WCS Care Group Limited

The Limes

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This inspection visit took place unannounced on 9 August 2018 and we returned announced on 10 August 2018 to look at the quality assurance systems and to speak with people and staff.

The Limes is a two-storey residential home which provides care to older people including people who are living with dementia. The Limes is registered to provide care for 30 people. At the time of our inspection visit there were 27 people living at the home. Care and support was provided across both floors and each floor had its own communal lounge and dining area.

People in care homes receive accommodation and nursing and/or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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.

At our last inspection we rated the service Good overall, with Well led being rated as 'Outstanding' because we found the provider learnt from previous inspections to drive improvements, shared good practice and the culture promoted open and continuous learning. At this inspection we found the service remained overall Good, however 'in Well led' we found the governance audit systems had not identified some of the issues we found which affected the standards of the care being provided.

Systems to ensure safe management of medicines were not always followed in line with current guidance and the provider's own policies. Medicines were not always stored, recorded and given in line with current NICE guidance and staff who administered medicines were not confident or had sufficient knowledge using the electronic medicines management system.

People and relatives were very complimentary and satisfied with the quality of care provided at the home. People felt safe living with other people in the home and they were supported by a consistent, kind and caring staff team.

Staff were available at the times people needed and there were enough staff to respond to people's needs and requests for assistance. Staff received training so that people's care and support needs were met by staff who knew how to support them. Staff understood their responsibility to safeguard people from harm and report any concerns they had to the management team.

People's changing needs were responded to promptly by staff and other healthcare professionals were contacted when needed. People were treated with respect by staff who addressed them by their preferred

names and who supported them in line with their personal preferences and wishes.

No one at the time of our visit received end of life care. The registered manager said care was given so if people wanted, 'this was a home for life'. Anticipatory and pain relief medicines were arranged and held so if people's condition quickly deteriorated, their care could remain as pain free and dignified as possible.

The provider worked in partnership with other healthcare professionals to ensure people received effective care that was responsive to their needs. People's medicines were not always stored and managed safely.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the procedures in the service supported best practice and decisions were made with family members who had legal authority to do so.

The registered manager understood their responsibility to comply with the requirements of the Deprivation of Liberty Safeguards (DoLS). People's right to make their own decisions about their care, were supported by staff who understood the principles of the Mental Capacity Act 2005.

There was a strong emphasis on people eating and drinking well. Staff had a good understanding of people's nutritional risks so they could meet their individual dietary requirements. People told us they enjoyed the food and where people had specific dietary needs, such as soft and pureed foods, vegetarian and culturally, these needs were met.

Staff knew and understood how to limit the risk of cross infection and followed safe infection control practices.

The provider continued to be responsive to people's needs and people were occupied and stimulated with a variety of activities and events. Staff sought information from relatives and extended families so they could get to know people better. Relatives were involved, included and updated whenever changes were identified.

The registered manager promoted a homely atmosphere within the service. People and relatives said, everyone got on well and it was like an extended family. The provider's governance systems recorded their audits and checks which were comprehensive in not only looking at this service, but how they rated in key areas, across other services within the providers organisation. However, some improvement was required to ensure audits such as care plans, medicines and equipment were more robust so they could identify some of the issues we found.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were enough staff to keep people safe, and the care staff team knew people's care and support needs. People's risks to their health and wellbeing were assessed and planned for. Systems to ensure safe management of medicines were not always followed in line with current guidance and the provider's own policies. People felt safe with staff who understood their safeguarding responsibilities. Accidents and incidents were recorded by staff and learning from such events was encouraged and acted upon.

Is the service effective?

Good

The service remains effective.

Is the service caring?

Good

The service remains caring.

Is the service responsive?

Good

The service remains responsive.

Is the service well-led?

Good

The service is well led.

At the last inspection we rated well led as 'outstanding' because the provider learnt from previous inspections to drive improvements and the culture promoted continuous learning and their audit systems were effective. At this inspection, completed audits did not always identify the issues we found, particularly around care plans and medicines management. Learning from other inspections within the provider's organisation had not been shared so we found similar issues that affected the quality of care people received.

