Nugent Care

# Lime House

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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 comprehensive inspection took place on 23 August 2016 and was unannounced. The inspection team consisted of two adult social care inspectors. At the time of the inspection, there were 30 people living at the home. Lime House is registered to provide personal care and support for up to 32 people. The home is part of Nugent Care and the head office is based in Liverpool. The home has a main house connected by link corridor to a lodge. Most rooms were for one person and there were also up to four shared rooms. There was a choice of several lounge and sitting areas throughout the home.

At the last inspection on 29 August 2014 we found the service to be compliant with all regulations we assessed at that time.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People we spoke with said they felt safe living at Lime House. There were systems in place to protect people from abuse. There was an up to date safeguarding policy in place, which referenced legislation and local protocols.

The service had a robust recruitment procedure in place. Appropriate checks were carried out before staff began working at the home to ensure they were fit to work with vulnerable adults.

There were sufficient numbers of staff working at the home to meet people's needs. All of the people spoken with including people living at the home, staff and visiting relatives told us they felt staffing levels were sufficient.

We looked at a sample of Medication Administration Records (MAR's) and observed medicines administration during the day and saw that MAR's were signed by staff when people received their medication, as required. We saw requirements relating to controlled drugs were being met. A medicines stock control form was used for each person receiving assistance with medicines. People living at the home told us they had no concerns about receiving their medicines.

We saw that care plan documentation contained risks assessments which covered Waterlow, pressure sores, moving and handling, nutrition, bathing and falls/mobility. Each risk assessment had a corresponding 'risk plan' which detailed how the risk was managed and any control measures that were in place.

The home was clean and tidy with no pervasive malodours present.

There was a staff induction programme in place which staff undertook when they first started working at the

home and this was aligned with the requirements of the care certificate. Staff told us they received supervision as part of their work and we looked at a sample of records which demonstrated these took place.

The registered manager demonstrated effective systems to manage DoLS applications.

During the inspection we observed staff seeking consent from people before providing assistance, such as asking people if they would like to take their medication.

We observed people were treated with kindness and dignity during the inspection. Each person we spoke with said they liked living at Lime House and were happy with the care they received.

We saw that people had specific nutrition care plans in place and where required, risk assessments had also been implemented if people were at risk with regards to their nutrition.

There was a four week rolling menu in place, which was available in the dining room. Special diets were catered for, food allergies were recorded and information on different diet types.

In care plans we saw people had access to a range of different service including district nurses, podiatrists, doctors, advanced nurse practitioners, GP's and opticians.

We saw that adaptations had been made to make the environment suitable for people living with dementia.

We found the service aimed to embed equality and human rights though good person-centred care planning. The people we talked with spoke highly of the staff who cared for them.

We observed staff were patient, respectful and friendly towards the people who lived in the home. Staff said they liked working at the home.

The service used an electronic care planning system called 'CareSys' with hard copy paper files also being in place. We saw detailed personal profiles in the care records.

People's care files identified that individuals and their relatives were involved in the planning of their care, and personal preferences were discussed.

We saw people had a choice of activities to stimulate them.

Our observations and discussions indicated people who used the service expressed their views and were involved in making decisions about their activities.

The home had procedures in place to receive and respond to complaints.

Residents and relatives meetings were held regularly and information from these meetings was used to inform the delivery of the service.

We saw a variety of positive comments about the home received from visiting professionals. The service worked in partnership with a wide variety of organisations and professionals.

The service undertook a range of audits, which were completed according to different schedules.

Observations of staff practice were regularly carried out and quality assurance audits were also carried out monthly at provider level.

There was a full range of policies and procedures in place which were available in paper copy format and electronically.

The service had a business continuity plan that was recently reviewed and audited in August 2016.

The local authority had also carried out an audit in March 2016 and the home had achieved a 97% compliance rating.

## 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. Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service and there was evidence of robust recruitment procedures.

People we spoke with who lived at Lime House told us they felt safe.

