The Limes Residential Care Home Limited

The Limes Residential Home

Inspection report

43 Foreland Road
Bembridge
Isle Of Wight
PO35 5XN

Tel: 01983873655

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

This inspection took place on 2 March 2016 and was unannounced. The home provides accommodation for up to 32 older people with personal care needs. There were 22 older people living at The Limes when we visited, some of whom had a physical disability or were living with dementia.

There was a registered manager in place. 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. When we completed this inspection the registered manager was not working at The Limes. The provider had arranged for an alternative manager who had been managing the service since December 2015.

After comprehensive inspections in July and November 2015, we identified that improvements were required to ensure people received a safe, well-led, effective service which was caring and responsive to their needs. We made compliance actions and issued three warning notices to the provider and registered manager requiring them to make improvements. We rated the service as inadequate and placed it in Special Measures. The provider then sent us action plans stating what they would do to meet the legal requirements in relation to improving their service. At this inspection we found improvements had been made. These need time to become sustained and fully embedded in practice, but we have taken the service out of Special Measures.

Environmental risks were not managed appropriately. All necessary action had not been taken to ensure deficiencies identified by a fire risk assessment had been completed. Arrangements were in place to check the temperature of hot water; however, the records showed these were frequently too high, placing people at risk of scalding.

People and relatives were positive about the service they received. They praised the staff and care provided. People felt safe at the home. Care staff knew how to prevent, identify and report abuse.

People received personalised care from staff who understood their needs and they were supported to make choices. Care plans provided comprehensive information about how people wished to be cared for and staff were aware of people's individual care needs. Most individual risks to people were managed effectively, although some concerns were identified about the management of pressure injuries.

People had access to healthcare services and were referred to doctors and specialists when needed. Suitable arrangements were in place for managing medicines, although use by dates were not recorded for prescribed topical creams.

Staff followed legislation designed to protect people's rights and freedom to help make sure decisions were only taken in the best interests of people.

People were positive about meals and the support they received to ensure they had a nutritious diet in sociable surroundings.

Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely.

The provider had identified a need for additional staff and were taking action to provide this. Safe recruitment practices were followed. Staff provided effective care; they were suitably trained and appropriately supported in their role.

Staff treated people with kindness and compassion and formed caring relationships with them and their relatives. Staff protected people's privacy, promoted their independence and involved them in planning the care and support they received.

There was an open and transparent culture. The provider encouraged staff feedback and visitors were welcomed. Complaints, when received, were investigated and responded to. Quality assurance processes were in place to assess key aspects of the service. Where these had identified a need for improvement action had or was being taken.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Environmental risks were not managed appropriately. However, most individual risks to people were managed correctly.

People felt safe. Staff knew how to identify and report abuse and were aware of how to respond in an emergency situation. Systems were in place to ensure people received most of their medicines as prescribed.

There were enough staff to meet people's needs. The process used to recruit staff was robust and helped ensure staff were suitable for their role.

Is the service effective?

Good

The service was effective.

Staff followed relevant legislation to protect people's rights and ensured decisions were made in the best interests of people.

Staff were suitably trained, skilled and knowledgeable about people's needs and received support through supervision and staff meetings.

People were given a choice of nutritious food and drink and received appropriate support to meet their nutritional needs. They had access to healthcare services when needed.

Is the service caring?

Good

The service was caring.

People were cared for with kindness, treated with consideration and were positive about the way staff treated them. Staff understood people's needs and met their preferences. At the end of their life people were treated with respect.

People (and their families where appropriate) were involved in assessing and planning the care and support they received.

People's privacy was protected and confidential information was kept securely.

Is the service responsive?

Good

The service was responsive.

People received care that was personalised to meet their individual needs. Care plans were comprehensive and reflected people's needs.

Staff were responsive to people's needs. People were supported to make choices and retain their independence.

People knew how to make complaints and they were dealt with promptly in accordance with the provider's policy. The manager sought and acted on feedback from people.

Is the service well-led?

Requires Improvement

The service was usually well led

The changes implemented by the new management team were positive; however, these were not yet fully embedded in practice and further improvements were required. Quality assurance systems were in place using formal audits, although they had not picked up all the issues we had identified.

There was an open and transparent culture within the home. People and visitors felt the home was run well. Staff understood their roles, were happy in their work and worked well as a team.

The management team was approachable. The manager and the directors of the provider's company had regular contact with people, relatives and staff.

