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	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?	Good

Summary of findings

Overall summary

This inspection took place on 25 April 2017 and was unannounced. The Limes Residential Home is a care home registered to provide accommodation with personal care for up to 32 people, including people living with a cognitive impairment. There were 27 people living in the home when we inspected.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

People and their families told us they felt the home was safe. Staff and the management team had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks while promoting choice and independence.

There were systems in place to monitor the quality of the care provided and the safety of the environment. Accidents and incidents were monitored and analysed and remedial actions identified to reduce the risk of reoccurrence.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and assessments. Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs. There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported people, when necessary in a patient and friendly manner while promoting their independence.

Staff developed caring and positive relationships with people and were sensitive to their individual choices and treated them with dignity and respect. People were encouraged to maintain relationships that were important to them.

People were provided with appropriate mental and physical stimulation and had access to activities that were important to them. Staff were knowledgeable about people's right to choose the types of activities they liked to do, and respected their choice.

There was an opportunity for people and their families to become involved in developing the service and they were encouraged to provide feedback on the service both informally and formally.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. This contributed to an open culture within the home. Visitors were welcomed and there were good working relationships with external professionals.

People and their families told us they felt the home was well-led and were positive about the registered manager who understood the responsibilities of their role.

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

The service was safe.

The registered manager had assessed individual risks to people and had taken action to minimise the likelihood of harm in the least restrictive way.

People received their medicines at the right time and in a way that their needs.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

Is the service effective?

Good

The service was effective.

Staff received an appropriate induction, supervision and on-going training to enable them to meet the needs of people using the service.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

People were encouraged to maintain friendships and important relationships.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

Care plans and activities were personalised and focused on individual needs and preferences.

The registered manager sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Good

The service was well-led.

The provider's values were clear and understood by staff.

The providers were fully engaged in the running of the service.

People, their families, health professionals and staff had the opportunity to become involved in developing the service.

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment.

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 25 April 2017 and was unannounced. The inspection was undertaken by two inspectors.

Before the inspection the provider 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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with eight people using the service, four visitors and two health professionals. We also spoke with a director of the provider's company, a representative of the provider, the registered manager, a deputy manager, six members of the care staff team, the cook and the housekeeper. We observed care and support being delivered in the communal areas of the home. 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.

We looked at care plans and associated records for eight people, staff duty records, staffing records, records of accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in May 2016 when it was rated as 'Requires Improvement'.

Good

Is the service safe?

Our findings

People told us and indicated they felt safe. One person said, "Oh yes, I feel absolutely safe". Another person told us, "staff look after me very well". Family members told us they did not have any concerns regarding their relative's safety. One family member said, "I have no concerns at all about [my loved ones] safety".

At the previous inspection, in May 2016 we identified a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Risks posed by the environment were not always assessed or managed effectively. The provider wrote to us detailing the action they would take to meet the regulation. At this inspection, we found action had been taken and the provider was meeting the requirements of this regulation.

The providers and staff actively managed and reduced environmental risks. All fire safety deficiencies that had been previously highlighted had been rectified. Regular tests of fire safety systems and equipment were conducted to make sure they were working effectively. Water outlets had thermostatic valves fitted to keep hot water at a safe temperature. Processes were in place to check the temperature of hot water in people's rooms on a monthly basis. The temperature of bath water was checked before people were assisted in to it. This was aided by the use a thermometer to make sure it was at a safe temperature, to prevent people coming to harm.

Processes were in place to ensure there was an appropriate standard of cleanliness and hygiene within the home to protect people, staff and visitors from the risk of infection. During the inspection we found the home was clean and well maintained. Staff were seen to be wearing protective clothing, including gloves and aprons when required.

A health and safety check of the environment and equipment was completed quarterly by the provider or registered manager. These checks reviewed all internal and external areas of the home and looked at the safety, cleanliness and condition of equipment and environments. These were supported by daily spot checks of the environment. All findings were recorded and acted on. For example, during a recent spot check it was noted that a window was loose and immediate action was taken to rectify the concern.