Records of medicines administration had been completed consistently and accurately. Accidents and incidents were recorded correctly.

### Is the service effective?

Good

The service was effective. Staff were subject to a formal induction process and probationary period and there was a staff supervision schedule in place.

Staff were aware of how to seek consent from people before providing care or support.

There were adaptions to the environment to assist people living with a dementia.

### Is the service caring?

Good

The service was caring. Staff spoken to had a good understanding of how to ensure dignity and respect and staff showed patience and encouragement when supporting people.

We heard lots of laughter between staff and people and there was a positive atmosphere within the home.

The service involved families when developing care plans or carrying out assessments.

### Is the service responsive?

Good

The service was responsive. Care files were well organised and contained information that covered a range of health and social care support needs.

Each person had a detailed care pathway, an assessment of possible risks and a description of the person's needs for support and treatment.

The home had procedures in place to receive and respond to complaints.

## Is the service well-led?

Good

The service was well-led.

There was a registered manager in post.

There were a variety of systems in place which helped the service to monitor the quality of care provided and the service undertook a range of audits.

Surveys were carried out and information was used to improve the quality of service.

# Lime House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 23 August 2016 and was unannounced. The inspection team consisted of two adult social care inspectors. At the time of the inspection 30 people were living at Lime House.

Prior to the inspection we reviewed information we held about the home in the form of notifications received from the service such as accidents and incidents. We also contacted Wigan Local Authority Quality Assurance Team, who regularly monitored the service.

We spoke with six people who used the service, one visiting relative, four members of care staff and the registered manager. We also looked at records held by the service, including 10 care files and four staff personnel files. As part of this inspection we 'case tracked' records of five people who used the service. This is a method we use to establish if people are receiving the care and support they need and that risks to people's health and well-being were being appropriately managed by the service.

We observed care within the home throughout the day including the lunchtime medicines round and the lunchtime meal.

Good

# Is the service safe?

## Our findings

The people we spoke with said they felt safe living at Lime House. Comments included , "I feel safe because I am able to lock my bedroom door and that makes me feel safe," and "I have access to my call bell which helps; if ever I need to use it the staff come straight away," and "Yes, very safe; the staff are all very good to me." A visiting relative also told us, "[My relative] is extremely safe living here."

There were systems in place to protect people from abuse. There was an up to date safeguarding policy in place, which referenced legislation and local protocols. The staff we spoke with demonstrated an understanding about safeguarding, whistleblowing and how they would report any concerns. One member of staff said, "Physical, mental and verbal are all types of abuse. If someone was slapped or I saw bruising that could be physical abuse. Changes in personality could also mean something isn't right. I would speak to my manager if I had concerns." Another member of staff said, "I would ask to speak with the person involved in confidence to see if they wished to disclose anything to me. If someone's money went missing that could be financial abuse. I would report it straight away to the manager."

The service had a robust recruitment procedure in place. Appropriate checks were carried out before staff began working at the home to ensure they were fit to work with vulnerable adults. During the inspection we looked at four staff personnel files. Each file we looked at contained application forms, Criminal Records Bureau/Disclosure Barring Service (CRB/DBS) checks and evidence of references being sought from previous employers. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people.

There were also interview notes which contained records of responses that had been given to questions asked at interview. The staff we spoke with told us they were asked to provide references and complete a DBS form, when applying for the job. These had been obtained before staff started working for the service.

There were sufficient numbers of staff working at the home to meet people's needs. We found that staffing levels at the home consisted of three care assistants and a senior carer during the day and two care assistants at night. This was to provide care to 30 people. The registered manager also provided hands-on additional support and advice to the staff group during the day. There was also a provider 'on-call' system which operated at all times throughout each day and night that provided access for staff to the manager or senior staff member if they were not present in the building, for example during the night.

During the inspection we observed staff responding to people's care needs when required such as providing support to people at meal times, answering call bells and assisting people to mobilise around the building. We saw that call bells were answered quickly and within 30 seconds on each occasion we heard them being activated.