The Limes

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 visit took place on 9 August 2018 which was unannounced and we returned announced on 10 August 2018. The inspection visits were undertaken by one inspector.

Before our inspection visit, we reviewed the information we held about the service. We looked at information received from the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. The commissioners did not share any concerns about the service.

Before the inspection visit, the provider completed a Provider Information Collection (PIC). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIC was comprehensive and we were able to review the information in the PIC during our inspection visits. We found the information in the PIC highlighted what the service did well and how they planned to drive improvements.

To help us understand people's experiences of the service, we spent time observing and talking with people in the communal areas of the home, or their bedrooms with their permission. This was to see how people spent their time, how staff involved them in how they spent their time, how staff provided their support and what they personally thought about the service they received.

We spoke with four people who lived at The Limes and four visiting relatives. We spoke with the registered manager, three care co-ordinators and three care staff (In the report we refer to these as staff). During our visit we also spoke with the provider's director of compliance and a director of delivery.

We looked at three people's care records and other records relevant to their support, such as medicines records, care plans, risk assessments and daily records. This was to see whether the care people received was recorded and delivered according to people's care plans.

Requires Improvement

Is the service safe?

Our findings

At this inspection, we found the same level of protection from abuse, harm and risks as at the previous inspection. People continued to be supported by staffing levels that met their needs. However, we had concerns that people's medicines were not stored and given in line with safe guidelines. Therefore, we have changed the rating to 'Requires Improvement'.

People told us they felt safe and secure living at The Limes because staff and people at the service were so kind and friendly. One person told us they felt safe because the front door was closed and 'unfamiliar faces' could not gain access. Relatives felt their family members were in a safe environment because staff were always on hand to support them. One relative said, "[Name] had falls at home but since moving here has not fallen." Relatives told us whenever they visited and left their family member, they were confident they would not come to any harm.

Staff received training in safeguarding people from abuse and they understood their responsibilities to protect people from avoidable harm, neglect and poor practice. Staff were confident to raise any concerns with senior staff, the registered manager or senior management within the organisation. One staff member said, "I would raise any concerns with senior staff and management." Staff told us they had not witnessed any poor practice they felt needed to be referred to the provider. The registered manager knew the procedure for reporting safeguarding concerns to the local authority and to us (CQC).

People and relatives said there were enough staff to meet their needs. People told us staff responded quickly if they needed assistance. Comments included: "If I ring my call bell, staff do come quickly" and "I can wait about 10 minutes or so, but that is fine." Relatives told us staffing at the home was consistent so staff knew people well and their relative got to know staff which they said was important. One relative said, "The staff turnover is very low, we can't fault it."

Staff told us there were enough of them to meet people's needs. The registered manager was confident staffing levels were correct, explaining there was, "Five staff and a float each day." On the day of our inspection visit we saw sufficient numbers of staff to provide safe care to the people who lived at The Limes. However, staff were sometimes very busy and there were occasions when they were not able to respond immediately to requests for assistance. For example, we pressed a person's call bell and deactivated it after four minutes, without staff responding. We observed lunchtime on the first day of our visit and found care staff were busy because they had to provide people with their meal choices and clear up, as well as assisting some people who required more help to eat. The provider had an expectation that staff sat with people but this did not happen when we observed lunch.

The care co-ordinator planned staffing levels based on the provider's standard model of care and we asked the registered manager how they were confident that staffing levels supported staff to provide safe care. They told us staffing levels were set by the provider, but they conducted daily 'walk arounds' of the home to check staffing levels met people's needs. They told us they would talk to the provider about increased staffing levels if they needed to and they gave us examples of when staffing levels had increased, such as

providing one to one support and covering appointments. They were satisfied that the staffing levels at the home kept people safe.