The Limes 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.

This inspection took place on the 2 March 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor and an expert by experience in the care of older people.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. Before the inspection, the manager 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.

We spoke with nine people living at the home and four family members. We also met other people who were unable verbally share their views about the service. We spoke with the three directors of the provider's company, the manager, six care staff, the chef, and two housekeeping staff. We also spoke with two external health and social care professionals who had regular involvement with the home. We looked at care plans and associated records for seven people, staff duty records, staff recruitment and training files, records of accidents and incidents, policies and procedures and quality assurance records. We observed a staff handover meeting and care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in November 2015 we found risks to people were not being assessed and all reasonable action was not being taken to mitigate these risks. We issued a warning notice as these concerns had also been identified at the inspection in July 2015. At this inspection we found action had been taken to improve the way risks to people were assessed and managed although this was not yet fully embedded in practice and further improvements were required.

Risks posed by the environment were not always managed effectively. The provider had employed a specialist contractor in June 2015 to complete a fire safety risk assessment of the home. This had identified fire safety deficiencies that needed to be addressed and graded them according to their urgency. Whilst most deficiencies had been rectified, 13 were still outstanding. These included six "high priority" issues, such as providing a smoke detector in the medicines room and a special fire extinguisher in the kitchen. The failure to rectify the deficiencies would have put people at risk in the event of a fire. However, regular tests of fire safety systems and equipment were conducted to make sure they were working effectively.

The Health and Safety Executive (HSE) provide guidance to care homes about managing the risks posed by hot water, as water above 44 degrees Celsius can cause serious injury. The provider's policy required all water outlets to be fitted with control valves to keep hot water at a safe temperature. Arrangements were in place to check the temperature of hot water in people's rooms on a monthly basis. However, the records showed these were frequently too high, and on some occasions were up to 60 degrees Celsius. Such temperatures could scald people, particularly those with reduced skin sensitivity or awareness.

The temperature of the hot water in the bathrooms was frequently recorded as up to 55 degrees Celsius. Best practice guidance recommends that the temperature of bath water is checked before people are placed in it. Whilst staff told us they dipped their hand in the water to check it, they did not use a thermometer to make sure it was at a safe temperature. This put people at risk of scalding.

The failure to ensure that risks posed by the environment were assessed and managed effectively was a breach of regulation 15 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider contacted us and said action had been taken to adjust the water temperatures and were arranging for the fire safety deficiencies to be rectified.

Risks of people developing pressure injuries were assessed but not always managed safely. A visiting nurse told us the management of pressure injuries was not always effective. They told us, "[Staff] did not initially listen to our advice to put [person name] on bed rest; they have now started to, recently, and their [pressure injury] is improving." They also told us another person had a special mattress to prevent them developing pressure injuries, but the setting kept being changed, which had led to the person developing a pressure injury. Another person was at high risk of developing pressure injuries and action had been taken to mitigate this risk. Staff had requested district nurses to supply a special mattress and were supporting the person to regularly change their position. However, although washing the person daily, staff had not noted the

changes in the person's skin indicating that a pressure injury was developing.

For other people who were at risk of skin damage we saw special cushions and pressure relief mattresses to reduce the risk of damage to their skin were in use. Pressure relief mattresses were set appropriately, according to the person's weight and there was a system to ensure settings remained correct with action taken to ensure the mattress settings were not altered. Where people needed to be assisted to change position to reduce the risk of pressure injury, their care records confirmed this was done regularly.

Staff had been trained to support people to move safely and we observed equipment, such as walking aids and hoists being used in accordance with best practice guidance. Moving and handling assessments clearly set out the way to move each person and correlated to other information in the person's care plan. All care plans included risk assessments which were relevant to the person and specified actions required to reduce the risk. These included the risk of people falling, use of bed rails, nutrition, infections and moving and handling. Risk assessments had been individualised to each person. People who were at risk of choking on their food had been referred to specialists for advice and were provided with suitable diets and drinks to reduce the risk. These procedures helped ensure people were safe from avoidable harm.

Following the inspection in November 2015 we made a compliance action telling the provider they needed to improve the way medicines were managed. At this inspection we found medicines were generally managed safely. All medicines were stored securely and appropriate arrangements were in place for obtaining and disposing of prescribed medicines. However, systems to manage prescribed topical creams were not always appropriate. Staff used a topical cream for a person for six weeks instead of the two weeks for which it was prescribed. Other topical creams, including barrier creams to protect people's skin, were being applied correctly; however, there was no date of when these creams had been opened. This meant they may have been used after their safe 'use after opening' date. Care staff told us they were aware of which routine topical creams should be applied for each person. Topical cream application charts were seen in care records showing most topical creams were applied as prescribed.