At the previous inspection, in May 2016 we identified that the risks of people developing pressure injuries were assessed but not always managed effectively. At this inspection, we found action had been taken and the risks to people had been assessed and action had been taken to mitigate risks. For example, people had pressure area care plans in place due to increased risk of skin breakdown. These care plans were informative and provided staff with clear guidance on action they should take to prevent skin damage. Actions included, ensuring appropriate equipment was in place and working effectively and providing the person with regular support to assist them to change their position. One risk assessment stated, 'Pressure area care; use [named cream] in place due to redness between the knees. Repositioning every 2 – 3 hours'. The risk assessment was supported with the use of body maps and a pressure area risk assessment tool. Repositioning charts were reviewed for two people and we saw that people were being supported as stated within their risk assessments.

The registered manager had assessed the risks associated with providing care to each individual. Each person's care file contained robust risks assessments which identified the risks along with the actions taken to reduce these risks. Risk assessments in place included; falls, nutrition, skin breakdown and moving and handling. Risk assessments were reviewed on a monthly basis or more frequently if required. Staff were able to explain the risks relating to people and the action they would take to help reduce the risks. Where an incident or accident had occurred, there was a clear record, which enabled the registered manager to identify any actions necessary to help reduce the risk of further incidents. For example, one person was at risk of rolling out of bed. The room layout had been reviewed and the furniture had been rearranged to enhance the person's safety, the bed had been lowered, a safety mat had been put in place and the person was regularly checked throughout the day and night.

Staff had the knowledge and confidence to identify safeguarding concerns and acted to keep people safe. All staff received training in safeguarding which helped them identify, report and prevent abuse. Staff told us how they would safeguard people and actions they would take if they thought someone was experiencing abuse. One member of staff told us, "If I was concerned I would tell the registered manager, I know they would act. I would whistle blow if I needed to, I wouldn't hesitate". Another staff member said, "If I had concerns I would document them and pass them to the manager, I am confident they would do something". The registered manager explained the action they would take when a safeguarding concern was raised and records confirmed this action had been taken.

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. The registered manager had a DBS declaration form in place that staff were to sign every two months to identify whether their circumstances had changed.

There were sufficient staff available to meet people's needs. The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner. Staff responded to people's needs promptly. Care staff were supported by other ancillary staff, such as housekeeping, maintenance and catering. This meant they were able to focus on providing care and engaging with the people they supported. People and their families told us there were enough staff to meet people's needs. Comments included, "There is always staff around when I need them", "They [staff] respond when I need help" and "When I press my button someone will come". Care staff members we spoke to all felt there were appropriate levels of staff to meet the needs of the people. A staff member said, "We [Staff] are encouraged to spend time with people, it's not frowned upon if we are sitting and chatting to them". Another staff member told us, "I am able to chat and spend time with the residents". A third member of staff said, "There is enough staff and the staffing levels mean we have more time to spend with people".

Staffing levels were determined by the registered manager who used a dependency tool to support them with this. This dependency tool took into account the level of support people using the service required and was reviewed weekly or more frequently if required. The registered manager told us the tool did not consider the size or layout of the building, but they took account of this by listening to feedback from people and staff and observing care and response times.

There was a duty roster system, which detailed the planned cover for the home. The registered manager said that when completing the duty rota they also considered the skill mix of the staff. Staff absence was usually covered by existing staff working additional hours. The registered manager, deputy managers and the directors of the provider's company regularly worked alongside the staff to provide support if needed

and cover staff absences at short notice when required.

People received their medicines safely. One person said, "they [staff] always give me my medicine when I need it." Medicines were administered by staff who had received appropriate training and their competency to administer medicines was assessed three monthly by the registered manager.

