Elmbank Residential Care Home Limited

The Limes Residential Care Home

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This was an unannounced inspection that took place on 8 July 2015.

The Limes Residential Care Home is owned by Elmbank Residential Care Home Limited and is registered to provide accommodation with care for up to 16 people. At the time of our visit, there were 16 older people living at the service. The majority of the people who live at the home are living with dementia, some have complex needs. The accommodation is provided over two floors that were accessible by stairs and a stair lift.

The registered provider was also the registered manager for The Limes. 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 were at risk because systems and procedures to protect them from harm were not being followed correctly. People told us that they felt safe. A relative told

Summary of findings

us, "I feel that mum is very safe here, staff are very caring." Although there were systems and processes in place to protect people from abuse and that staff had received safeguarding training. We found there were inconsistencies in regard to staff's knowledge and understanding of the various types of abuse. There was an incident where the person living at the home or their relative were not informed of their rights to contact the police when items went missing.

People's rights were not protected when they were unable to make decisions for themselves. People's human rights were not protected as restrictions were put in place which were not in accordance with current legislation.

Medicines were administered by staff in a safe manner; however arrangements for storage of medicines that required refrigeration or their disposal were not always followed. We recommended that the provider reviews current guidance regarding the management of medicines.

Recruitment practices were in place and were followed to ensure that relevant checks had been completed before staff commenced work.

The manager ensured staff had the skills and experience which were necessary to carry out their role. We found the staff team were knowledgeable about people's care needs; however staff's knowledge and understanding of people living with dementia was not sufficient to support their additional needs. We recommend that the provider reviews current best practices regarding people living with dementia and other complex needs.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk. Staff provided care and support which promoted well-being. However there were some inconsistencies with the level of involvement from healthcare professionals when assessing health risks. People were supported to have access to healthcare services.

The design and decoration of the home did not meet people's individual needs and help people find their way independently. We recommended that the provider researches and implements relevant guidance on how to make environments more 'dementia friendly'.

Staff treated people with kindness and respect. Positive caring relationships had been developed between people and staff. Staff showed kindness to people and interacted with them in a positive and proactive way. Staff were caring. People told us that staff treated them with respect and dignity when providing personal care. People felt that staff knew them well. People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's relatives and friends were able to visit.

The activities that were provided were not always what people wanted and were not always age appropriate. There was no physical stimulation for people living with dementia or complex needs. We recommended that the provider reviews activities in accordance with people's hobbies and interests.

People said that staff were attentive and responsive to people's needs. People's needs were assessed when they entered the service and reviewed regularly. Care records were updated by staff involved in their care. People had access to equipment to assist with their care and support to enable them to be independent.

There were quality assurance systems in place, to review and monitor the quality of service provided, however they were not robust or effective at identifying and correcting poor practice.

People told us if they had any issues they would speak to the manager or provider. People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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.

People were at risk because systems and procedures to protect them from harm were not being followed correctly.

Medicines were administered by staff in a safe manner; however arrangements for storage of medicines that required refrigeration or their disposal were not always followed.

Although there were safeguarding procedures in place to protect people from potential abuse, these were not always followed. There were inconsistencies in regard to staff's knowledge and understanding of the various types of abuse.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff received training for their role, however their knowledge and understanding of people living with dementia was not sufficient to support people.

People's rights were not protected when they were unable to make decisions for themselves. People's human rights were not protected as restrictions were put in place but were not in accordance with current legislation.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk.

Staff provided care, and support which promoted well-being. However there were some inconsistencies with the level of involvement from healthcare professionals when assessing health risks.

People were supported to have access to healthcare services.

Is the service caring?

Good

People said that staff were kind and treated with them with respect.

Positive caring relationships had been developed between people and staff.

Staff showed kindness to people and interacted with them in a positive and proactive way. Staff were caring.

People told us that staff treated them with respect and dignity when providing personal care.

Summary of findings

People felt that staff knew them well and they were supported to make choices so they could maintain their independence.

People's relatives and friends were able to visit.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

The activities that were provided were not always what people wanted and were not always age appropriate. There was no physical stimulation for people living with dementia or complex needs.

People said that staff were attentive and responsive to people's needs.

People's needs were assessed when they entered the service and reviewed regularly. Care records were updated by staff involved in their care.

People were provided with the necessary equipment to assist with their care and support to enable them to be independent.

