Mrs Zeenat Nanji & Mr Salim Nanji

Lime Tree House Residential Home

Inspection report

Lewes Road
Ringmer
Lewes
East Sussex
BN8 5ES

Tel: 01273813755
Website: www.southcarehomes.com

Date of inspection visit:
17 October 2016

Date of publication:
23 November 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Lime Tree House Residential Home on the 17 October 2016 and the inspection was unannounced. Lime Tree House provides accommodation for up to 30 older people. On the day of our inspection there were 28 people living at the home. Lime Tree House is a residential care home that provides support for older people. Some people had illnesses or disabilities associated with old age such as limited mobility, physical frailty or lived with health problems such as heart disease, diabetes and strokes. Some people lived with dementia and sensory impairment. Accommodation was arranged over two floors with stairs and a lift connecting each level.

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.

The provider's quality assurance framework was not consistently effective or robust. Shortfalls and omissions in documentation were evident. Risks associated with the environment had been identified but not acted upon, placing people at risk of falling.

People commented they felt safe living at Lime Tree House. People commented positively about the care, treatment and support received. One person said, "Yes, I have a safe room and the corridors are excellent." A range of risk assessments were in place, however, the risk management of skin breakdown was not robust. We have made a recommendation about risk assessments.

Staff demonstrated good knowledge and understanding of the Mental Capacity Act (MCA 2005). One staff member told us, "We have to assume a person has capacity until proven otherwise. If a decision is made on their behalf it has to be in their best interest. People can make an unwise decision but it doesn't mean they lack capacity." However, mental capacity assessments were not completed in line with legal requirements. We have made a recommendation about the completion of mental capacity assessments.

Care and support was provided to people living with dementia, however, improvements were required to make the environment dementia friendly. We have made a recommendation about sourcing input from a national source on dementia friendly environments.

People we spoke with were complimentary about the caring nature of staff. People told us care staff were kind and compassionate. People were treated with respect when they received care. One person told us, "Staff are kind and caring at all times." Dignity champions were in post and the registered manager worked with Skills for Care to promote awareness and understanding of the importance of privacy and dignity.

Systems were in place for the safe storage, administration and disposal of medicines. Records showed people received their medicines as prescribed and in their preferred manner. People had access to

healthcare services to maintain good health.

People were protected from the risk of harm and abuse. Staff had received safeguarding adults training and were aware of their responsibility to report any concerns. Policies and procedures were in place to advice staff on what they should do if they had concerns. Safe recruitment practices were followed before new staff were employed to work with people.

People, staff and relatives were complimentary about the leadership and management of the home. A staff member told us, "I feel supported by the team I could go and ask any of the care workers or seniors or manager for help at any time. Everyone is so kind and supportive."

Positive relationships had been developed between people as well as between people and staff. There was a friendly, caring, warm and relaxed atmosphere within the home and people were encouraged to maintain relationships with family and friends. A wide range of activities were available for people to participate in. One person told us, "I love the activities, quizzes are my favourite, we have been to Middle Farm, I like animals."

People were supported to have sufficient to eat and drink. Where people required assistance this was done at a pace appropriate to them. Special dietary requirements were met, and people's weight was monitored, with action taken when required. People spoke highly of the food provided. One person told us, "Food has considerably improved, a new lovely chef who is very good and the other chef, plenty to eat and she comes round and makes her presence known every mealtime."

During our inspection we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered providers 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?

Good

Lime Tree House was safe.

There were enough staff to provide care and support to people in line with their assessed needs and wishes. Recruitment records demonstrated there were systems in place to ensure staff were suitable to work within the care sector.

Medicines were managed safely. Storage and guidance about administration was robust and effective meaning people received the right amount of medication as prescribed.

Staff had a clear understanding of the procedures for safeguarding people and recognised the importance of positive risk taking.

Is the service effective?

Good

Lime Tree House was effective.

Staff received the training they needed to do their job, were well supported and had regular supervision.

People were supported to have a balanced diet and support to eat healthily. Where nutritional risks were identified, people received the necessary support.

People had good access to healthcare professionals for routine check-ups, or if they felt unwell. People's health was seen to improve as a result of the care and support they received.

Is the service caring?