Since December 2016 The Limes used an Electronic Medication Administration Record (eMAR) to support staff with ensuring that medicines are appropriately administered. The eMAR system provided a record of which medicines were prescribed to a person and when they were given. The deputy manager explained that having the eMAR system helped to mitigate any errors in omission as there was a constant reminder on screen if something hadn't been given. On viewing the information on the eMAR no concerns were identified, indicating that people received their medicines safety and appropriately.

Guidance was in place to help staff know when to administer 'as required' (PRN) medicines, such as pain relief. Each person who needed PRN medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. People told us they received pain relief when they required it. One person said, "They [staff] will get me some pain relief if I ask". A recognised pain assessment tool was used to help staff identify when pain medicine may be required by people unable to state that they were in pain. The eMAR system would not let staff administer something that was outside of the prescribed range e.g. paracetamol that exceeded the daily dose.

There were suitable systems in place to ensure prescribed topical creams and ointments were applied correctly. This included body charts to identify where specific creams should be applied and records completed by care staff to confirm application. Topical creams had an 'opened on' date to help ensure these were not used after the safe time limit.

Staff respected people's rights to refuse prescribed medicines. There was a procedure in place for the covert administration of medicines. This is when essential medicines are placed in small amounts of food or drink and given to people. We saw that all the correct documentation had been completed, in line with the current legislation that protects people's rights when people required their medicine to be administered covertly.

There was a medicines policy in place which was up to date and comprehensive. Suitable systems were in place to ensure the safe storage of medicines, the ordering of repeat prescriptions and disposal of unwanted medicines. Where medicine was required to be stored in a fridge there was a clear protocol for monitoring the fridge temperature and actions for staff if the fridge temperature went out of range. Full medicine audits are completed every 30 days, with the exception of controlled medicines which were completed by two staff on a weekly basis. We saw that these checks had been completed and no areas of concerns were noted.

During the medicine administration round staff were heard asking people how they would like to take their medicines. For example, we heard the staff member say to a person, "Would you like one [tablet] at a time". Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought people's consent. Staff remained with people until they were sure all medicines had been taken.

There were appropriate plans in case of an emergency occurring. Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Staff were aware of the fire safety procedures and the action they

would take if an evacuation was necessary.

Good

Is the service effective?

Our findings

People and their families told us they felt the service was effective; staff understood people's needs and had the skills to meet them. One person said, "We are very well looked after, the staff and manager are brilliant in every way". Another person told us, "There is no comparison with other homes; this has to be the best". A family member said, "I am very happy, we couldn't ask for more". A health professional told us, "There are no concerns that I am aware of".

Arrangements were in place to ensure all new staff received an effective induction to enable them meet the needs of the people they were supporting. Staff told us that when they started working at The Limes they received a period of induction which included working alongside experienced staff before being permitted to work unsupervised. New staff received mandatory training which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. It aims to ensure workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. One care staff member who had never worked in care previously told us, "I had a good induction, was given lots of information and encouraged to ask questions". All new staff completed a three month probationary period before being made permanent. The registered manager explained that this was to ensure that staff fitted into the service and there was a staff team in place that put people first.

Staff had the skills and knowledge to carry out their roles and responsibilities effectively. Family members were confident in the abilities of the staff. A family member said, "Staff know what they are doing". The provider had a system to record the training that staff had completed and to identify when training needed to be updated. This included essential training, such as medicines training, safeguarding adults, fire safety and first aid. Staff had access to other training which focused on the specific needs of people using the service such as: dementia awareness, pressure area care and end of life care. Staff understood the training they had received and how to apply it. For example, they explained how they would support a person to mobilise, how to use moving and handling equipment appropriately and how they provided care to people living with dementia. Members of care staffs comments about the training they received included, "We have really good training", "We are given the opportunity and encouraged to complete further care qualifications" and "I am doing my level five (health and social care qualification) at the moment".