For 'as required' medicines there were individual guidelines for staff as to when these should be administered. These included when necessary a recognised pain assessment tool to help staff identify when pain medicine may be required by people unable to state that they were in pain. Safe systems were also in place to ensure people received regular medicines appropriately spaced throughout the day.

There were effective processes for the ordering of medicines and checking these into the home to ensure the medicines provided for people were correct. A weekly medicines audit was completed to identify if adequate stocks were held and ensure fresh supplies were requested in a timely way. However, staff were not recording when new stocks (new boxes) were opened meaning it was not possible to audit and account for boxed medicines to ensure these were being administered as prescribed.

Medicines were administered by staff who had undertaken relevant training and been assessed as competent to administer medicines. When administering medicines staff checked the records of administration for any previous medicines to ensure these had been completed correctly. We observed staff administered medicines competently; they explained what the medicines were for and did not hurry people.

People said they felt safe at The Limes. One person said they felt safe because "it is locked at night". The provider had appropriate policies in place to protect people from abuse. Staff had received training in safeguarding adults, knew how to identify and report abuse and how to contact external organisations for support if needed. They said they would have no hesitation in reporting abuse and were confident the

manager or the provider's representative would act on their concerns. One staff member told us, "If I had any concerns, I'd report it to CQC first, then to the manager, as I think that's the way it should be." They added that they were confident the manager would take the necessary action but knew how to contact the local safeguarding team if required. The manager and provider's representative were also aware of the action they should take if they had any concerns or concerns were passed to them. The manager was clear about the process they followed to investigate allegations of abuse and provided examples where they had done this.

The manager followed local safeguarding processes and responded appropriately to any allegation of abuse. We looked at investigations conducted into two recent incidents. They were conducted promptly, were thorough and showed staff liaised closely with the local safeguarding authority throughout.

People were supported by sufficient staff to meet their individual needs. People said call bells were responded to promptly by staff. One person said, "Staff respond quickly to alarm bells, although sometimes it can be a while". Another person said, "They respond quickly, I keep count the quickest is six bleeps but they usually come in about 20 bleeps". One staff member said, "Since the new management have come in I feel there are sufficient staff to meet people's needs". Other staff also commented that an increase in staff in the evening had meant they were better able to meet people's needs.

The manager told us they had based the staffing levels on feedback from people and staff and the level of people's needs. However, a 'dependency matrix', used to calculate people's needs, was not up to date, so did not provide an accurate assessment of people's current needs. The manager had recognised that additional staff were needed at night and were recruiting more staff for this. In the interim, an additional staff member was scheduled to work a 'twilight shift' to provide additional support to people between 5:00pm and 10:00pm. The provider had made arrangements for agency staff to cover shifts which could not be filled by regular staff. This was limited to a small number of staff from a particular agency, who had got to know people well and were able to meet their needs effectively. The manager told us "The people [the agency] have sent have all been good and work well." We spoke with one agency staff member. They told us they had completed "about half a dozen or so" shifts at the home and felt they knew the people and the home.

The provider carried out relevant checks to make sure staff were of good character, with the necessary skills and experience needed to support people effectively. The manager had recognised that the previous application form used to recruit staff was not fit for purpose, so had developed a more effective one. We saw that recent applications were more thorough, and included the full employment history of prospective staff.

Arrangements were in place to deal with foreseeable emergencies. Staff knew what action to take if the fire alarm sounded, completed regular fire drills, and had been trained in fire safety and the use of evacuation equipment. Records showed fire detection and fighting equipment was regularly checked. Staff were also aware of how to respond to other emergencies.

Good

Is the service effective?

Our findings

Following the inspection in July 2015 we found improvements were needed to ensure staff received appropriate induction, supervision and training. We also found the Mental Capacity Act 2005 was not being implemented and staff were restraining a person during personal care. We made requirements and an action plan was received telling us how improvements would be made. At this inspection we found improvements had been made. The new management team had introduced systems to ensure staff were supported and received the induction and continuing training they required.