Good

Lime Tree House was caring.

People and visitors were positive about the care received. This was supported by our observations.

People had high praise for staff and spoke of staff's caring nature. Dignity champions were in place and staff understood the importance of respecting people's privacy.

People were supported in a stable and caring environment. The staff promoted an atmosphere which was kind and friendly.

Is the service responsive?

Good

Lime Tree House was responsive.

People had access to a wide range of meaningful activities which were tailored to individual needs. The importance of music and promoting people's well-being was embedded into practice.

People were aware of how to make a complaint and people felt that they had their views listened to and responded to.

People were able to make individual and everyday choices and we saw staff supporting people to do this.

Is the service well-led?

Requires Improvement

Lime Tree House was not consistently well-led.

Quality monitoring systems and procedures did not always establish best practice or identify all areas for improvement.

Staff, people and relatives spoke positively of the registered manager's management approach and availability. People were able to comment on the service provided to influence service delivery.

Links with the local community had been established and the home organised events which were accessible to members of the public.

Lime Tree House Residential 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.

The inspection took place on the 17 October 2016 and was unannounced. 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.

The provider had completed 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.

Before the inspection we checked the information that we held about the home and the provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with eight people, two visiting relatives, five care staff, a cook, an activities coordinator and the registered manager. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at six care plans and associated risk assessments, three staff files, medication administration record (MAR) sheets, incidents and accidents, policies and procedures other records relating to the management of the service. We also 'pathway tracked' people living at the home. This is when we followed

the care and support a person's received and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We lasted inspected Lime Tree House on the 4 September 2013 where we had no concerns.

Good

Is the service safe?

Our findings

People appeared relaxed and comfortable within a calm and friendly environment at Lime Tree House. People and visiting relatives confirmed they felt safe living at the home. One person told us, "Yes I do (feel safe), I can walk well with the rail in the corridors, and the safety is very good here." A visiting relative told us, "I'm not worried about her safety, we know she is safe, warm and cared for, her room is spotless with adequate furniture but not too much to make it unsafe, it is always clean and tidy."

People were protected from individual risks in a supportive way which promoted their choice and independence. A wide range of risk assessments were in place which covered areas such as mobility, falls, tissue viability and malnutrition. Risk assessments were based on nationally guidance and tools, such as the Health and Safety Executive (HSE). Where people required the assistance of two staff members to move and transfer along with a mobility aid (hoist), risk assessments considered the equipment required, handling constraints and other factors which may prevent a safe transfer. Some people were supported to undertake positive risks. A staff member told us, "There are residents that like to go out and walk around the garden. We encourage them to do as much as they can for themselves and with our support if they need it. They have good mobility and walk independently with a walking stick but there is still a risk of falls." We observed some people, who had been assessed as being at risk of falling, walking independently around the home using their mobility aids. To further mitigate the risk of harm, some people had crash mats in place which alerted staff when they suffered a fall.

Pressure relieving equipment was used as a preventative tool for people with reduced mobility and who were assessed as at risk. For example, pressure relieving mattresses were set according to people's individual weight to ensure the mattress provided the correct therapeutic support. When receiving care on an air mattress, it is important that the setting of the air mattress matches the person's weight. Otherwise, it may increase the risk of a person sustaining skin breakdown. Documentation confirmed the setting of the air mattresses was checked daily. Risk assessments were in place which assessed people's risk of skin breaking down (Waterlow score). However, where people were assessed at high risk of skin breakdown, this was not consistently reflected in their tissue viability care plan along with the steps required to mitigate the risk. For example, one person's Waterlow score was calculated as 19 (high risk of skin breakdown). However, this risk was not reflected in their tissue viability care plan along with the actions required to mitigate the risk. Staff were aware of the steps required to mitigate any potential harm, such as the application of barrier creams and monitoring the area at risk. Where people required regular re-positioning, the frequency of re-positioning was not documented in their care plan. Repositioning charts reflected they could go up to eight hours without being re-positioned. The registered manager told us, "During the day, when awake they can re-positon themselves, however, this should be reflected in their care plan." Staff confirmed that during the night they would reposition the person every four hours (documentation confirmed this) and during the day when asleep, they would support the person to re-position every three hours. However, this detail was not available in the person's care plan and associated risk assessment.