There was a robust staff supervision programme in place and all staff had signed a supervision contract which outlined the arrangements and expectations for each supervision session. This contact was reviewed by the registered manager/supervisor and staff members annually. All staff received two one-to-one sessions of supervision, two practice observations and two group discussions about relevant topics per year. All supervision was clearly documented and action taken if needed. The registered manager told us that when required the frequency of supervision was increased. Staff who had worked at the home for over a year had also received an annual appraisal with a director of the provider's company or the provider's representative, to assess their performance and identify development needs. Staff told us that supervisions and appraisals were helpful and spoke positively about the support they received from management on a day to day basis. One staff member told us, "We get good support and receive regular supervision". Another

staff member said, "I am really well supported and can approach the registered manager or providers at any time".

Staff obtained verbal consent from the people before providing them with care and treatment, such as offering to help them mobilise or to have an assisted wash. One person said, "They [staff] will always ask me if they can do something; like come into my bedroom or help me to have a wash. They let me know what they are doing". A staff member told us, "I will always ask the person before I help them". A care plan stated, 'Always get [persons] permission before providing support'. We observed staff seeking consent from people using simple questions and giving them time to respond.

Staff assessed people's abilities to make decisions in line with the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. For example, where personal care was to be provided and the use of equipment and bed rails.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements and DoLS applications had been made to the supervisory body where relevant. Staff had been trained in MCA and DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence. People's families and other representatives had been consulted when decisions were made to ensure that they were made in people's best interests and the least restrictive option.

People were supported to have enough to eat and drink. Fluids and snacks were offered throughout the day and evening, including homemade cakes, biscuits, fresh fruit and warm snacks. A person told us, "I don't always sleep well and can become anxious at night; the staff will bring me [named milk drink] and a snack if I want one". People told us they enjoyed their meals. One person said, "The food is excellent, we can have seconds if we wish". Another person told us, "The puddings are particularly nice, all the food is very good".

People were given the opportunity to choose where to have their meals. The home had a large dining area which was welcoming and tables were attractively laid out. Meal times were calm and relaxed and provided people with social interactions. During lunch music was playing in the background which people seemed to enjoy. Lunch was served up from a hot trolley in the dining room to allow people to make informed decisions about what they ate and the size of food portions. People were offered a drink of their choice, including alcoholic beverages and a variety of soft drinks. Staff members offered drinks and topped up glasses when required.

Staff were aware of people's needs and offered support when appropriate. For example, one person needed full assistance with their meal and they were supported in a caring and unhurried way. A member of care staff sat with them and spoke to them kindly about things that were important to the person. Another person was at risk of choking and a staff member stayed with them, kindly reminded them to eat slowly, but still encouraged them to eat independently. Where necessary specialist cups, crockery and cutlery were

provided to support people to eat independently.

When people's food and fluid intake was reduced or poor this was closely monitored by the care staff supported by the use of individual food and fluid intake charts. Staff checked these at the end of each shift and where issues and concerns were highlighted appropriate action was taken. Action included, requesting guidance from health professionals and making changes to the menu. People had nutrition care plans in place, which included information about people's food and drinks preferences, allergies, levels of support needed and special dietary requirements. One person's care plan highlighted that they required a pureed diet and thickened fluids. This plan was supported by appropriate risk assessments. Food and fluids provided to the person were given as described in the risk assessment and care plan.

People were supported to access appropriate healthcare services. Their records showed that people were seen regularly by doctors, specialist nurses and chiropodists. They also had access to dental care and eyesight tests when needed. All appointments with health professionals and the outcomes were recorded in detail. Staff knew people's health needs well and were able to describe how they met these needs. During the inspection we heard staff talk about a changes in people's health and actions they were going to take, which included close monitoring and contact with healthcare professionals. The registered manager had devised an 'early intervention form'. This aimed to ensure that when health input was needed for a person, appropriate, relevant and up to date information would be communicated to the GP, ambulance service or 111 to allow timely and effective interventions to be provided.