All of the people spoken with including people living at the home and staff told us they felt staffing levels were sufficient. One member of staff said, "At times we could sometimes do with an extra pair of hand when it's busy but we do cope. We manage ok I would say." Another member of staff said, "If ever there is sickness or absence, cover is always provided. We are able to meet people's needs with current staffing numbers." A

person living at the home also told us, "There always seems to be plenty of staff, however they are busy." Another person added, "Whenever I have needed the staff they have always been there."

We looked at how the service managed the administration of medicines. We saw that the home did not have the available space to create a separate medicines room and the medication trolley was stored on a corridor just outside one of the main lounge areas. We observed the trolley was locked at all times when not in use and secured to the wall, with only senior members of staff having access to the key. Staff were required to sign for the handover of these keys on each occasion.

We looked at a sample of Medication Administration Records (MAR's) and observed medicines administration during the day and saw that MAR's were signed by staff when people received their medication, as required. All staff we spoke with said they received training in medication which we verified from looking at training records. Any overstock of medicines was clearly identified with the persons' name and stored separately in preparation for collection by the supporting pharmacy. Disposal records were completed appropriately. Some medicines were required to be stored in a fridge and we saw that minimum and maximum fridge temperatures were being recorded as required.

We checked the controlled drugs (CD) cabinet which was securely locked. The CD register was up to date and the balance of stock was correct.

A medicines stock control form was used for each person receiving assistance with medicines and this included the date the medicine was received, the name of the person concerned, the details of the actual medicine prescribed, the quantity received, when it was transferred to the medicines trolley and the current stock level. These forms contained two staff signatures.

We asked people living at the home if they had any concerns about receiving their medication. One person said, "The staff give me my medicine. I get a top up both morning and night and always get it when I need it." Another person said, "It's always on time give or take a few minutes or so."

We looked at how the home managed risk. We saw that care plan documentation contained risk assessments which covered Waterlow, pressure sores, moving and handling, nutrition, bathing and falls/mobility. Each risk assessment had a corresponding 'risk plan' which detailed how the risk was managed and any control measures that were in place. For example, one person was described as having poor balance and needed to have either a walking stick or Zimmer frame with them to help them mobilise safer. We observed this person walking with Zimmer frame during the inspection.

At the time of the inspection we noted the dining room area was being refurbished. We observed that this area was kept locked at all times to ensure people did not enter the area, potentially placing themselves at risk. As part of this work the service had temporarily moved the kitchen preparation area to a different part of the home to enable remedial work in the kitchen to take place and reduce the potential for harm if people accessed these areas independently. There was also a steep staircase leading to the basement and the door to the staircase was kept locked and secure throughout the day.

We looked at the systems in place with regards to cleanliness and infection control. The home was clean and tidy with no pervasive malodours present. We saw that bedrooms, corridors, lounges and communal area were tidy, with domestic staff undertaking cleaning activities during the early part of the day. We also saw toilets and bathrooms were equipped with paper towels and soap and hygiene guidance was posted on the wall. Domestic staff followed a daily and monthly tasks list which gave information on what cleaning activity was required each day. Records of these were fully completed and up to date.

There was an up to date fire policy and procedure. Fire safety and fire risk assessments were in place. People had an individual risk assessment regarding their mobility support needs in the event of the need to evacuate the building. Tests of the fire system were made regularly and the servicing of related equipment, such as fire extinguishers was up to date.

Good

# Is the service effective?

## Our findings

The staff we spoke with told us they completed the induction when they first started working at the home. One member of staff said, "When I did the induction it covered safeguarding, moving and handling, and infection control. It gave me a good introduction into working at the home and how everything worked." Another member of staff said, "I was happy with the induction and it gave me everything I needed."

We saw that the staff induction programme was aligned with the requirements of the care certificate and covered areas such as equality and diversity, privacy and dignity, safeguarding, dementia and health and safety. At the start of employment, staff were also able to shadow existing members of staff to see what the job entailed and how certain tasks needed to be done, until they were assessed as being competent to work independently.