We recommend that the provider reviews their management of skin breakdown and associated risk assessments.

Staff recruitment practices were thorough; people were only supported by staff who had been checked to ensure they were safe and suitable to work with them. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). A DBS check helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care and support. All potential employees were interviewed by the registered manager to ensure they were suitable for the role. All new staff were required to undergo a probationary period during which they received regular opportunities for practice supervision.

People were supported to be safe, with systems in place to reduce the risk of harm and potential abuse. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Training records confirmed safeguarding training was up to date and relevant. Staff knew of the procedures they should follow if they suspected any abuse was taking place. One staff member told us, "We are here to protect vulnerable people from all types of abuse physical, emotional, financial, sexual. If I saw unexplained bruises I would record it in the notes and body map and report it to my senior and the manager. The manager would investigate into it and report it to social services and the CQC." They were also able to tell us who they could contact in the event they wished to report concerns outside of the home, such as the local authority or CQC. Safeguarding policies and procedures were in place and readily available for staff to access.

People's medicines were administered to them safely and as they required them. There were systems in place to ensure the safe storage and management of medicines with organisational medicine policies and procedures in place for staff to follow. People who wanted to administer their own medicines were able to do so once staff had assessed any risks associated with this. For example, one person staying at the home on respite wished to retain their independence with their medicine regime. A risk assessment was in place and staff supported the person to remain independent with the management of their medicines.

All medicines were stored in locked cupboards and within drug trollies with the keys held securely. Medicines were only administered by senior care staff who had completed additional training and competency checks. When administering medicines, staff followed best practice guidelines. For example medicines were administered individually with the Medication Administration Record (MAR) chart only being signed once the medicine had been administered. Staff ensured people had a drink and asked people what medicines they needed. Medicine profiles were in place along with medicine care plans. These considered the person's prescribed medicines, dosage and reason for administration. Guidance was in place to aid staff to monitor for any side effects. For example, one person was supported by the district nurses to have regular injections. Guidance included for staff to monitor for any unusual bruising or bleeding.

There were sufficient staff available on each shift to ensure people's needs were met safely and in a timely way. People, relatives and staff confirmed staffing levels were sufficient. One person told us, "You can usually find someone to help you, I think there are enough staff." Another person told us, "They are caring, considerate and helpful in every way, the staff couldn't be better. Always seem to be plenty about, if I press my buzzer they are here very quickly." The registered manager told us, "Staffing levels are based on the individual needs of people. From that assessment of their needs, I then determine the number of staff required." Staffing levels consisted of six staff throughout the day and two staff at night. Staff rota's confirmed this. Shift patterns were based on the individual preferences and needs of people. The registered manager told us, "I have a large number of residents that prefer to get up early, so some shifts start at 07.00am to facilitate that." Observations demonstrated that there were sufficient numbers of staff available to meet people's needs in a person-centred way.

Plans were in place to keep people safe in an emergency such as a fire. Each person had a personal evacuation plan to inform staff about what support they would need in the event of a fire. However, these did not consistently reflect the number of staff the person would require to aid a safe evacuation. We brought these concerns to the attention of the registered manager who took action immediately and started to review personal evacuation plans during the inspection.

Good

Is the service effective?

Our findings

People told us they received care and support which was effective and met their needs. One person told us, "Staff are excellent, nothing is too much trouble, they are caring and kind." Another person told us, "Staff are sensitive to our needs." A visiting relative told us, "The manager has an open door policy which is very good; all the staff understand my mother's needs."

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. Staff confirmed they had received training on the MCA 2005 and documentation confirmed this. Staff told us how they worked within the principles of the Act and gained consent from people before delivering any care. A staff member told us, "The MCA is there to protect people who may be unable to make decisions about their care and life choices. I always presume a person has capacity and just because they make a choice we don't agree with doesn't mean they don't have capacity. Any decisions made on their behalf has to be in their best interest and the least restrictive." Mental capacity assessments were in place for specific decisions such as; use of bed rails and medication. Although people's capacity was assessed, the provider was not following all the principles of the MCA 2005 Code of Practice. For example, documentation did not follow best practice guidelines. Mental capacity assessments did not explore whether the person had an impairment of the mind or brain; whether that impairment or disturbance meant they were unable to make a decision at that specific time and whether they could weigh up, retain, communicate or understand the information to make an informed decision.