People told us they knew what to do if they needed to make a complaint. People were encouraged to voice their concerns or complaints about the service and they were dealt with promptly.

Is the service well-led?

Requires improvement

The service was not consistently well led.

The provider had systems in place to regularly assess and monitor the quality of the service provided were not robust or effective enough to identify, correct poor practice and improve the service provided.

The provider had sought, encouraged and supported people's involvement in the improvement of the service. People's opinions had been recorded but no information regarding action taken had been captured.

People told us the staff were friendly, supportive and management were visible and approachable.

The Limes Residential Care 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.

We visited the service on 8 July 2015 and it was an unannounced inspection. The inspection was conducted by two inspectors.

During the visit we spoke to eight people who use the service, two relatives, four care staff, a chef, an activity co-ordinator, manager and the provider. We spent time in communal areas observing the interaction between staff and people and watched how people were being cared for by staff. We looked at one bedroom with the agreement of the relevant person. We reviewed a variety of documents which included four people's care plans, risk assessments, medicines administration records and accident and incident records. We also reviewed minutes of meetings, complaints records and some policies and procedures in relation to the quality of the service provided.

On this occasion we had not asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we were responding to some concerns we had received.

Before the inspection we gathered information about the service by contacting the local authority safeguarding and quality assurance team. We also reviewed records held by Care Quality Commission (CQC) which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We contacted the local authority and health authority, who had funding responsibility for people using the service. We also contacted one social care professional who visited the service to obtain their views about the service.

We last carried out an inspection to The Limes in April 2014 and found no concerns.

Requires improvement

Is the service safe?

Our findings

We found that risks to people had not always been managed safely. People's care records included assessments for communication, mobility, mental wellbeing, nutrition, hygiene, social interaction, continence, pressure areas, sleeping, falls and behaviour. However, none of the assessments included an actual assessment of the individual risk, level of concerns or potential impact. None of the assessments followed any nationally recognised formats for assessing and taking action to reduce potential risks to people.

Risk assessments did not involve guidance from other healthcare professionals such as speech and language therapists or occupational therapists. For example, one person's records stated that they had a history of falls. All that the falls assessment stated was 'X walks with the Zimmer frame, can have a fall if not supervised. X can be unsteady on her feet. Staff to assist X at all times.' The manager confirmed that apart from the district nurse having been involved in arranging pressure relieving cushions and mattresses for people, she had not sought the help and advice of external healthcare professionals when assessing potential risks to people. This meant that due to the lack of involvement from healthcare professionals measures had not been put in place to protect people from the risk of harm in accordance to their needs.

At lunchtime we saw that one person was served a pureed meal. The chef told us of three people who required pureed meals due to a risk of choking. The chef said that no one who lived at the home was at risk of hydration or malnutrition. The manager told us that she decided who required a pureed meal based on observations, reading of care plans and discussions with staff but had not involved speech and language therapist in assessing these people's specific needs. They had not liaised with the Speech and Language therapist to assess people who have swallowing, drinking or eating difficulties.

Staff were knowledgeable about people's needs and how to provide support when people were distressed or at risk of harm. However, they did not always put this into practice; we received concerns that staff were not using best practice guidelines when assisting people who were at risk of falls. We were informed that staff were using non authorised and restrictive techniques to keep a person from falling over. We reviewed completed daily handover sheets which relayed changes to people's needs. We reviewed information that confirmed staff were using restrictive techniques. For example, staff had recorded 'Have been informed that X must not be tied down, must leave blanket loose.' We spoke to the provider and manager who confirmed that staff during their absence had loosely tied a person to a chair to prevent them from falling over. This meant that staff were not always using the least restrictive techniques to keep people safe from harm.

We observed instances when safe moving and handling practices were not followed. These included staff holding onto people's clothing when transferring them or assisting them to move from one part of the home to another. When this occurred people looked unsteady on their feet. We asked a member of staff who we observed about the moving and handling training they had received. They said, "I've not had formal moving and handling training yet. The owner said they were going to give this soon."

We also saw two members of staff using equipment to transfer a person with limited mobility from a chair to their wheelchair or walking frame. This was carried out sensitively and skilfully. During the process the person was constantly reassured and told what was happening. This meant that staff did not consistently follow best practice guidelines when transferring or assisting an individual in moving from one place to another. People's assessments did not include details of what equipment should be used to assist them with mobility and to transfer safely. The manager told us that they had decided what equipment for moving and handling was required by observing people but that this was not recorded and had not been assessed by a healthcare professional.