We looked at staff training, staff supervision and appraisal information. The staff we spoke with told us they had enough training available to them and felt supported to undertake their work. One member of staff said, "The support is good here and there is enough training. The most recent training I have done has been moving and handling, infection control, safeguarding, health and safety and first aid." Another member of staff said, "We do get a lot of training. I've done quite a bit recently and I do feel very well supported."

Staff told us they received supervision as part of their work and we looked at a sample of records which demonstrated these took place. We saw that some of the areas discussed included personal matters, actions from the previous meetings, responsibilities and performance, working relationships, training and development and things to work towards for the next meeting. One member of staff said, "They seem to be about every three months. They seem to be consistent and allow us to discuss what is going on and any problems."

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.

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 and hospitals 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. The registered manager demonstrated effective systems to manage DoLS applications. We found that the service was complying with the conditions applied to the authorisations. Where applications had not yet been authorised, peoples' care plans contained restrictive practice screening tools, which ensured that the least restrictive practice was being followed.

In instances where people were deemed not to have capacity to consent to living at the home, the registered manager had completed standard authorisation forms which had been submitted to the local authority. There was a current policy in place detailing the procedures to follow. All the staff we spoke with had an understanding of DoLS and told us they had been provided with appropriate training, which we verified by looking at training records. We saw people were supported by staff throughout the day of the inspection to go outside and access the secure and pleasant garden area if it had been deemed unsafe for them to leave the building alone and unaccompanied.

During the inspection we observed staff seeking consent from people before providing assistance, such as asking people if they would like to take their medication as opposed to giving them no option. The people living at the home said staff sought their consent and care files showed records of consent to care and treatment. Staff were also able to describe how they aimed to do this before providing care and support. One person said, "The staff helped me to have a wash this morning and they asked first before assisting me." Another person said, "When I am supported to have a bath or a shower, the staff always check that it is what I want." A member of staff also added, "I would ask first, although some people struggle to give consent due to capacity. I would aim to work in people's best interests in that case."

We observed staff knocking on people's doors and waiting for permission before entering. For example, after doing this one staff member entered the person's bedroom and said, "Good morning, how are you today?" before explaining where another person was after being asked. Staff also explained the role of CQC and the reason for the inspection to people as they noticed our presence in the home and asked about us.

We looked at how people were supported with regards to nutrition and hydration. We saw that people had specific nutrition care plans in place and where required, risk assessments had also been implemented if people were at risk with regards to their nutrition. The care plans detailed the type of support people required, such as if they needed full assistance from staff. Each person also had a kitchen notification form and this took into account their likes/dislikes, the types of foods they liked to eat at each meal and any food allergies. People were also weighed at regular intervals, with records maintained in each person's care plan.

On the day of the inspection, the weather was hot and sunny and due to this we saw people had access to regular drinks throughout the day to ensure they stayed hydrated, and there were several drinks stations situated throughout the home with a choice of soft drinks available.

We asked people for their opinions of the food at the home. One person said, "The food has been very good up until now. They have built my weight back up. I have gone from being four stone and thirteen pounds up to six stone in four weeks." Another person said, "I have been here for about 15 months and the food has been wonderful. There are choices and alternatives if I don't want something in particular." A third person added, "It varies, and overall it is quite good."

There was a four week rolling menu in place, which was available in the dining room and a new pictorial menu was being developed that was due to be introduced following the refurbishment of the kitchen, which would assist some people living with a dementia to understand what was being offered. We saw that breakfast was a choice of cereal, toast, yoghurts, fresh fruit juice, tea or coffee. This was followed by a hot cooked breakfast on request. Lunch was hot-pot and beetroot with jelly and cream. Tea was soup and sandwiches, whist pies or pasty and chocolate fudge cake. Hot drinks and snacks such as biscuits/cake/tea cakes/cheese were also available throughout the day and night.

