovely examples of kind and attentive care from staff. One member of staff sat with a

person who could not communicate stroking their hand so they had contact. Another member of staff showed real compassion to a person who became upset. They listened to them attentively and comforted and reassured them. When the person said they were being a "Nuisance" the member of staff responded saying, "Not at all, you are no trouble at all." We watched how this member of staff requested a member of care staff to sit and talk to them over a cup of tea. Another member of staff had a kind and supportive word for each person as they showed us around the home.

People were cared for by staff who knew them and treated them as individuals. One staff member described to us people's individual characteristics and their preferred daily routines. For example, how some people preferred to stay in bed longer in the morning because they did not sleep well during the night. Staff were able to tell us which people liked to join in on activities and which preferred their own company. One person said, "They very much treat you as an individual."

The atmosphere in the home was peaceful and relaxed and staff understood the importance of respecting people's privacy and allowing them their independence. Staff knocked on people's doors before they entered and called out as they went into the room so the person would know who it was. For example, we heard staff say, "Hello, it's only me." One person said, "They always knock on my door before coming in." They added, "I am lucky that I don't need much help, but I know that is there if I need it. They (staff) help me with a bath, but otherwise I can do everything myself."

Relatives were made to feel welcome in the home and people were encouraged to keep in touch with those who were important to them. One person said they had regular contact with their family. One relative said, "The staff know me and I know them." Another relative told us, "They make me and my brother feel very welcome. Nice atmosphere to walk in to." We heard staff offer relative's refreshments when they came into the home and it was evident staff knew relatives well.

Requires Improvement

Is the service responsive?

Our findings

People may not always receive responsive care. For example, one person's care plan stated, 'needs to be encouraged to take fluids' but staff had not put in place a chart to show how much or little the person was drinking. This needed to be assessed as if they did not drink enough it may lead to them becoming dehydrated. Another person (who had lost weight) had, 'offer food supplement between meals' written in their care plan but staff had not introduced a food diary to monitor what they ate. A third person required their legs to be elevated upon instruction from the GP, however we did not see staff do this. A further person suffered from anxiety and although there was reference to this in their care plan there was no guidance to staff on how they might support this person to reduce their anxiety beyond being, 'left alone in their room', 'supported by familiar staff' and 'monitoring their mood'.

Staff did not always respond to people in a way people required. For example, one person walked around a lot and tried to access the garden on several occasions. We saw staff ignore this person several times and on one occasion a member of staff, who was sitting in the garden, redirected the person back indoors rather than encouraging them to sit in the garden in the sun. The person seemed agitated and annoyed and at times raised their voice to staff because they were not receiving the response they were looking for from staff. We looked at this person's care plan which recorded they used to be a hairdresser and loved the garden and gardening. Staff had not taken the time to consider ways in which to meet this person's needs. For example they could have arranged for them to 'help' out in the in-house hairdressing salon, or access the garden as and when they wished. This person's care plan stated, 'divert attention – have a cup of tea with her' and 'spend time doing activities'. We did not see this happen. Suitable intervention from staff may have reduced this person's anxiety. Another person had slept in their chair for four days, rather than their bed, but staff had taken no action in relation to this.

The lack of person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records contained information about people's care needs. For example, in the management of specific medical conditions. Care plans also contained information about personal histories and likes and dislikes. People's choices and preferences were documented. For example, what clothes a person liked to wear on a daily basis and how often they would like a shower or a bath. The daily records showed that these were taken into account when people received care.

People knew about their care plans. One person told us they had one written when they, "First came here. They now update it once a year." Relatives told us they were involved in the review of their family member's care plan. There was evidenced in care plans that they were regularly reviewed by staff and relatives were involved.

People gave us positive feedback about the activities. One person told us, We have a team of activities (people). One is very good and one keeps our memories going. I like the gentle physical exercises." A second person said, "Activities. They are very good. Physical first then on to quizzes. There is bingo, poetry and

listening to music. We also have reminiscence time. This is very good." A relative told us, "There is a quiz every week and one person living in the home plays the accordion entertaining others with this." Links to a local church had been established and a clergyman visited the home twice a month. Another relative told us staff took their family member to the church across the road as they used to sing in the church choir. They added, "Mum is involved in the activities and enjoys her outings."