The home had a policy and procedure in place for risk management. This stated that a formal risk assessment should be undertaken by a trained and qualified person that lists the benefits of taking the risks against the possible adverse outcome, the precautions that should be taken and the arrangement's for reconsidering the matters. The evidence above demonstrates that the home was not following its own policy.

Staff knew how to support people with behaviours that were challenging. One member of staff told us, "Always talk politely, keep calm, offer help. Try and sort out whatever trouble they may be having. Inform the manager and seek further guidelines from her if needed."

Requires improvement

Is the service safe?

Failure to have systems and arrangements in place to provide safe care to people is a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of the people living at the home are living with various forms of dementia. Some people were unable to communicate with us verbally, but others told us they felt safe. One person told us, "I can't compare to other places as this is the first place like this I've stayed in but I feel ok." We observed that people looked at ease with the staff that were caring for them.

Staff confirmed that they had received safeguarding training and the majority were aware of their responsibilities in relation to safeguarding. Some staff were able to describe the different types of abuse and what might indicate that abuse was taking place. For example, one member of staff said, "If I see something or think anyone is at risk, I would make sure the resident is safe and notify my manager. If I had concerns about the manager I would inform CQC." One member of staff was not able to explain and said that abuse was "When they get angry they can pull your hair."

The service had a copy of the most recent local authority safeguarding policy and company policy on safeguarding adults. This should have provided staff with up to date guidance about what to do in the event of suspected or actual abuse. However, when discussing safeguarding peoples' valuables with the manager they told us of an incident when a person's watch went missing. They said, "I was told by a care assistant who had been informed by a relative. I searched their room and it wasn't there. We offered to replace it." The manager confirmed that they had not explained to the person and their relative of their rights to report this to the police. This demonstrated that staff did not always follow the current guidance when reporting or protecting people's possessions.

Failure to operate procedures effectively upon becoming aware of, any allegation or evidence of abuse is a breach of Regulation 13 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were happy with the support they received to manage their medicines. One person told us, "She's (pointing to a member of staff) a good one. She gives the tablets out. They check the books to see what you have." Only staff who had attended training in the safe management of medicines were authorised to give medicines. We saw evidence that staff attended regular refresher training in this area. Once they had attended this training, managers observed staff administering medicines to assess their competency before they were authorised to do this without supervision. We saw staff administered medicines to one person, they explained the medicine and its function. Staff waited patiently until the person had taken the medicine. Any changes to people's medicines were verified and prescribed by the person's GP.

All medicines coming into the home were recorded and medicines returned for disposal were recorded in a register. Medicines were checked at each handover and these checks were recorded.

We checked the arrangements for the storage and recording of medicines. We found that most medicines were stored securely and in appropriate conditions. We saw that medicine which was no longer in use and had not been disposed of remained in a refrigerator. This refrigerator was located in a communal area, not locked, and accessible to people. We saw that there was a sheet to monitor daily the temperature of the refrigerator; the last entry was dated 21 March 2015. When we asked staff, they stated that they had forgotten to remove the medicine and to monitor the temperature of the refrigerator. This meant that for medicine that required refrigeration or were for disposal, arrangements were not followed to monitor and keep them at the optimum temperature and secured safely.

We checked medicines records and found that a medicines profile had been completed for each person and any allergies to medicines recorded. The medicines administration records we checked were accurate and contained no gaps or errors. However, information about the quantity of each medicine in stock had not been completed. This along with the concern stated above demonstrated that staff did not follow the instructions provided.

There were no written individual PRN [medicines to be taken as required] protocols in place for each medicine that people took. This would provide information to staff about the person taking the medicine, the type of medicine,

Requires improvement

Is the service safe?

maximum dose, the reason for taking the medicine and any possible side effects to be aware of. These procedures are required to ensure people receive their medicines in a consistent way.

We recommend that the provider review current guidelines regarding managing medicines in care homes.