We recommend that the provider implements the principles of the MCA 2005 Code of Practice.

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 application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS referrals had been made for five people living at Lime Tree House. The registered manager was awaiting further contact regarding the outcome and had been in touch with the Local Authority DoLS team to seek an update. On the day of the inspection, we identified a further person who was potentially deprived of their liberty. We brought these concerns to the attention of the registered manager who was responsive to our concerns and made a DoLS referral for the person during the inspection.

Systems were in place to ensure staff received the training and experience they required to carry out their roles. Upon commencing employment with the provider, new staff were subject to an induction programme. This included shadowing more senior staff before they could demonstrate their competence and work on their own. A staff member told us, "I shadowed for one week I was happy with that because I worked in caring before. The shadowing helped me to learn how to approach the people that live here and for them to get to know me." Staff had undertaken induction workbooks and the registered manager was aware of the

Care Certificate and explained that new staff were working towards this. The Care Certificate is a set of standards that social care and health workers should work in accordance with. It is the new minimum standards that should be covered as part of the induction training of new care workers. In addition to this staff that were new to working in the health and social care sector were able to shadow existing staff to enable them to become familiar with the home and people's needs as well as to have an awareness of the expectations of their role.

Staff told us they were well supported and had received the training they needed to be effective in their role. Training records demonstrated that staff received essential training in a wide range of areas such as first aid, moving and handling and safeguarding. Staff spoke highly of the training provided. The registered manager expressed a commitment to supporting staff to develop and obtain professional qualifications. They told us, "I have staff completing level 2, 3 and 5 diplomas in health and social care. I want my staff to be confident, competent and I want to support them." One staff member told us, "I am being supported by my registered manager to do the Level 5 in leadership and management. Whenever I need support I can ask and I get the time I need to study." Care staff received one to one supervision sessions on a regular basis to review their performance and development needs.

Effective management of people's healthcare needs means people can live long healthy, independent and fulfilling lives. Staff worked in partnership with external health care professionals to promote good outcomes for people. Input was sought from GPs, district nurses, dieticians and Speech and Language Therapists (SALT) and other healthcare professionals. A visiting chiropodist also visited the home on a regular basis. Each person had a multi-disciplinary record within their care plan which recorded an overview of the appointment and any outcomes. The registered manager told us, "We have a good working relationship with the local GPs. For example, we recently had one person with behaviours that presented as challenging, we worked with the GP to explore those behaviours and the person is much more settled now." During the inspection, one person told staff they felt unwell. Staff reacted promptly and supported the person to go to a quiet area of the home.

Care and support was provided to people living with a swallowing difficulty. For people assessed with swallowing difficulty, the use of thickened fluids when drinking is required to minimise the risk of choking. Thickened fluids are easier to swallow; however, the quantity and texture must be appropriate for the individual. Guidance was available which clearly documented the quantity of thickener people required compared to fluid. A staff member told us, "We have two people who are under SALT because they have problems with their swallowing. One person has to have fork mash-able and the other person has their food pre-mashed. They both have thickener in their drinks. We have to ensure all their meals follow the SALT guidelines." Nutritional care plans were in place which provided guidance on the steps required to mitigate the risk of malnutrition. Some people were assessed at risk of losing weight, so a fortified diet was required. Some people required a soft or pureed diet and we saw these were provided. Where people had lost weight, referrals had been made to appropriate healthcare professionals to ensure guidance was sought. Documentation confirmed people were maintaining a stable weight.