Risks to people's health had been assessed using nationally recognised tools, for example, any nutritional risks or risks associated with people at risk of weight loss. Care plans guided staff with the action they needed to take to minimise risks and keep people safe. For example, one person at high risk of skin damage had equipment in place to relieve pressure to their vulnerable areas such as a pressure relieving mattress on their bed and a pressure cushion on their chair. Regular checks of people's pressure equipment ensured it remained fit for use and continued to protect people from unnecessary risk. In addition, stickers were placed on the electrical plugs to prevent them being switched off by mistake. However, some risk assessments needed more detail for staff to support people, for example those at risk of falling. There was limited information for staff to know what to do and how to prevent further falls, such as use of appropriate footwear, or if the person fell at night or in the day and what they needed to do to reassure the person.

People told us they received their medicines at the required times. Medicines that were identified as requiring stricter controls were accurately checked, recorded and dispensed. However, we could not be confident, medicines were given safely and as prescribed. Recent spells of hot weather meant medicines were stored at over 30 degrees Celsius (room thermometer recording) and there was no consideration to how this may affect certain medicines. Some medicines were stored in a medicines refrigerator within safe temperature ranges, however we saw eye drops that should be stored at room temperature once opened, were still stored in the refrigerator. Staff explained how they took the eye drops straight from the refrigerator and administered the eye drops directly into the person's eye. This could provide discomfort to the person receiving the eye drops. Staff had not read the instructions to determine safe storage and the application of this medicine once opened.

Where people had medicines on an 'as required' (PRN) basis there were guidelines and policies in place to ensure they were given safely and consistently. We looked at one person who had 12 PRN medicines but there were only written protocols in place for two of the medicines. Another person did not have a PRN protocol in place for pain relief management. Although there was unclear information, staff understood when to offer this medicine and signs that indicated if the person was experiencing pain.

Staff told us the electronic medicines recording system only allowed staff to give people their medicines at the prescribed times but they could only record if the medicines were taken. The provider's medicine policy stated that staff were to offer and record the answer, however staff were unable to record this on the electronic system which did not support their policy. This recording would identify if these medicines were taken regularly or not and if the provider needed to contact the prescriber to review their use.

Some people received their pain relieving medicines via a trans-dermal patch applied directly to their skin. It is important the patches are rotated around the body in line with the prescribing instructions, to avoid people experiencing unnecessary side effects. Staff had not completed records of where patches had been applied to ensure people were protected from these risks. For one person's records we looked at, staff did not rotate the medicine in line with safe guidance. In some cases, there was no record of daily checks to ensure the patches were still in place. Daily checks are important as patches can fall off or be removed by people, which could result in them experiencing unnecessary pain.

We were told staff trained in the administration of medicines, were assessed as competent but records to support this were not readily available. Following our visit, the registered manager sent us copies of staff certification. These staff were recently assessed as competent however their knowledge and practice of safe administration of medicines was not in line with NICE guidance. Speaking with staff, it was clear from the

introduction of the electronic medicines system staff encountered a number of issues such as poor connectivity and limited knowledge of how to record and store certain medicines and what the system would allow.

The registered manager took action to address the issues we identified during our inspection visit. They confirmed guidelines were in place for all PRN medicines and records had been implemented to ensure patch medicines were administered safely and in accordance with the prescribing instructions. Action had been taken to monitor and store all medicines within safe temperature ranges to ensure they remained effective.

The environment was clean and free of odour. The registered manager completed regular infection control checks and they and staff understood the importance of safe infection controls. The registered manager gave us one example of how they supported one person whose condition posed an infection risk to others. The registered manager said they separated this person's laundry items from others to limit the risk of cross infection. Normal practice included using different laundry bags to separate soiled laundry from normal laundry. We did not see personal care provided, but staff knew when to use personal protective equipment to reduce the chances of cross infection.

Staff recorded accidents and incidents and the registered manager and provider, analysed the reports to ensure appropriate action had been taken and any necessary referrals to other healthcare professionals had been made.