People who lived at The Limes, relatives and staff told us that there were, on the whole, sufficient staff on duty to support people at the times they wanted or needed. They did say that shifts could be busy and that some routines were in place to ensure everyone's care needs were met. One person told us, "I get lonely sometimes and have no one to talk to. I can talk to the staff but sometimes they are so busy. It's not their fault." During our inspection we observed that staff were available when people needed assistance with personal care. The home had a call bell system in place that enabled people who chose to stay in their rooms to call for assistance when needed. One person told us, "If you're in trouble at night you press the bell and they have to react quickly." We reviewed the staffing rota and there were arrangements in place to ensure there was sufficient amount of staff to meet people's needs.

There was a staff recruitment and selection policy in place and this had been followed, to ensure that people were supported by staff who were suitable. Staff confirmed that they were asked to complete an application form which recorded their employment and training history, provide proof of identification and contact details for references. Staff confirmed they were not allowed to commence employment until satisfactory criminal records checks and references had been obtained. Staff also confirmed that they attended induction training and shadowed an experienced member of staff until they were competent to carry out their role.

There was a business contingency plan in place; staff had a clear understanding of what to do in the event of an emergency such as fire, adverse weather conditions, power cuts and flooding. The provider had identified alternative locations which would be used if the home was unable to be used. This minimised the impact to people if emergencies took place.

Requires improvement

Is the service effective?

Our findings

People's rights were not protected when they were unable to make decisions for themselves. The provider and manager did not have a full understanding of their role and responsibilities with regards to the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. DoLS provide a legal framework to prevent unlawful deprivation and restrictions of liberty. They protect people in care homes and hospitals who lack capacity to consent to care or treatment and need such restrictions to protect them from harm. We had been informed and saw recorded information that staff had restrained a person which deprived them of their liberty. We found that not all of the DoLS applications had been completed and submitted to the local authority in accordance with legislation to ensure people's care did not compromise their human rights.

The majority of staff had received training on the MCA and DoLS as part of the safeguarding adults training that they had completed. Despite having received training staff did not demonstrate a clear understanding of MCA or DoLS. For example, one member of staff told us, "It's how the residents act, try and meet their needs and everything." Another member of staff said they did not know what the MCA was or how this impacted on people's rights to consent.

We saw that mental capacity was not routinely assessed or considered and action taken when a person was found to lack capacity to consent. As a result people's legal rights were not upheld. One person's record included a statement 'I confirm the care plan has been discussed with me and I consent to the plan of care being delivered, and changes made, where appropriate, without prior consent.' The statement had been signed by a relative of the person. There was no record on the person's file that demonstrated the person did not have capacity to consent or that showed the relative had legal responsibilities to make decisions on their behalf. This meant that people's right were not upheld in light with current guidelines.

People's records included Do Not Attempt Cardiopulmary Resuscitation (DNACPR) forms that had been completed by the manager. In all but two cases these had not been signed by a health care professional. The manager had recorded on the majority of forms that the person concerned did not have the capacity to make a decision about whether they wanted CPR or not. The manager had recorded the reasons why CPR would not be appropriate as 'Confusion' 'Memory Loss' 'Alzheimer.' None of the forms we reviewed had recorded that the person concerned and or their representatives had been consulted. The manager said that a GP had told her to complete the forms, talk to relatives and gain their agreement. She said that once this was in place the GP had said they would come and sign the forms. The manager told us, "I have not done these before; it's all new to me." Before we finished our inspection the manager removed all the DNACPR forms from people's files apart from the two that had been signed by the person's GP.

Failure to gain appropriate consent in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us that there were no restrictions on their movements. They said, "I use the stairs, it's my bit of independence." People said that they were happy with care and attention they received. One person told us, "Last year I was not very well, I'm perfect now, thanks to them." Another person told us, "It's very nice here. I have help getting out of bed, washing and dressing as my legs are bad. Apart from that I'm an independent lady." A third person told us, "I have my hair done every fortnight. I wash most of myself and let them do my back else I splash water everywhere." This meant that staff encouraged people to be independent according to their needs.

Despite formal consent processes not being followed in full, we observed that staff checked with people that they were happy with support being provided on a regular basis and attempted to gain their consent. During our inspection we observed staff seeking people's agreement before supporting them and then waiting for a response before acting on their wishes. Staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them. They repeated questions if necessary in order to be satisfied that the person understood the options available. Where people declined assistance or choices offered, staff respected

Requires improvement

Is the service effective?

these decisions. One person told us, "It's up to us what help we get. They don't force us." Another person told us, "After lunch I go to my room. I prefer that. It suits me to do that. They (staff) don't stop me."