With permission, we joined people for their lunchtime meal. Tables were neatly decorated and laid and people were asked where they would like to sit. The menu was displayed on each table, acting as a visual prompt for people. On the day of the inspection, people had the options of vegetable pie or beef Rogan. People's independence with eating and drinking was promoted. For example, some people had plate guard which enabled them to eat independently. Where people requested small portion sizes, we observed those were provided. Some people requested alternative meals and we saw those requests were acted upon. For example, one person initially chose the beef Rogan but then decided they preferred the look of the vegetable pie. The atmosphere in the dining room was quiet but calm. People sat and chatted on their

individual tables. Where people required support to eat and drink, staff sat down at the table with them, providing support at their own pace. One person was observed having vegetable pie and chips for lunch. However, after a few mouthfuls of chips, they pushed their plate away. Staff asked if they had finished but didn't offer an alternative. The person subsequently asked for more chips, however, again, only ate a few mouthfuls. We spent time with this person and observed that unfortunately they only had a few teeth. We then queried whether they may have struggled with the texture and toughness of the vegetable pie because of this. We brought these concerns to the attention of the registered manager who confirmed they would explore whether soft diet would be beneficial.

Good

Is the service caring?

Our findings

The home had a relaxed atmosphere and people responded well to staff because they approached them in a kind and dignified way. People were consistently well cared for, supported and listened to and this had a positive effect on people's individual wellbeing. People and relatives spoke highly of the caring nature of staff. One person told us staff were "kind and caring at all times." A visiting relative told us, "Staff are kind, understanding and patient with her, when she gets agitated they calm her down."

The atmosphere in the home was calm and relaxed and staff spoke to people in a caring and respectful manner. Upon arrival to the home, people were relaxing in the lounge listening to old time music whilst having their morning cup of tea. The design and layout of the home meant people had access to various lounges, conservatories and quiet areas. Seating was available throughout the home so people could find company or solitude as desired. For example, a person and their relative spent the afternoon in a quiet lounge having a pot of tea and a good catch up. A staff photo board was on display which acted as a visual reminder for people as to who was working each day and what they looked like.

People's bedrooms were spacious, in good decorative order and had been personalised, for example with photographs, art and items of memorabilia. This helped to create a familiar, safe space for people. The registered manager told us, "We encourage people to bring items from home to help personalise their bedroom and make it feel more homely." One person told us how they were pleased to have their own chair, TV and photographs in their bedroom.

People were supported to be independent and make day to day decisions. We observed that people were offered choices. For example, where to sit, what to eat and what they would like to do. Staff worked in partnership with people to promote their independence. A staff member told us, "We support people to do as much for themselves as possible. So we may encourage people to wash their face and we'll help to wash their back and feet." Throughout the inspection, we observed that people spent the day as they wished. For example, one person preferred to sit in the quiet lounge watching television, another person spent time sitting in the entrance hall of the home, watching people come and go.

Staff were people focused and treated everyone with the same respect, kindness and compassion. Dignity was promoted for example, a visiting relative told us, "Her dignity is supported, they help her to get dressed with matching clothes and jewellery which is important to her." Dignity champions were in post. Led by the dignity in care campaign, dignity champions provides advice and guidance to other staff members on how to respect people's dignity and ensure the 10 dignity do's are upheld. Staff members understood the importance of upholding people's privacy and dignity. One staff member told us, "People get washed and dressed when they want to. People are offered the choice of a bath or a shower in the morning and they have a wash in the morning and evening if they want. I make sure people's curtains and doors are closed when helping them and they wear the clothes of their choice every day."

A dignity board was readily available within the home which included pictures of the dignity champions and guidance on the importance of dignity. The registered manager also worked in partnership with Skills for

Care on the promotion of dignity. A dignity toolkit had been sourced from Skills for Care and was on display providing guidance on the common core principles of dignity. Meetings from the staff meeting in August 2016 demonstrated that the tool kit had been discussed with staff along with the common principles. As part of the toolkit, staff had been completing the 'What random acts of kindness have you given to residents' board. Comments from staff included, 'I like to bring fresh flowers from my garden to give to the residents.'

People and their relatives had been included in the care planning process; this was evident from care records that were signed by individuals and /or family members to indicate their involvement. A visiting relative told us, "I get involved with her care plan and any concerns are always addressed." All staff spoke kindly about the people they cared for. They demonstrated a good understanding of the individual choices, wishes and support needs for people within their care. All were respectful of people's needs and described a sensitive and empathetic approach to their role. Staff told us they enjoyed their work because the atmosphere in the home was very caring. One staff member told us, "I love it here, very much so." Another staff member told us, "I enjoy working here because there is a god relationship between the staff. It is a good atmosphere and we work well together."