Records showed regular safety checks were carried out on the premises and equipment used in the delivery of care, such as hoists, slings, wheelchairs, pressure mattresses and water quality checks. However, upon checking the call alarm logs, we identified a person's alarm mat was not detected on the alarm system. We were concerned this presented a risk that either staff may not be alerted to a person's movement, or, if call responses were slow, this would not be identified. We asked the registered manager to ensure all similar mats were checked to ensure they effectively linked to the alarm system and remained fit for use. They agreed all mats would be checked.

The provider had plans to minimise risks to people in the event of an emergency, such as a fire risk. Regular testing and checks of fire equipment, fire drills, emergency lighting and alarms were completed. The registered manager showed us examples of completed PEEPS (personal emergency evacuation plans) that were updated so emergency personnel could provide the correct interventions to keep people safe.

Good

Is the service effective?

Our findings

The service continued to provide effective care and support to people. A relative said staff provided effective care because staff knew people well and knew how to care for them. We continue to rate `Effective' as `Good'.

People said the care and support they received showed them staff knew what to do and how to do it. People and relatives commented to us saying that the staff were, "Excellent." Relatives told us staff were consistent and knew people well which made the service more effective because, "Staff could make the decision if the person could not."

Staff told us they had received essential training and the training they received equipped them to support people in their care. Staff said they communicated well with each other so if they had any questions or where unsure, other staff could help. Following our inspection visit the provider sent us their training schedule that showed staff training was regularly refreshed.

Staff 'household' meetings took place monthly and discussed a variety of issues. In July 2018, the meeting discussed mealtimes, call bells and the provider's values. Staff said the meetings were useful to communicate important messages.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager reviewed each person's care needs to assess whether people were being deprived of their liberties, or their care involved any restrictions. We saw appropriate DoLS authorisations were in place to lawfully deprive people of their liberty for their own safety.

The provider understood their obligations and acted in accordance with the MCA. People's understanding and memory had been assessed to check whether they could make their own decisions, or decisions needed to be made in their best interests. The provider had applied to the supervisory body to restrict people's liberty, when it was in their best interests to do so, because the person lacked the capacity to recognise risks for themselves. However, at the time of our visit, no one had restrictions placed on their freedoms. Doors to the home were coded but people were given the code so they could come and go as they wished. For those who could not remember the code, staff supported them to go outside or to access other parts of the home.

Staff recognised and understood the importance of promoting independence and choice. Most people were able to express themselves and said they were able to choose what time they got up and went to bed, what to wear and what they did throughout their day. People told us staff respected their individual decisions. Staff had limited knowledge of people's capacity to make specific decisions because this was not always accessible on their hand-held device. However, staff said they spoke with other staff and senior staff so they knew how to approach people to help them to make a more informed choice.

People told us they enjoyed the food and they were offered a choice. Staff told us people were asked the night before and their choice was recorded, however the registered manager said people were asked again at lunchtime in case their choice had changed or had been forgotten. Good dementia care practice would be to offer people visual choices such as a pictorial menu, picture card or a small plated option. We observed lunchtime in two dining rooms and we did not see people being offered visual prompts to help them make a choice. One person was given another person's meal choice and not their own and they were not even asked what they wanted. Following our visit, the registered manager introduced a plated visual option and removed the practice of people having to decide the night before.

For people at risk, staff regularly weighed people to check they maintained their normal weight. Staff told us if people were at risk of not eating or drinking enough, they monitored and recorded what the person ate and drank and reported to a senior staff member if the person did not eat enough. Four people had been identified 'at risk' and were weighed weekly and we saw their weights remained consistent whilst being monitored.

Staff knew which people needed their meals 'fortifying' with additional full-fat milk or cream, to increase their calorific intake. The registered manager promoted the benefits of hydration, especially during the hot spell of weather. They had set a personal goal for everyone living at the home to be encouraged to drink a minimum of 1.5 litres of fluid per day. The electronic recording system enabled the registered manager to monitor each person's diet, and to prompt staff to encourage people to eat and drink more if they were at risk. The registered manager told us the focus on hydration had reduced urine infections which meant people's health and wellbeing was being managed.