There were qualified, skilled and experienced staff to support people living at the home. The registered manager ensured staff had the skills and experience which were necessary to carry out their roles. Staff confirmed that a staff induction programme was in place. One member of staff said, "I attended food safety and infection control training. The owner and manager gave me guidelines to help me understand the residents. My induction was for two days. I was shown what I needed to do, how I have to involve people, talk to people, how to feed." We found the staff team were knowledgeable about people's care needs; however the service has a high proportion of people living with dementia, had complex needs and whose behaviour challenged the service. Staff only had the basic understanding of dementia which was not sufficient knowledge to support people living with various stages of dementia and complex needs. For example staff lacked an understanding of the different types of dementia people may experience, how this impacted on their life, affected their behaviour and how to support them.

Training was provided during induction and then on an ongoing basis. Staff said that they received training that helped them care for people and meet their needs. One said, "I have a NVQ level 3 and have just finished some dementia training." Certificates were on file that demonstrated staff had received training in areas that included first aid, health and safety, food hygiene and infection control.

We recommend that the provider reviews current best practice, in relation to the specialist needs of people living with dementia and other complex needs.

People told us about the food at the home. One person told us, "We get unlimited cups of tea. They know I don't like coffee and always give me tea." Another person told us, "The meals are alright. We get something different every day." A third person gave a thumb up sign when asked about the meals at the home and smiled which indicated their satisfaction. A fourth person told us, "X (chef) is a good one. He knows I don't like stew and does me an omelette. He gives me smaller portions which I prefer."

We observed the lunchtime experience; people were able to choose where they wanted to sit. Most people had their lunch in the lounge and dining area. A member of staff was observed encouraging a person who lived with dementia to join others in the lunchtime experience. They said to the person, "Do you want to come up to the table for lunch? The person replied, "No". The member of staff then said, "Why not, it would be nice for your to stretch your legs and meet X (another person who lived at the home) your friend." The person then smiled and joined others at the table.

A member of staff was present during the lunchtime period who offered assistance to people when needed. People were offered a choice of juices with their lunch. We did note that condiments were not placed on the dining table for people to use freely. One person was heard to say, "Is there any pepper and salt? This was brought to the person but not offered to others unless they requested it. People appeared to enjoy the meal and staff were observed offering and giving seconds to people. Comments included, "That was lovely" and "Nice." The mood throughout lunch was relaxed and friendly and people were enjoying the food and each other's company. People confirmed that they had sufficient quantities of food and drink.

There was evidence of people being offered choices in relation to food and drink but this did not include visual assistance that would have helped people who lived with dementia. The provider told us that there was a visual menu board but confirmed that this was not in place at the time of our inspection. The chef told us that he spoke with each person in the morning, explaining what options were available. None of the people that we spoke with were aware of a menu. One person told us, "There is no menu but we are offered choices and alternatives." The chef was able to explain to us the individual preferences of people and some actions that he undertook to fortify meals to reduce the risk of malnutrition. The chef had not undertaken any specific training in relation to nutrition and malnutrition.

We saw staff assisting people to get ready for lunch, at a slow and steady pace, they were not rushed. People who were unable to eat independently were supported by a member of staff. Throughout the day people were encouraged to take regular drinks, to ensure that people were kept hydrated.

Requires improvement

Is the service effective?

Staff told us they had regular meetings with their line manager to discuss their work and performance. Staff said that since the manager had been in post the support they received had improved. One member of staff told us, "They call me upstairs to give me guidance. We talk about what I have been doing and plans for the future." Staff files included that they were now receiving one to one supervision and appraisals.

People had access to healthcare professional such as doctors, district nurses, chiropodists, opticians, dentists and other health and social care professionals. One person told us, "I have top dentures but nothing in the bottom. I would like them in the bottom but I've not seen anyone since living here." Records confirmed that a dentist was due to visit the home in August 2015. People were supported by staff or relatives to attend their health appointments. Outcomes of people's visits to healthcare professionals were recorded in the care records. This showed the management and staff ensured people's health needs were met.