Special diets were catered for, food allergies were recorded and information on different diet types, such as a soft diet, informed the kitchen staff how to prepare and serve these types of foods. Food temperatures

were recorded at each meal before serving.

We saw that people had access to various health services, with staff seeking assistance as required or if ever there were any concerns. In care plans we saw people had access to a range of different service including district nurses, podiatrists, doctors, advanced nurse practitioners, GP's and opticians.

We saw that adaptations had been made to make the environment suitable for people living with dementia. For example there was signage and pictures on all bathroom and toilet doors making it easier for people to locate them. There were also were also pictures and memorabilia throughout the building associated with the town of Leigh which people could relate to from their previous experiences. There were also coloured hand rails and paper towel dispensers, with assisted people to use these facilities independently. Each person also had their own picture and name on their bedroom door, making it easier for them to locate.

Good

# Is the service caring?

## Our findings

We saw staff showed patience and encouragement when supporting people. We observed people were treated with kindness and dignity during the inspection. Care staff spoke with people in a respectful manner. For example at the lunch time meal we saw staff gently encouraging people to eat their food.

Each person we spoke with said they liked living at Lime House and were happy with the care they received. One person said, "I feel I receive good care." Other comments from people included; "I like being here, it's a lovely place to be," and "It's very good; they are looking after me and taking good care of me."

During our inspection we looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights though good person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure people from different groups received the help and support they needed to lead fulfilling lives, which met their individual needs.

A visiting relative told us they were happy with the level of care provided at the home. We were told, "It's exemplary and I can't fault them at all; they definitely provide good care. The home never smells either compared with some places you go to. [My relative] is always clean and well-presented when I visit. They give her a shower and wash her hair. I have no concerns about anything at all."

The people we talked with spoke highly of the staff who cared for them. Comments included, "The staff are lovely, all of them; they can't do enough for you," and "The staff are very good, very good indeed and nothing is too much trouble for them," and "The staff are all very nice with me I can't fault them and they have really looked after me," and "The staff are very good and very kind."

Throughout the course of the inspection we heard lots of chatter between staff and people who used the service and there was a positive atmosphere within the home. Staff interacted with people throughout the day and it was clear that they had a good understanding of each individual person. We observed many occasions where staff spoke privately on a one-to-one basis with people.

The people living at Lime House said they felt treated with dignity and respect by staff. Staff were also able to describe how they aimed to do this when delivering care. One person said, "They certainly do treat me with dignity and respect and we always seem to be able to have a laugh as well." Another person said, "They have always treated me very well since living here." A member of staff also said to us' "If I'm assisting someone to the toilet then I wouldn't announce it in front of people, I would make sure it was done in private." Another member of staff added, "I'll knock on doors before entry and cover people up during personal care so that they aren't exposed."

People told us that staff tried to promote their independence as much as possible. Staff were also able to describe how they did this when delivering care. One person told us, "I do as much as I can wherever possible but the staff only assist me when I really need them." Another person said, "I have a wash on my

own, but the staff assist me to the bathroom. They are very good." A member of staff also said, "I will encourage people to do as much for themselves as possible as I don't want them to lose that independence. I assist one person to get dressed but will help put their jumper over their head, but then leave them to fasten the buttons themselves."

People's care files contained end of life care plans, which documented people's wishes at this stage of life where they had been open to discussing this. Staff told us they involved families when developing care plans or carrying out assessments. The people we spoke with living at the home and visitors to the service confirmed this was the case. At the time of the inspection no person was in receipt of end of life care and each care file had a section about advanced decisions. Where people had made an advanced decision regarding end of life care this was recorded correctly, dated and signed appropriately.

We looked at records of residents and relatives meetings, which were held regularly. Records were kept of each meeting and notes were given to people and their relatives. Areas discussed included general refurbishment, the garden area/sensory garden, menus and activities.

Good

# Is the service responsive?

## Our findings

We observed staff were patient, respectful and friendly towards the people who lived in the home. One person told us, "It's been excellent. They have been very good with me. When I came in I was underweight and now it's increased." Another person said, "My overall impressions are good. If I need help, then it's there."