Staff communicated information about people because they recorded when and how they supported people on hand held devices. Staff told us they recorded what people had eaten, drank, and they shared the information verbally at handover meetings at the beginning of each shift. People's daily records were available on the hand-held devices staff used to make sure all staff knew of any changes in how people were supported or cared for. However, we spoke with two care co-ordinators about making the records clearer. For example, at handover, one person was recorded as 'slept well, no concerns' for four consecutive days, yet their care records showed they suffered with constipation. We checked the person's medicine records and found they had been given medication to relieve their constipation, but this information had not been shared with staff as they were not aware of it when we asked them. The care co-ordinators agreed to remind staff of the importance of accurate records.

Staff supported people to maintain good health and access health services when required, such as district nurses, occupational therapists and the GP. The registered manager told us they had established a good relationship with all healthcare professionals involved in supporting people at the home, such as a nurse practitioner who visited the home weekly to support people with regular injections. This meant they could be proactive in responding to any changes in people's health. If people had to be admitted to hospital, arrangements were in place to support co-ordinated care. The registered manager told us staff would either accompany the person or arrange for a family member to meet the person there. The registered manager told us key documentation about the person and how to meet their needs was sent with the person, which ensured they received consistent care.

The environment within the home was supportive of people, especially those living with dementia. A staff member told us the provider had made adaptions to the lighting within the home. Some lights had been repositioned and bulbs had been changed to 'daylight' bulbs. We were told this had improved the light and ambience in the room, as well as limiting people's sight being affected by glare. People's rooms were personalised to their own taste and colours. People and families could bring their own possessions to make

their room feel 'homely'. People's bedroom doors had a number and a name plaque to help them locate their room. The home was accessible for people with limited mobility.

Good

Is the service caring?

Our findings

People continued to be cared for by staff who treated them with kindness and compassion. Every person who lived at The Limes and their relatives, were complimentary of staff. Typical comments included, "Exceptionally good" and "Staff are caring, they are not just going through the notes."

Relatives said staff spent time with their family member and because staff were known and familiar, this promoted better outcomes. Two relatives told us since their relation had moved into The Limes, their overall health and wellbeing had improved. One relative said their relative was now going out of their room and venturing into the dining room and other areas of the home. They said their relation was asking to go out, rather than stay in their room which made them believe their relative had become settled. They said this had helped the person to start to make friendships with other people in the home.

Another relative said they were impressed with the care provided. They told us, "The staff do not judge people." This relative explained why they chose The Limes having visited other homes in the area. They said we chose this home, "With my eyes out…. [persons] eye's in." They said this approach meant they recognised what characteristics their relative would want in a home. They told us The Limes was warm, welcoming and had a family feel. Another relative shared these feelings saying they felt the atmosphere was 'homely'. Another relative said it was 'characterful'.

The registered manager constantly emphasised to us during our visits, the core values of the provider which were, 'Play, make someone's day, be there and choose your attitude'. The registered manager said to us, "We are living in their home…we as staff, have to choose our attitude, we want to make someone's day." They said they achieved this by, "Listening to people's stories, having impromptu fun like a sing a long and getting the small things right." They were confident they and the care staff provided good care to people.

We spoke with staff about what qualities made a 'good carer'. One staff member explained, "Patience". This was echoed by other staff, and from speaking with staff they wanted to help people and do their best for people in their care. It was clear when we spoke with senior staff about improving the accuracy of care plans, medicines and daily records, they wanted to get that right.

The registered manager recognised and discussed with us, the 'wider needs' of people and said staff had been trained in dignity in care, equal opportunities, spirituality in practice and sexuality and the older person. The registered manager recognised the diverse nature and cultures and wanted to further enhance staff knowledge to better support people now and in the future. About sexuality, they said they had heard some unkind stories (outside of this home) in how some people lived their lives and they wanted to promote openness. The registered manager also understood they had a role in protecting people.

People who needed support with personal care told us they received this from staff whom they felt comfortable with and that staff made them feel relaxed. People told us they were not offered a choice of gender of care staff, but felt happy with those who helped them.