The environment was suitable for the people living at The Limes. Where necessary, action had been taken to support people living with dementia to understand their environment and move around freely. For example, toilets and bathrooms were easily identifiable due to large signs and brightly coloured doors, this helped people recognise these rooms. All bedrooms had ensuite facilities of at least a toilet and wash hand basin. There was an 'activity lounge' together with two further lounges where people could socialise. A spacious dining room with bar area was also provided. There was level access to a large rear secure garden which people could access freely.

Good

Is the service caring?

Our findings

People and their families were all consistently positive about the care received at The Limes. People, their relatives and staff described the service as, having "A homely atmosphere", "Like a family" and "A home from home". A family member said, "The care is excellent. The staff are kind and caring". People's comments included, "Staff are lovely. I'm really happy", "I am very happy. Staff are wonderful and kind" and "Staff are fantastic". A health professional told us "The care is very good. Staff are helpful".

People were cared for with dignity and respect. Staff were heard speaking to people in a kind and caring way, with interactions between people and staff positive and friendly. We saw staff kneeling down to people's eye level to communicate with them. We heard good natured banter between people and staff, showing they knew people well. Staff were attentive to people and checked whether they required any support and were happy. For example, one person had arrived at the home the previous day and staff were heard to ask them, "How was your room" and "Did you sleep alright". Care staff took prompt and immediate action to relieve people's distress or discomfort and noticed when people appeared uncomfortable or required support. For example, one person was sat at the dining table and looked to be sat uncomfortably. A staff member respectfully and gently checked they were alright and offered them support to change their sitting position.

Staff understood the importance of respecting people's choice. They spoke with us about how they cared for people and offered them choices in what they preferred to eat, if they wished to participate in activities and where they wanted to spend their time. Choices were offered in line with people's care plans and preferred communication style. Throughout people's care files there were comments about providing choices to people in relation to their care. A person told us, "I always get asked [by the care staff] if I want a wash or a shower, they let me choose and I can have a shower whenever I want. They don't mind". Another person said, "I get lots of choices around what I want to eat and if I want to do the activities".

People's privacy was respected when they were supported with personal care. Staff were able to describe the practical steps they took to preserve people's dignity and privacy when providing personal care. This included ensuring doors and curtains were closed and making sure people were covered. We saw all staff knocking on doors, and asking people's permission before entering their bedrooms. We observed staff assisting a person to move to a lounge chair using moving and handling equipment. A screen was used to preserve the person's dignity and staff explained to the person what they were about to do throughout the transfer and gained consent before commencing the procedure. Confidential care records were kept securely and only accessed by staff authorised to view them.

People were encouraged to be as independent as possible. A person told us, "The [staff] will help me if I need them". Comments in care plans highlighted to staff what people could do for themselves and when support may be needed. For example one care plan stated, '[Person] can feed self but requires prompting at times". Another care plan stated, '[Person] is able to wash face and hands if provided with encouragement and given simple instructions'. We saw a staff member assisting a person with a walking frame; the staff member provided good verbal guidance and prompts and did not rush the person. Where appropriate,

adjustments had been made to the environment to support people to remain independent, including handrails.

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. This identified people who were important to the person. All of the families we spoke with confirmed that the registered manager and staff supported their relatives to maintain their relationships. One family member said, "We [family] are made very welcome". Another family member told us, "I am kept updated with things going on in the home".

People's bedrooms were individualised, reflected people's interests and preferences and were personalised with photographs, pictures and other possessions of the person's choosing. One person's bedroom was a mirror image of their living room at home and another person told us, that before they moved to the home the provider had organised a bird feeder to be put on their balcony as they knew they liked birds. These personal touches helped people feel valued and helped them settle into the home.

Good

Is the service responsive?

Our findings

People received personalised care from staff that understood and met their needs well. People's comments included, "I am well looked after, everything about the care and home is brilliant", "I am really happy here", "We have everything we need" and "Couldn't ask for more. We have our own space and company when we want it".