The service used an electronic care planning system called 'CareSys' with hard copy paper files also being in place. Each staff member had their own personal password to log into this system and there were three lap-tops available; one for each section of the building. Before implementing this system the service had received authorisation for its use from the Assistant Director of Adult Services within the local authority.

We found the CareSys system to be very easy to use with information that was well organised and contained care plans that covered a range of health and social care support needs, including a section titled 'person-centred care plan.' This included information on mobility support, activity preferences, people's social histories, sleep, dressing and personal preferences regarding how they would like to be supported at different times of the day, communication and getting out and about. For example one care plan stated, 'I require people to speak to me in a strong and clear voice and look at me directly.' Another plan stated, 'I don't like showers; I require staff to support me with using the bath.' We saw that prior to any new admission a pre-assessment was carried out with the person and their relative(s). People's needs for support were carefully described on their care plans so care staff knew exactly what tasks to undertake.

We saw detailed personal profiles in the care records, which included people's life story, a list of priorities about their care and quality of life, their memories, risk assessments and relationships. This meant staff had information to ensure people's care was as personalised as possible. The staff we spoke with understood the contents of the care plans, and knew people's needs and preferences. People's dependency levels were identified in their care plan and this covered areas such as mobility, dressing, personal hygiene, eating/drinking, eyesight, hearing, pressure sore risk, continence, communication, social dependency, behaviour.

People's care files identified that individuals and their relatives were involved in the planning of their care and personal preferences were discussed. The care records showed regular visits form relevant other professionals such as a GP, an optician, a chiropodist and advanced nurse practitioners. This meant appropriate healthcare professionals were accessed when people required them. Each person had a detailed care pathway, an assessment of possible risks and a description of the person's needs for support and treatment. The care plans were reviewed monthly by the senior carer or manager.

We saw people had a choice of activities to stimulate them. These included reminiscence, trips to local shops and amenities, events in the home such as a tea dance, watching films or sitting quietly in their room. There was also a hairdressing salon in situ that people could access on request. There was an activities board on display which identified different types of activities on offer. There was a mobile shop where people could buy snacks and a library was in place to enable people to borrow books, videos or CD's.

We saw that on the day of the inspection several people were accessing the enclosed secure garden area either independently or with the assistance of staff. Due to the hot weather, people were sat in shaded areas, either collectively or independently. One person told us, "Isn't it great; I've just been in the garden area which I love to do." Another person said, "I love sitting in the garden, its great here."

We saw one person taking a relaxing stroll around the garden area whilst linking arms with a staff member and this was concurrent with the support needs identified in the person's care plan. We saw that regular rests were taken with the person sitting alongside the staff member, chatting and laughing. In the afternoon a gentle soft-ball game was taking place in the garden with seven people participating. All people had a plentiful supply of cold drinks to avoid the potential for dehydration in the warm weather.

During the afternoon we saw people who did not wish to go outside taking part in a gentle dance sessions indoors with staff members. Another person was sat in the lounge area doing their knitting; they told us in a jovial manner, "Oh there's too much dancing for me, I need a rest." Other people were sat in a different lounge area taking part in a concert sing-along with staff members.

Our observations and discussions indicated people who used the service expressed their views and were involved in making decisions about their activities. The service celebrated people's birthdays where it was their wish to do so.

We looked at how the service managed complaints and we found that the home had procedures in place to receive and respond to complaints. There was a complaints policy and procedure in use and this was up to date. People we spoke with told us they had never had to raise a complaint, but would feel comfortable doing so if required. There was information displayed on the notice boards in various parts of the home and in the service user guide about the process to follow if people wished to make a complaint.

Resident and relatives meetings were held regularly and information from these meetings was used to inform the delivery of the service. People we spoke with and a relative told us they were made aware of these meetings in advance and previous meetings had discussed the menu, activities and special events. We saw records from a range of meetings that verified this.