Information about forthcoming activities was available to people and staff prompted and reminded people when an activity was about to take place. Organised activities took place in different areas of the home in order to help ensure as many people as possible could access them. There were routine bus trips to areas of interest local to the home as well as regular quizzes, music, arts and crafts and reminiscence events. Several people together with relatives attended an exercise game, followed by a quiz during the morning. Staff made refreshments for people and there was a good atmosphere throughout the whole period. People were laughing and making conversation with each other.

Although activities were available for people they were not based on any demonstrable research in relation to people who may be living with dementia. The activities coordinators told us that work was being completed to analyse the uptake of activities with the aim of reviewing the activities on offer.

Information on what to do in the event of needing to make a complaint was displayed in the home. The complaints procedure included the contact details of other agencies that people could talk to if they had a concern. A record was in place of complaints received and the registered manager had introduced a complaints log that included a record of actions taken to investigate the complaint and outcome. The records demonstrated that when issues were raised prompt action had been taken to resolve these. For example, there was a complaint about the shabbiness of the décor in the home and the registered manager had responded to inform this person of the impending redecoration. One person said, "I would go to the team leader or the manager if I ever wanted a word." A second person told us, "If I am not happy about something I complain." A relative told us, "I would not hesitate to speak to staff if I had a problem and I know they would listen." Another relative said, "They do seem to care and have the mechanisms to put things in place."

Requires Improvement

Is the service well-led?

Our findings

Care records were not always up to date. For example, one person's care plan stated their pressure mattress had been removed on the advice of the district nurse and at the person's request. However, in two other parts of their care plan it was written, 'pressure relieving overlay mattress provided by the district nurse in place'. This same person required three-monthly injections but the records appeared these were last administered in September 2015. We spoke with a team leader about this who confirmed the injections had been given December 2015, but the care plan was not up to date. Other care records had topical creams charts but these did not always contain all the necessary information for staff. For example, one chart said, 'apply on both legs and both arms' however it did not state the frequency the cream should be applied. Another person's chart said, 'apply all over body' but again it did not state how often this should be done. One person's care plan stated, 'I am able to stand safely and move from sitting to standing independently' however, we saw this person being assisted by staff each time they wished to stand up.

Although we could see that people were referred to health care professionals when appropriate, staff did not always record the outcome. For example, one person was referred to the falls team in February 2016, but no further information was recorded on the outcome of this referral. Another person had a mental health review in early March 2016 but there was nothing further about this. The registered manager told us they had identified a need for all care records to be reviewed.

The lack of contemporaneous care records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had completed a range of quality assurance audits to help ensure standards were maintained and legislation complied with. These included audits of medicines, accidents and incidents, health and safety and infection control. Actions identified during these audits were completed by staff. For example, a bath in one unit was out of order and we saw this was being replaced. Other quality assurance audits included a local authority quality visits and provider quality assurance visits.

The registered manager held meetings with people in order that their views could be used to drive improvements at the home. We saw some comments from people displayed in the communal areas. These included, 'not enough staff', 'not enough activities' and 'poor food'. The registered manager had responded to these by increasing the staffing levels across the home, recruiting additional activities' personnel and (with the support and involvement of the chef) reviewing the weekly menus. On the whole people told us they knew who the registered manager was. One person said, "She is a lovely lady. She will talk to you anytime." Another told us, "She is very, very good, very approachable. You can knock on her door anytime." A third person said, "Yes, she does come round and speak to us."

Annual surveys were carried out to obtain people and relative's feedback. We looked at the most recent responses which showed of the 44 people who had completed the survey 93% of people were, 'happy overall with the care provided in Limegrove. Relative's feedback showed a similar response. For example, 95% of the 21 relatives who took part felt staff, 'showed kindness to their family member'.

Staff were involved in the running of the home. Various departmental meetings were held which included catering staff, care staff, night staff, team leaders and housekeepers. Minutes showed that a wide range of topics were discussed from people's individual needs to changing procedures in relation to the laundry.

Staff felt supported. One member of staff said, "The manager is very supportive. I can always knock on her door, even if it's closed and I am never made to feel stupid asking for help." Another member of staff told us, "I feel supported by the manager and the team leaders." A third member of staff said, "It's a lovely place to work."

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 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 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not ensured people received person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had not ensured staff always treated people with respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured safe medicines management procedures were always followed by staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured contemporaneous records were held by staff.