Care staff said they felt they now had the skills required to meet people's needs. For example, staff were able to describe the care people required such as in relation to diabetes management and what they should do in emergency situations. They also confirmed they had received training to support people living with dementia. Visitors felt staff knew how to care for their relatives. One visitor said, "The residents are well looked after here". This showed they felt staff had the necessary skills to meet people's needs.

New staff now completed a comprehensive induction programme before working on their own. For example, a new member of care staff was working with kitchen staff, offering drinks to people. The manager told us this was to help them meet and get to know people, before they started delivering personal care to them, under the supervision of experienced care staff. In addition, arrangements were in place for staff who were new to care to complete the Care Certificate. The Care Certificate is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate support to people.

Experienced staff had completed a nationally recognised assessment tool to identify additional training needs. These, together with refresher training in the provider's mandatory subjects were now scheduled for completion within an appropriate timescale. Some care staff had obtained, or were working towards vocational qualifications, and all senior staff had achieved level three qualifications in health and social care. The manager told us, "I'm aware staff need a lot of support at the moment. I think personal development is so important, we'll look for all suitable courses."

Care staff received regular supervisions. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. These had led to individual training plans being developed for each staff member to support them in their work. The manager had also created a template to record observations of staff practice, to assess whether care staff worked in an effective and compassionate way; they were planning to introduce this in the near future. Staff had not received yearly appraisals of their performance, but these were being introduced from April 2016. The manager worked every weekday. In addition, the deputy manager and the head of care worked alternate weekends, and a 'duty manager' was always available to provide support and advice to staff out of hours.

Staff showed an understanding of the need for consent. Before providing care, we observed they sought consent from people either verbally, using simple questions and gave them time to respond, or by observing their body language. One staff member said "If they have mental capacity I ask them". They added they did

not use restraint to ensure people received care and said "If a person says that they don't want care or their medicines then we leave them and go back later". We observed staff doing this throughout the inspection.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). 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 demonstrated a clear understanding of the legislation in relation to people living with dementia. There were procedures and recording systems for use when people may not be able to make decisions about their care or support. These were seen in care plans and demonstrated that an assessment had been made of the person's ability to make specific decisions. Where the assessment identified the person was not able to make a specific decision a best interest decision was made. The best interest decisions included consultation with family members and other professionals where appropriate. For example, one person was receiving their prescribed medicines covertly. Covert administration of medicines is when the medicine was disguised in food so the person would not know they would be taking it. This was detailed in the person's medication care plan and a mental capacity assessment and best interest decision was documented. This had included the person's GP and family.

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 the Deprivation of Liberty Safeguards (DoLS). The provider had appropriate policies in place in relation to DoLS. An authorisation was in place for one person and staff were aware of the support they needed to keep them safe and protect their rights. Where appropriate people were able to enter and leave the home independently and their freedom was not restricted. For example, we saw a person preparing to leave the home towards the start of the inspection. The manager clarified with the person if they would be back for lunch and assisted them to open the front door.

People were able to access healthcare services and received the personal care they required and they received effective care and support. A family member said "[Relative's name] is looked after well". We saw people were supported to have their personal care needs met in a sensitive way and looked well cared for. Individual daily records of care were up to date and showed care was being provided in accordance with people's individual identified needs. A visiting health professional told us they felt they were contacted appropriately when staff identified a need for medical support.

Everyone we spoke with told us they could see a doctor when required and that staff were available to assist with personal care if needed. Relatives also confirmed medical advice was sought when required. Care records contained information about people's previous known healthcare needs and treatment, and showed people were referred to GPs, community nurses and other specialists when changes in their health were identified. Where specialists had made recommendations we saw that these were followed. For example, a person was having their drinks thickened to aid swallowing in accordance with the speech and language therapist (SaLT) guidance. The person's care plan was clear about the amount of thickener needed and we saw their drinks were made to the correct consistency. Where people had specific health needs there was guidance for staff as to how these should be managed. For example, one person was on a medicine which made them at higher risk of bleeding. Their care plan stated that if they fell and there was any risk of a head or other injury then emergency services should be contacted. We saw that this had occurred following a recent incident.

People could choose where to eat their meals and were able to have breakfast at whatever time suited

them. We observed people eating breakfast in both of the lounges and in the dining room at various times as late as 12 noon. A person said "There is always enough to eat, quite a selection". A visitor said "The food is very nice". Another visitor told us their relative was eating better and had gained a small amount of weight.