Good

# Is the service well-led?

## Our findings

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. The registered manager had been in place since March 2011. 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.

Staff said they liked working at the home. They told us they thought the home was well led and said that the registered manager was approachable and fair. One staff member told us, "It's a wonderful place to work. The manager is always available every day and I've no concerns about working here."

The registered manager told us that they sometimes undertook shifts in the care staff role and said, "It helps me to keep in touch with the care staff role and understand their position."

We saw a variety of positive comments about the home received from visiting professionals. Comments included, 'Can't praise the staff highly enough,' and 'Always a pleasure to visit; staff always professional and helpful; residents always appear happy and content.'

The service supported student nurse placements. One student nurse told us, "The manager has been brilliant and gave me all the information I needed on day one." Other comments included, "It's been a lovely experience to have done my first practice learning at Lime House which is an epitome of good practice; at Lime House staff work together as a team to promote resident's choice and independence."

We looked at documents, which the service used to monitor the quality of service by seeking feedback from people who used the service, their families, staff and visitors and we found that residents' meetings had been held regularly. Records of these meetings were detailed and showed that various issues had been discussed.

The most recent survey identified the following responses: 88% of relatives felt the home met the needs of their relative; 82% felt the home kept in touch; 82% felt they were informed of any issues; 94% felt the home provided the care that they expected; 100% felt the home treated their relative with dignity and respected their privacy and confidentiality.

Following this survey a letter was sent to people's families/relatives identifying the results and asking them if they felt the format of the survey should be changed, if anything needed adding/deleting and if they had any suggestions for improvement. Relatives were also asked if they would prefer future surveys to be sent by email and to sign to agree to the use of their email address for this purpose. Responses had subsequently been received and changes made as a result.

The service worked in partnership with a wide variety of organisations and professionals including local faith groups and local schools, local clubs and facilities such as community centres and libraries. Holidays were

also supported for people who wished to undertake this type of activity.

The service undertook a range of audits, which were completed according to different schedules and these included areas such as care plans, the environment and equipment, including the fire system, building safety, lighting and heating. The manager received a 'handover' at the start of each day from care staff which included information on any incidents, visitors to the home and issues raised. We saw there were reviews of people's care by health professionals who visited the home, reviews of any complaints, a monthly care plan audit and monthly health and safety audit. We saw evidence of action plans that the manager used to improve care or practice. Monthly medicines audits were also undertaken and observations of medicines administration practice had also been carried out, which staff verified.

Quality assurance audits carried out by the manager also included staff training files, care files (including pre-admission information, mealtimes and refreshments, dependency assessments, person-centred risk assessments, and daily progress reports), staff supervision records and any accidents/incidents.

Observations of staff practice were regularly carried out and quality assurance audits were also carried out monthly at provider level, which included talking to staff and checking records. After these visits, or after the manager had carried out their own quality assurance checks a 'quality audit - managers action plan' document was drawn up, which identified the actions required to meet any deficit areas and how these related to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Visits from the provider quality assurance officer verified that actions previously identified had been implemented.

There was a full range of policies and procedures in place which were available in paper copy format and electronically. These covered all areas of care provision as well as providing specific guidance and safe systems of working in relation to use of equipment. There was evidence in minutes of staff team meetings that findings from audits were communicated to staff and actions taken. For example one audit had identified the need for consent to the administration of medicines forms, and we saw that these forms were in use and in people's care records.

The local authority had also carried out an audit in March 2016 and the home had achieved a 97% compliance rating. Records of staff competency assessments via observation were also available and these included individual feedback to staff on their performance and there was a staff supervision schedule in operation, which was posted on the manager's office wall. We saw that the office was neat and tidy and well-organised and information was clearly labelled and easy to access.

The service had a business continuity plan that was recently reviewed and audited in August 2016. This included details of the actions to be taken in the event of an unexpected event such as the loss of utilities supplies, fire, and loss of IT/telephony, an infectious outbreak or flood. The plan also identified the need to report to CQC.