People's spiritual needs and beliefs were supported. One person was supported to attend church every Sunday and people felt their spiritual needs were met. A Baptist choir visited the home on a monthly basis and people spoke highly of the visiting choir. Every Thursday of the month, a local vicar visited the home which enabled people's spiritual and religious needs to be maintained.

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and they were always made to feel welcome. A relative told us, "All the staff seem very fond of the residents; I am always made welcome and offered a drink." During our inspection, one relative visited along with their dog. They spent time in the communal lounge with people and staff. People enjoyed the presence of the dog. The visiting relative took time to take the dog around to people, so people could stroke and pet the dog. People commented that they enjoyed having the dog come and visit.

Good

Is the service responsive?

Our findings

People were confident that the care they received was focussed on their individual need and reflected their choices and preferences. Everyone was treated as an individual and all support was personalised to their needs and wishes. One person told us, "Staff are very kind and caring, I have had no problems, I choose where I go, I am a bit of a loner." People told us they felt staff were responsive to their needs. One person told us, "The staff definitely know me and what I need."

People's needs were assessed prior to them entering the home and this information was used to develop care plans. Care plans covered a range of areas from communication; medication, mobility, personal care and continence. Care plans considered the assessed need, goal and action (steps required to be taken). One's person's continence care plan identified they were incontinent and wore incontinence pads for protection. The recorded goal was, 'to maintain current level of continence.' Required actions included one carer to assist or supervise with continence care.

Despite care plans being in place, we found care plans were not consistently personalised. Personalised care planning is at the heart of the health and social care. It refers to an approach aimed at enabling people to plan and formulate their own care plans and to get the services that they need. Personalised care plans consider the person's past, their life story, their wishes, goals, aspirations and what's important for them when receiving care. People's individual life histories were recorded in care plans. For example, one person worked for the British Government during the Second World War. However, information was not readily available on people's wishes, what was important to them and how they preferred to receive care. Information in care plans was functional and provided a list of tasks staff were required to do. For example, the personal hygiene for one person noted, 'Carer to ask consent before giving personal care and/or any activity. (Person) is unable to wash, bath or shower and dress without assistance. Needs two carers for bed bath. Needs carer to apply prescribed creams to moisture the skin.' Information was not available on what the person prefers to wear, if they enjoy a bed bath etc. From talking to staff, it was clear they had a firm awareness of people's likes, dislikes, preferences and understanding of what was important to people. One staff member told us, "One lady likes someone to sit and listen to her, to see a familiar face and to have a laugh and a joke. She had two Siamese cats and I use the picture she has of them to talk and reminisce with her." However, the knowledge held by staff was not reflected in people's individual care plans.

We recommend that the provider seeks guidance from a national source on the implementation of person-centred care plans.

People were engaged in activities that were meaningful to them. Considerable thought and energy created an environment that provided stimulation and interaction. People and staff spoke highly about the activities provided and opportunities for social engagement. One staff member told us, "The activities here are really good because people are getting more active. They can do what they used to do at home, their hobbies, interests and entertainment. One person likes scrabble so they use that. People also enjoy the singing because it reminds them of good times in the past. We have an entertainer that comes and dances with the residents." People spoke fondly of the activities, comments included "I love the activities, quizzes are my

favourite, we have been to Middle Farm, I like animals." A visiting relative told us, "Amazing choice of activities." Another relative told us, "The activities coordinator is very good, plays, pumpkin carving, flower arranging, sloe gin, music and exercise." The provider employed a dedicated activities coordinator who worked five days a week in the afternoons. A wide ranging activity timetable was available. The activity coordinator told us, "We have a range of activities, from music and movement, quizzes, pumpkin carving, arts and crafts. In the summer, we made bunting for our summer BBQ and the other day we made autumn decorations which are on display in the dining room. I try and get suggestions from people about what activities they want to do. One person suggested a choir, so we have now started the Lime Tree choir. Our aim is to perform for family members. We made sloe gin last month which people enjoyed. I try and ensure the activities are meaningful to people and based on what they want to do." On the day of the inspection, a game of snakes and ladders took place. Staff and the activity coordinator all participated and people enjoyed the competitive nature of the game.