People were satisfied with the food. A choice of meals was provided. Tables were set with table cloths, vases of flowers and condiments; vegetables were served from serving dishes, so people could choose the vegetables they preferred and a portion size in line with their appetite; and people were sat in small groups with people they knew well. This made the mealtime a relaxed and sociable occasion for people.

People received appropriate support to eat and drink and appeared well hydrated. A range of drinking vessels was provided, according to people's needs, including mugs with two handles and a drinking spout for people who were at risk of spilling their drinks. Where needed, other people were given plates with high lips to make it easier for them to use their cutlery and retain their independence. One person ate very little of their meal, so staff tempted them with a wide range of alternatives, including additional desserts. Drinks were available throughout the day and staff prompted people to drink often. Staff monitored the fluid intake of people although the individual amount each person should be aiming to drink per day was not specified. Therefore staff may not be aware if people were drinking inadequate amounts. Staff monitored the weight of people each month or more frequently if required due to concerns about low weight or unplanned weight loss, and nutritional risk assessments were in place.

Catering staff were aware of people's special dietary needs and described how they would meet these. Snacks were available to people at any time with staff having full access to the kitchen and food stocks to prepare these when a chef was not on duty. Care staff had a good knowledge of people's individual nutritional needs and preferences.

All bedrooms were for single occupancy and had ensuite facilities of at least a toilet and wash hand basin. There was a passenger lift connecting the three floors of the home with a bathroom on each floor. There was an 'activity lounge' together with two further lounges where people could socialise. Chairs in one of the lounges were set out in clusters, in a way that would help promote conversation between people. A spacious dining room with bar area was also provided. There was level access to a large rear enclosed garden which we were told was popular with people on warmer days.

Good

Is the service caring?

Our findings

Following the inspection in July 2015 we found improvements were needed to ensure people were treated with dignity and respect. We made a compliance action and an action plan was received telling us how improvements would be made. At this inspection we found improvements had been made and people were treated with dignity and respect.

People and their relatives were consistently positive about the way staff treated them. People said they were treated with kindness and compassion and that all the staff were kind and caring. During lunch we saw a care staff member ask a person if they needed their spectacles, the person said they did. The care staff member fetched the spectacles and noted they required cleaning which they offered to do. A person attracted care staff attention by wiggling their fingers, the care staff member responded to the person immediately demonstrating that they were keeping a watchful eye on people. Staff met people's individual needs. For example, at lunch time one person had eaten only a small amount and refused all the menu alternatives. We saw they were offered and accepted some cheese which was not on the menu. For another person a care staff member made up some banana and custard which had also not been on the menu.

People felt able to assertively ask care staff to do something and care staff responded positively to people's requests. For example, after lunch a care staff member was taking a person to the lounge in a wheelchair. The person said, "No, no, no"; the care staff member listened to where the person wanted to go and took them there. When people were brought into the dining room, they were offered the choice of transferring to a dining chair or remaining in a wheelchair. During lunch we saw people were confident to ask for more drinks or seconds of their meals.

From conversations with staff and observations of the interactions between them and people it was clear that staff understood the importance of promoting people's dignity. Staff described how they promoted dignity and privacy, such as ensuring doors were closed and people were covered as far as possible during personal care. A staff member said, "When providing personal care we try and keep them [people] covered as much as possible". We saw staff knocked on people's bedroom doors and asked permission to enter. All staff were able to name a person who had requested to only have care staff of the same gender as themselves. Another staff member said "All staff are aware of this [name person] does not want a male carer". Confidential information, such as care records, was kept securely and only accessed by staff authorised to view them.

People received individual care and support from staff who knew and understood their needs and preferences. A staff member said "Everyone's different; we need to treat people as individuals". A housekeeper told us, "Everyone likes their beds making differently, so we try and do it like they like it." A visitor said, "That's [the person's] preferred name and everyone uses it". Staff were aware of the actions they could take to promote choice and ensure people were cared for in accordance with their individual wishes. Staff offered people choices, took time to listen to people and gave them time to respond. People were supported to make choices and decisions about their daily lives. For example, a person was asked what they wanted to watch on television. Staff had knowledge of people and their preferences and beliefs; they

referred to care plans and also said information was provided at handovers. Another staff member said, "That's covered in the care plans; we talk to families and the residents themselves".