Staff were responsive to people's communication styles and gave people information and choices in a way they could understand. Staff used plain English and repeated messages as necessary to help people understand what was being said. Staff were patient when speaking with people and understood and respected that some people needed more time to respond. People's care plans contained a 'communication care plan' which provided information on how best to communicate with individual people reminding staff to consider tone of voice, eye contact and the use of clear and closed questioning. For example, one person's communication care plan stated, 'When talking to [person], speak clearly and slowly and ensure [person] has understood' and went on to say, '[Person] may not always respond well, it sometimes helps if staff are wearing something bright and their approach is calm'.

Care plans provided comprehensive information about how people wished to receive care and support and provided information to enable staff to give appropriate care in a consistent way. These care files also included specific individual information to ensure medical needs were responded to in a timely way. We saw people being supported by the staff as described in their care plans to maximise their independence. Staff were able to describe the care provided to individual people and were aware of what was important to the person in the way they were cared for. Records of daily care confirmed people had received care in a personalised way.

Staff were kept up to date about people's needs through handover meetings which were held at the start of every shift. Information was provided to staff during this meeting which included information about changes in peoples emotional and physical health needs and where people had declined assistance with personal care. During this handover meeting staff shared ideas and knowledge of how best to provide support to individual people.

People and where appropriate, their families were involved in discussions about developing their care plans, which were centred on the person as an individual. When people moved to the home, they (and their families, where appropriate) were involved in assessing and planning the care and support they needed. A person told us how they were visited by the registered manager before moving to The Limes who talked with them about their needs and expectations.

Comments in care plans showed that family members were involved in discussions about care and kept up to date with any changes. The management team reviewed care plans monthly or more frequently if required. A family member said, "I am always informed if [my loved one] is unwell".

People were provided with appropriate mental and physical stimulation through a range of varied activities

which were provided seven days per week. The service employed an activities co-ordinator and care staff told us that they often had time to sit and interact with the people living at the home. Activities were provided both in groups and individually and were adapted according to the likes and preferences of people on a day to day basis. People and their families were kept informed of up and coming events and daily activities though an activities timetable, emails, the monthly newsletter and directly from the staff. Activities included music for health, music, gardening, baking, arm chair yoga and arts and crafts. One person said, "There is lots to do, I don't go to all the activities but I particularly like the gardening and arm chair yoga". Another person told us, "I never get bored; there is too much going on".

People were provided with the opportunity to go on frequent outings in groups or individually, to places of their choosing. A photo album was used to help people make informed decisions about where they would like to go. This included pictures of local places of interest and cafes and restaurants. One person told us, "The activities coordinator will take me to my local hairdresser" and another person told us how they were supported to visit the grave of a loved one. Staff were responsive to people's religious beliefs and they were supported to maintain these if they wished. A local church group visited to home monthly and one person told us how they were supported regularly to visit the local church.

The registered manager sought feedback from people's families on an informal basis when they met with them at the home, during telephone contact, email correspondence and during resident and relative meetings. Both people and their families felt able to approach the manager and providers at any time. Their comments included, "The registered manager is really approachable", "I am always kept up to date about what is going on" and "If I have any concerns, I only need to go and see the manager, they will listen"

Residents and relative meetings were held two monthly to discuss all aspects of care, update people on any changes in the home and to get people's view on the service provided. During these meetings people and their families were given the opportunity to talk about any concerns or issues they had and to share ideas about the development of the service. Past meeting minutes were viewed which demonstrated that actions had been taken where required and people and their families had been fully involved in developing the service.

The registered manager and directors of the provider's company also sought formal feedback through the use of quality assurance survey questionnaires sent six monthly to people, their families, professionals and staff. We looked at the feedback from the latest survey completed in January 2017. All responses to this survey were positive.