The Department of Health states that music can be extremely beneficial for older people with dementia, improving such things as communication, memory, enjoyment of life and creative thinking. It also has a positive effective on physical wellbeing through taking part in singing and dancing. We found there was a firm focus on the importance of music and the arts at Lime Tree House. The activity coordinator told us, "I've been working with people to create their desert island disco. This is a playlist of music people have told me they would want to listen to if they were stuck on a desert island. I've slowly created this playlist and during activities we play the music. We also had a disco where we played everyone's desert island playlist and had a dance, sing along and reminiscence." Throughout the inspection, music was playing in the background. Staff and residents were heard singing along and staff danced with people.

A poem writing class had been established and people participated in reading and writing poems. One person had written their own poem which was proudly displayed on a notice board. During the inspection, a visiting relative provided us with a copy of a poem they had written about the home. Extracts from the poem included, 'In afternoon there's the activity coordinator, I challenge anyone not to smile, she engages the hearts and mind in the elderly, she goes that extra mile.'

Staff were mindful of people who chose not to go to the communal lounge and ensured that they were not isolated in their rooms. Every day, the activity coordinator visited people in their bedroom and had that important 1:1 time. One person told us, "I am a private person; I like to read my book in my room." Another person told us, "Activities, not if I can help it!" Staff respected people's choices and this was observed throughout the inspection.

The use of technology was integrated into providing meaningful activities and to reduce social isolation. The activity coordinator told us, "We've recently just purchased a tablet which has been really useful. I use it to engage with people and support people to remain in contact with their families. We send pictures and emails to relatives." One person told us how they used the tablet to play solitaire and to communicate with her son.

Staff interacted with people as they walked past, they used humour and, where it was appropriate, touch to engage with people. People responded to staff with smiles and chat and staff recognised the importance of supporting people to feel that they mattered. During the inspection, staff spent time with people in the communal lounge during the morning. Staff engaged with people and asked them about their Grandchildren whilst playing a game of ball. The environment was open and people were not restricted, if they wanted to be mobile and walk, they could do this safely both inside the home and in the garden. The home had an accessible secure garden area. Staff were responsive to people's individual needs. After lunch, one lady commented she felt cold. Staff immediately closed the window and fetched a long sleeved

cardigan for her.

There was a complaints procedure in place and people and their representatives told us they knew how to access and use this. People also told us they could bring up any concerns and issues at the residents meeting. People and relatives felt they would be listened to and would usually approach the registered manager directly as she was available and approachable.

Requires Improvement

Is the service well-led?

Our findings

People told us they were happy living at Lime Tree House and felt the home was well managed. People, relatives and staff spoke highly of the registered manager and their leadership style. One staff member told us, "The manager is approachable, her door is always open." One person told us, "The manager is great, very calm which filters down through the staff and whole home." Another person told us, "I like her very much, she is very helpful, very friendly soul, no concerns, I have been in other places but this is the best one by far."

Whilst all feedback about the management was very positive we found the leadership of the service was not effective in all areas. A governance framework was in place and the registered manager had access to range of tools to help them monitor, review and assess the quality of the service. These included; satisfaction surveys, medication audits, health and safety checks, pressure care audits and night spot checks. However, the supporting governance framework and audit system was not robust and did not identify that care plans were not consistently personalised, or that there were shortfalls in documentation. Care plans were reviewed monthly, however, where people's level of need had changed, this was not always updated in the main body of their care plan. For example, the identified area of need for one person identified that they needed one person to safely bathe. However, in the care plan review in February 2016 it identified that the person now required two people to safely bathe. This had not been updated in the main assessment of need. This meant staff had to read through months of review to ascertain the person's current level of need. Therefore information was not readily available for staff. We found this was a consistent theme throughout documentation.

Food and fluid charts were in place and completed indicating a good intake of food and drink for people and we observed staff updating charts. However, people's fluid charts were not consistently totalled and information on the amount of fluid they should be drinking was missing. We assessed that this did not result in harm occurring, however, this lack of information meant that it was not possible to determine fully if people were at risk of dehydration.