The provider was respectful of people's relationships with their families and friends which were encouraged. The provider had an open house policy and visitors were welcome at any time of the day, without restriction. Relatives were able to choose to visit their family member in their bedroom or in communal areas of the home and staff respected their privacy.

People's records were stored electronically and on hand held devices which we were told by staff, were locked away at the end of a shift. We looked at a handset for one staff member and once the staff member had logged in, there was limited security so if the device was left unattended, there was potential for this to be accessed without permission. We recommended the use of additional security such as a secondary password or a time lockout to limit potential security issues.

Good

Is the service responsive?

Our findings

People continued to feel involved in their own care decisions and people said they were able to be involved in how they lived they lives. We continue to rate `Responsive' as `Good'.

Recent satisfaction results were positive and showed people and relatives feedback was asked for and valued. Typical comments were, "There is a lot right with this home and the activities are wonderful." One relative shared their experience and said, "Staff are incredibly caring and I have noticed a huge improvement because person is now up and dressed every day and wanting to interact with others." They said, "That is huge for [name]."

Relatives said staff were responsive to individual needs. One relative said their family member had a lot of time with staff and staff were always available to spend time with them. They said they were cared for by familiar faces which helped reduce their family member's anxieties. Their relative had visual impairments and we were told they responded well to staff voices because they were known to them. Staff knew what this person liked, and they knew how to transfer them safely with specialist equipment. Another relative said staff had responded well when providing personal care to their family member because staff had noticed a small sore. They told us the GP was called without delay.

People had individual electronic care plans which included people's sensory needs that had been assessed and recorded in their care plans, what support or equipment they needed to enhance their ability to communicate effectively.

Risk assessments supported care plans but they both needed more detail so staff understood how best to support people. For example, one person's records identified they were at risk of falling, but there was limited information about the number of falls, why they fell, and what staff must do to support them. Another person's care plan stated they were able to go to the toilet independently, however this person was unable to walk without support and they were incontinent. Although care records had not always been updated when people's abilities changed, staff knew people's needs. We shared this with the registered manager to ensure when care reviews were completed, they reflected people's changing needs.

People said they were able to pursue their hobbies and interests. One person told us they had a 'bucket list' and had done a zip wire, took part in a local theatre play and was planning to do a balloon flight. They showed us the garden area they helped to plant and they had other hobbies they enjoyed such as photography, making hats and raising money for the resident's funds.

The registered manager said following people's feedback a knitting club had been formed so people could knit together rather than in isolation. The provider used a recognised activity programme to ensure people received mental and physical stimulation regularly. During our visits we saw people were engaged in a quiz and exercise.

Throughout the home, there were objects and areas to stimulate memories but we did not see anyone

interacting with these. One relative said their family member did not join in with activities out of choice, but said staff visited them on a one to one basis to reduce the risk of social isolation. Staff also offered encouragement for the person to join in activities, in case they had changed their mind. The relative told us, "They are very happy here and they are well loved."

At the time of our visit, no one was in receipt of 'end of life' care. The registered manager said they were able to support people to spend their final days at the home, if it was their wish to do so. The registered manager said they had anticipatory medicines available to help manage pain relief and they had worked in partnership with other health professionals to support people to have a pain free and dignified death.

People did not share any complaints with us about the service but told us if they did have any concerns, they would share these with the registered manager. The provider's records showed there was one complaint in the last 12 months which had been addressed and resolved in line with the provider's policies and procedures.

Good

Is the service well-led?

Our findings

The provider had a strong track record of delivering high standards of care and a number of their services were rated by us as 'Outstanding'. At the last inspection in March 2016, The Limes was rated as 'Outstanding' in well led because the provider had effective systems in place to share best practice, and learn from areas of improvement that had been identified at their other homes. At this inspection we saw some detailed audits and checks to monitor the quality of the service. However, these had not been consistently effective in driving improvements to meet the high standards of care reflected within the provider's own vision and values. The rating for `Well led' has changed to 'Good'.