Staff supported people to be as independent as possible. For example, a person was supported to self-administer their inhalers whilst staff managed the rest of their prescribed medicines. At meal times people were provided with the level of support they needed to maximise their independence, including adapted cutlery and plate guards when required. When a person stopped eating, staff observed to see if they would continue. When they didn't, they stepped in to prompt and encourage the person. When the person starting eating, they stepped back again and allowed the person to continue. This was in line with the person's care plan and helped them retain their independence. Care staff described how they encouraged people to be as independent as possible with personal care. One said "If I'm washing somebody I ask if they would like to wash their face or body and what products to use". Information in care plans detailed what people could do for themselves and what they required staff to support them to do. This helped ensure all staff provided support in a consistent way which promoted independence.

Staff showed a good understanding of the needs of people living at The Limes. When it was difficult to understand what people were saying, staff used facial expressions, body language and appropriate touching to aid communication, to reassure people and make them feel listened to. Staff were observed explaining to people what they were going to do before offering support. When people were supported to move using equipment such as hoists staff talked to people throughout explaining what they were doing. Non care staff, such as housekeepers and kitchen staff, were also seen talking to people in a pleasant and interactive manner which indicated they knew the people well.

People or relatives were involved in reviews of care. Staff told us families were being invited in for reviews and to sign the new care plans. Care plans contained information about people's backgrounds and family history. Family members told us they were always kept up to date with any changes to the health of their relatives. One person was supported to change bedrooms as the bathroom was too small for their liking. They had chosen the new room after walking round the home and being shown all the available rooms.

Staff demonstrated an understanding of how to maintain people's dignity after death. This included making sure the person was covered, changing any continence aids, bushing the person's hair, washing their faces and ensuring the person looked comfortable.

Good

Is the service responsive?

Our findings

Following the inspection in July 2015 we found improvements were needed to ensure care records reflected people's needs and preferences and were regularly updated. We made a compliance action and an action plan was received telling us how improvements would be made. We also recommended that the provider researched and adopted best practice in relation to providing meaningful activities for older people. At this inspection we found improvements had been made and care records reflected people's needs and how these should be met. Action had also been taken to ensure activities were appropriate and meaningful for people.

People and relatives said they were happy with the way their personal and care needs were met. One person told us they could "have a bath or shower whenever they wanted one".

Care staff were able to describe the care and support required by individual people. For example, they were able to describe the help a person required with repositioning to reduce the risk of pressure injuries occurring. They were also able to describe the support people required to meet nutritional needs. It was evident that they and other staff knew everyone living at The Limes and how their needs should be met. Staff had noted when a person was unwell and arranged for a GP home visit. Staff were kept up to date about people's needs through a formal handover meeting at the start of each shift. Relevant information about risks or concerns about specific people was handed over. All oncoming staff were present and the handover was of an appropriate duration to allow staff to ask questions or clarify information.

Care plans provided comprehensive information about how people wished to receive care and support. Individual care plans were well organised and the guidance and information for staff within them was individualised and detailed. Care plans also included specific individual information to ensure medical needs were responded to in a timely way. For example, we saw a diabetes care plan which contained specific information for care staff about symptoms the person may experience if their blood sugar levels were either too high or too low. This included guidance for staff as to what action they should take if the person showed these symptoms. Another care plan contained specific guidance as to the support a person with a urinary catheter required and how the risk of infection could be reduced.

Care plans and related risk assessments had all been rewritten by senior staff in February 2016 shortly before the inspection. Senior staff told us they now planned to review the care plans and where necessary add to or amend the information they contained. Care plans were centred on the individual, considered aspects of their individual circumstances and reflected their needs and preferences.

People had access to a range of activities to meet their individual interests. One person had grown up with chickens, so a plan was in place for them to care for chicks in the run up to Easter and to keep the fully grown chickens after that. Another person was keen on exercise and had been given an exercise bike. Two people had experience of yoga and were being supported to start a yoga group which other people were encouraged to join.

An activity coordinator had been appointed and had worked with people to develop a programme of trips to local attractions, using the home's minibus. These included local visits as well as island-wide events, such as carnivals and regattas. Plans were also in place for competitions involving mixed groups of staff and people, including baking challenges and quizzes. The manager told us the purpose was to help build positive relationships.

The provider sought and acted on feedback from people. They had started to hold regular 'residents meetings' where people were encouraged to discuss all aspects of life at the home. At a recent meeting they had discussed the mealtimes. One person asked to have their main meal of the day in the evenings rather than at lunchtime. Arrangements were put in place for this to happen. Having tried it, the person decided they wanted to change back to having their main meal at lunchtime, so this was done. Following suggestions from people, the evening meal times were about to be changed, to make them more flexible.