People and their families knew how to complain or make comments about the service provided. People and family members said they had no reason to complain, but felt that if they needed to action would be taken. One person said, "I would go and see the manager if I needed to complain, they are always ready to listen". Complaints information was displayed in the entrance hall of the home along with complaints and dissatisfaction leaflets which could be easily accessed by the people and visitors. The information provided explained how people could complain and included details of external organisations, such as the Care Quality Commission and the Local Government Ombudsman. The registered manager told us that where people were dissatisfied with the service and needed support to raise concerns they were supported to access independent advocacy services if required. Records showed that over the last 12 months two complaints had been received. Both had been dealt with promptly and investigated in accordance with the provider's policy.

Good

Is the service well-led?

Our findings

People and their families told us they felt the service was well-led. Family members also said they would recommend the home to their families and friends. One person said, "the way it is run is excellent". Another person told us, "I can't fault anything about the manager, the staff or the running of the home".

There was a clear management structure in place, which consisted of two directors of the provider's company, a representative of the provider, a registered manager, two deputy managers and care staff. Staff understood the role each person played within this structure and what was expected of them. A member of the management team was present throughout our inspection and they were responsive to requests for information and support from the inspector, people using the service, staff and visitors. This demonstrated that people, their families and visitors knew who to go to if they had any issues or concerns.

The directors of the provider's company were fully engaged in running the service and were also included on the staff rota in a junior carer role. One member of care staff said, "I am really impressed with the directors being so hands on and they know what it's like". Both the directors and the providers' representative had completed a full induction, the Care Certificate and were in the process of completing further health and social care qualifications.

The provider's representative told us the vision and values were built around, "Helping people live their lives in a way they choose" and described the service as aiming to be a, "Home from home that does not just provide support to the people but their families too". Care staff were aware of the provider's vision and values and how they related to their work. Staff meetings were held monthly and these provided the opportunity for the registered manager to engage with staff and reinforce the provider's values and vision. A staff member told us, "I love the person-centred care we provide, I am proud to work here and of the work we have done to improve things for the people".

Observations and feedback from staff showed the home had a positive and open culture. Staff confirmed they were able to raise issues and make suggestions about the service and care provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. A staff member said, "I can approach the manager or owners at any time, any ideas I have are considered and I feel valued". Another staff member told us, "We are a really good team, we all help each other". Staff commented on the improvement of the service over the last six months. One staff member said, "Things are so much better, we [staff] have regular meetings now. The staff now have a management team they can count on."

The registered manager and directors was aware of, and kept under review, the day to day culture in the service, including the attitudes and behaviour of the staff. This was done through observations of care provision, working alongside staff and regular staff supervision. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. Additionally, the registered manager completed regular unannounced spot checks of the service during the night. This was to ensure that they had insight into the quality and effectiveness of the service over a 24 hour period. There was a duty of candour policy in place, this required staff to be open with people and relatives when accidents or

incidents occurred. The registered manager was able to demonstrate where incidents or accidents had occurred these were discussed with people and their families where appropriate and put in writing.

The provider had suitable arrangements in place to support the registered manager, for example regular meetings, which also formed part of their quality assurance process. The registered manager told us that support was available to them from the directors at any time.

The providers' representative told us, "The registered manager is very proactive at working jointly with professionals". The registered manager was responsive to new ideas and was developing links with external organisations and professionals to enhance the staff's and their own knowledge of best practice to drive forward improvements. They had also contacted other registered managers of care homes in the area to arrange a 'manager care forum' to allow a wider support network to care home managers, to share ideas, knowledge and best practice.

Quality assurance systems were in place to monitor both the safety of the environment and the quality of the care provided. Routine checks and audits were regularly carried out for a range of areas to enable the registered manager to monitor the operation of the service and to identify any issues requiring attention. Other formal quality assurance systems were in place, including seeking the views of people, their relatives, staff and health professionals about the service they received via quality assurance questionnaires.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

The provider and the manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed in the reception area of the home.