People and relatives were complimentary of the registered manager and the staff team and said they were always available to listen to any concerns or feedback. One relative said the management was 'overall – good', but gave examples of a couple of areas where they had suggested minor improvements they felt would have a positive impact on the home and those who lived there. Whilst they were pleased action had been taken in response to one of their suggestions, they were disappointed no action had been taken to follow up their other suggestion. The relative stressed, "There is a huge amount right with this home", but felt, "There is no closing the loop" in the provider's response to minor initiatives.

Since the last inspection visit, the provider had embraced technology further by the addition of an electronic medicines management system (EMARS). This, coupled with the care planning system, meant staff were reliant on electronic systems to record and evidence the care people received. However, problems with internet connectivity and system updates staff were not always aware of, meant there were challenges for staff in maintaining accurate records and managing their frustrations. Staff spoke highly of the electronic care plans but felt they would like more training to achieve the optimum effectiveness from the system and ensure plans reflected people's changing needs. We also found that some of the provider's policies and procedures were not integrated with the electronic system so audits had not always identified areas for improvement that were critical to good outcomes. For example, the registered manager said each day, two people's medicines were audited on the EMAR, but the audits did not look at PRN protocols or patch medicine records. Therefore, the issues we found in respect of those medicines had not been identified. It was also not clear whether action was taken in a timely way when issues were identified. A medicines audit in April 2018 had identified creams were not being recorded on EMARS that were given PRN. The same issue was identified at an audit in June 2018, but there was no evidence to show this had been followed up. The registered manager agreed to strengthen their audit system.

At a household meeting in July 2018 the registered manager reminded staff to make mealtimes more of a social occasion. The expectation was for staff to sit with people at lunch time and have a meal. We found staff prioritised the tasks of clearing up so they did not have time to do this. Staff practice to support people to choose what they wanted to eat was not effective for people living with dementia. The registered manager said this was not what they wanted to happen and agreed to complete further observations. Following our visit, they confirmed they had implemented pictorial choices for people to make on the day.

Equipment checks were completed but we found an alarm mat that was not working in line with the call

alarm system which meant staff would not be alerted to the person's movement, or if they had fallen and needed urgent assistance. The registered manager checked all the other alarm mats to ensure they were fit for use. We discussed these concerns with the registered manager, director of delivery and director of compliance who agreed actions would be taken swiftly to prevent this happening again.

The registered manger was responsive to our feedback. Following our inspection visits, the registered manager sent us an action plan and they had already instructed staff to make the required improvements. On the day of our visit, the registered manager said they looked at CQC inspections and findings as a positive way to improve their practice.

The registered manager told us their audits, as well as internal audits fed into the provider's monthly reports so the provider could be assured that care was delivered and monitored consistently across the provider's homes. The provider produced monthly statistics for a range of subject areas which enabled managers to compare their performance and learn from others. In the most recent provider results, The Limes was rated the second-best home within the organisation with 84%, with the highest performing service at 87%.

The registered manager continued to promote the home and the quality of service they provided. In 2018, The Limes participated in the National Care Home Open Day that provides homes with an opportunity to celebrate and demonstrate to the wider community what services they provide and to what standard.

The technology advancements by this provider gives an opportunity called, `Relatives Gateway'. The gateway provides relatives with a live window into the care provided to family members (with their permission) that can be accessed anywhere in the world with an internet connection. We spoke with a relative who did not live locally and they were not aware of this so we asked them to speak with the registered manager to discuss access. All the relatives we spoke with said they were always kept informed if there were any changes. People and relatives were encouraged to provide feedback and make suggestions to improve the quality of care provided. This was through regular questionnaires, meetings and suggestion cards.

The provider fulfilled their legal obligations. There was a registered manager in post who had been at the service for some time and who knew people and staff well. People and relatives said consistent management was positive for the home. The registered manager had notified CQC appropriately of incidents at the home by submitting statutory notifications. We use this information to monitor the service and ensure they respond appropriately to keep people safe. The provider had displayed the rating of their previous inspection in the home, which is a legal requirement as part of their registration.