A wide range of health and safety checks were in place. These included weekly water temperature checks, call bells and fire alarm checks. However, omissions in documentation were evident. For example, call bell checks had not been completed for the month of June 2016. Weekly fire alarm checks had not been recorded from the 10 June to 3 July 2016 and various date in July, August and October 2016. The registered manager acknowledged there were omissions in recording and identified they were recruiting a full time maintenance worker to ensure strategic oversight of all health and safety checks.

Systems were in place to mitigate the risks relating to health, safety and the welfare of people living at the home. On a monthly basis the registered manager completed health and safety audits which considered all areas of the home, such as flooring, windows and lighting. On the day of the inspection, we noted that the under flooring on the first floor was uneven in certain areas and holes could be felt in certain areas. This posed a significant falls risk to people as people could lose their footing. Incidents and accidents reflected that no one had fallen as a result of uneven flooring; however, the risk had been identified by the registered manager back in April 2016. The registered manager told us, "I've escalated the concern to the provider;

however, I'm awaiting their approval and quotes for the under-flooring to be replaced." Although the potential for harm had been identified, action had not yet been taken to mitigate the risk. Inspectors raised concerns to the registered manager about the level of risk this posed and requested that action was taken immediately.

From talking to staff and observations, people received the care that was required to meet their individual needs, despite the omissions in documentation. However, records that contain omissions, or are completed incorrectly can undermine people's care. Accurate record keeping forms the basis for planning peoples' care and treatment, obtaining feedback on their progress and suggesting actions for prevention and health promotion. Risks to people's safety had been identified but action not taken to mitigate those risks.

The registered manager had failed to ensure that there were effective systems in place to assess, monitor and improve the quality and safety of the service, to mitigate risk, or to maintain accurate and complete records of care and treatment. This is a breach of Regulation 17 of the Health and Social Care Act2008 (Regulated Activities) Regulations 2014.

During the inspection, we identified that a large number of people were living with dementia. A safe, well designed and caring living space is a key part of providing dementia friendly care. A dementia friendly environment can help people be as independent as possible for as long as possible. For people living with dementia, signage can help promote independence, such as signs to the toilet, or signs to the lounge and dining room. The environment at Lime Tree House was not specifically designed for people living with dementia and signage was not readily available. The carpets throughout the home were a flecked design (patterned). Flecked design carpets have been identified as inappropriate and a risk factor for people who are living with dementia and visual difficulties. Throughout the inspection, we observed that people could independently navigate the home and find their way about. However, it is seen as good practice for care homes to be dementia friendly.

We recommend that the provider seeks guidance from a national source on the design of dementia friendly environments.

There was a friendly, warm and homely atmosphere and a positive culture. People appeared to be at ease, happy and comfortable. Staff and relatives further confirmed people's positive comments. One visiting relative told us, "We looked at several homes, the culture is welcoming, feels like a home, comfortable warm and cosy and we are involved with meetings about her care." Another relative told us, "There is a caring culture, top of my list, friendly, open, clean and nurturing."

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The registered manager was also aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and sets out specific guidelines providers must follow if things go wrong with care and treatment.

Systems and forums were in place for staff, people and relatives to make suggestions or raise any concerns or queries. Resident and relative meetings were held on a regular basis. Minutes from the last meeting in July 2016 demonstrated that staff changes, dementia forum and CQC regulations were discussed. People confirmed they found the forum of residents meetings very helpful. One person told us, "We have monthly meetings for all the residents where we can speak our minds if we want to." Staff meetings were held and

staff commented that they found these meetings helpful. Minutes from the staff meeting in August 2016 demonstrated that dignity in care, infection control; health and safety and fire procedures were discussed.

The home maintained good links with the local community. A recent initiative developed by the registered manager and with input from the staff, was a dementia awareness event. The registered manager told us, "The event was a great success; we had various professionals come and talk to us (and people, relatives and members of the public) on dementia. Professionals included a GP, Occupational Therapist and a professional from Alzheimer's research. Feedback on the event was extremely positive". One person commented, "The dementia event was a great success and was well organised."

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 not ensured that there were effective systems to assess and quality assure the service. Regulation (17) (1) (2) (a) (b) The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. Regulation (17) (2) (c)