The provider had an appropriate complaints policy in place. A copy was available in the reception area and plans were in place to include it within a 'resident's handbook' that was being developed. The policy had been updated since the last inspection, contained details of how to make a complaint and outside agencies that could be contacted if the complainant was not satisfied with the outcome. We looked at two recent complaints and saw they had been dealt with promptly and in accordance with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

Following the inspection in July 2015 we found improvements were needed to quality assurance procedures and to ensure that accurate and complete records of the care provided were maintained for each person. We also identified that there had been a failure to notify CQC of all incidents which providers are required by law to notify us about. We made compliance actions and an action plan was received telling us how improvements would be made. At this inspection we found improvements had been made and the service was better managed, although this was not yet fully embedded in practice and further improvements were required.

People liked living at the home and were aware of the changes in the home's management. A person said, "I like it here". Another person said, "The management has changed recently". A visitor said, "I wouldn't mind living here". Another visitor was aware of the concerns identified during previous inspections; they said, "I am a great supporter of the care home and I understand about the issues with the CQC markings". They added that they visited every day and felt their relative was "looked after well". A third visitor said "I like the atmosphere here; I chat to everyone, both staff and residents."

Auditing of some key aspects of the service, such as accidents and infection control were effective. Where changes were needed, action plans were developed and changes made; the plans were then monitored to ensure they were completed promptly. However, an auditing process for care plans was still being developed and the auditing of water temperatures had not identified that some were too high.

There was a clear management structure in place, though the registered manager had not been working at the home since November 2015.This included a manager, two deputy managers, a head of care, and heads of housekeeping and catering. In addition, 'lead seniors' took charge of each shift, and were responsible for deploying care staff to make sure people's needs were met. A visiting nurse told us, "Things are much tighter now; we used to be able to come and go as we wanted, but it's better controlled now. Things are now improving generally."

Staff said they felt supported by the new management team who they felt they could approach with any concerns. They described improvements such as the increase in staffing numbers since the new management team had taken over. A staff member said, "The new management is very supportive; they are fighting to get all the old problems sorted. The atmosphere now is much better". Another staff member said, "Now it's brilliant. I find the new management team very supportive and also willing to encourage training which I asked for". Staff understood their roles and were happy in their work. Comments included: "I'm very happy here; it's a nice place to work"; and "I'm happy with everything here."

A representative of the provider told us, "We just want to improve and provide safe, high quality care." They had identified visions and values they considered important. They were planning to involve people and key staff members from each department in the development of these, before communicating and promoting them further. The manager held monthly staff meetings, as well as weekly management meetings to keep staff informed of changes and monitor their impact.

In order to develop their knowledge and understanding of the care sector, three directors of the provider's company were planning to complete the Care Certificate. We saw they were actively involved in the home including providing support to care staff. For example, at lunch time the serving of vegetables was too slow and one of the directors of the provider's company stepped in and helped serve the vegetables. We saw another provider responding to a person in a way which showed they knew the person well. The providers had joined the local care homes association and had sought support from colleagues working in neighbouring homes. The two deputy managers were being supported to complete level five management qualifications to develop their skills further.

There was an open and transparent culture in the home. A visitor told us "They [care home staff] let me know if there are any issues; for example, following a fall last Monday when [person's name] banged their head". The provider had written to people and their families to inform them about action CQC had taken following their last inspection. The previous inspection report and rating was displayed prominently in the reception area. The provider notified CQC of all significant events. Visitors were welcomed and the home was building links with the community through schools and faith groups. The provider had an appropriate duty of candour policy in place which required staff to act in an open way when accidents or incidents occurred, together with a whistle blowing policy. This encouraged staff to report any concerns to the manager, but did not provide details of external organisations that staff could contact with concerns. We discussed this with a representative of the provider, who agreed to add this information to their policy.

The provider had an effective system in place to analyse incidents and accidents in order to reduce the likelihood of them recurring. This showed thorough investigations were conducted and action taken to reduce the likelihood of recurrence. This included installing equipment to monitor when people moved to alert staff they may be at risk before an accident occurred.

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 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured that the premises were properly maintained in relation to the health and safety risks posed by hot water outlets and fire safety arrangements. Regulation 15(1)(e)