The design and decoration of the home did not meet people's individual needs and help people orientate independently. During our inspection, we observed that the majority of people spent their time in the lounge. The chairs in the main lounge were positioned all around the edge of the room. There was a date board that helped orientate people living with dementia. Carpets throughout the communal areas were patterned and walls, doors and frames were all painted the same colour which did not help people to find their way around the home independently. People's names were on their bedroom doors and some included a photograph of the person but no further objects of reference were located in any parts of the home that would help people who were living with dementia to find their way around without the assistance of staff. People's bedrooms were personalised with pictures, photographs or items of personal interest. However we saw no evidence of anyone's individual or personal interests integrated into the home outside of their rooms.

We recommend that the provider researches and implements relevant guidance on how to make environments used by people who live with dementia more 'dementia friendly'.

Good

Is the service caring?

Our findings

People said that staff were kind and treated with them with respect The atmosphere in the home was calm and relaxed during our inspection. Staff showed kindness to people and interacted with them in a positive and proactive way. One person told us, “The staff are alright, very polite.” Another person told us, “I get on pretty well with all the staff.” A third person told us, “They are kind here. I get tearful at times and they give me a hug.” A relative told us said, “The staff are very pleasant. They treat X very nice.”

Positive caring relationships had been developed between people and staff. Staff were observed smiling at people as they went about their roles. One person told us, “The staff are very nice. You can tell them a joke and they come back for more. It’s a difficult job they undertake and I could never do it.” Another person told us, “She’s (pointing to a member of staff) one of the good ones. She will always help you, she’s great. She listens to you. I’ve sobbed on her shoulder many a time.”

Staff showed kindness to people and interacted with them in a positive and proactive way. Staff were caring. Staff were observed knocking on people’s bedrooms doors before entering. When they assisted people to move from one part of the home to another staff were heard offering encouragement and words of reassurance to people. Comments included, “That’s good” and “You’re doing fine.” People were seen to smile in response.

We saw a member of staff stroking a person’s hair, shoulder and hands. The person appeared to appreciate this contact with the member of staff and was seen visibly relaxing into their chair with a big smile on their face. This meant that people were supported by staff who knew their individual needs.

People told us that staff treated them with respect and dignity when providing personal care. When people needed assistance with personal care we observed that staff did this behind closed doors in bedrooms and bathrooms. Attention to detail had been given with people’s appearance. People were seen wearing colour co-ordinated clothing and non-slip footwear. Several people were wearing clean reading glasses and many ladies had their nails painted.

People felt that staff knew them well and people were able to make choices about when to get up in the morning, what to eat, what to wear and activities they would like to participate in, so they could maintain their independence. One person told us, “I usually go to my room after 1pm because I like to watch my TV. I’m loving the tennis at the moment. I can watch it in peace in my room.”

People were able to personalise their room with their own furniture, personal items and choosing the décor, so that they were surrounded by things that were familiar to them. Staff knew about the people they supported. They were able to talk about people, their likes, dislikes and interests and the care and support they needed.

There was little evidence of formal processes for actively involving people in making decisions about their care and treatment however; no one that we spoke with raised any concerns about this. Since the manager had been in post a residents meeting had been held in order to support people to express their views and to be involved in making decisions about their care and support. None of the people that we spoke with could recall a residents meeting having taken place. A member of staff told us, “We tend to have informal chats more than meetings which suits people here who have dementia.” We reviewed notes from a resident’s meeting held in December 2014 where issues in regards to food and activities were discussed. There was no record of actions taken.

Relatives and friends were encouraged to visit and maintain relationships with people. A relative told us, “Staff are very kind and caring to my mother.” People confirmed that they were able to practice their religious beliefs, because the provider offered support to attend the local religious centres.

Requires improvement

Is the service responsive?

Our findings

People told us that the activities that were provided were not always what they wanted and were not always age appropriate. One person told us, "It can be boring here. I wish I could do more. People say I'm old but I don't feel old. I wish I could get out more." Another person told us, "I have a television in my room and some good books. That's important to me." An activity programme was in place, but was not person centred. It consisted of bingo, skittles and board games. The activity person told us that they were new in post and that in addition to the games in the activity book they "Sometimes do dancing to music and exercises." We also noted and the activity person confirmed that hairdressing and chiropody was recorded as an activity. We raised this with the manager who agreed these should be seen as basic personal care requirements and not activities for stimulation.

During our inspection an external pet therapy session took place where people were encouraged to interact with a small dog. People appeared to enjoy this activity, with many seen talking to and stroking the dog. Comments included, "Your sweet" and "You're a little baby." One person told us, "They come every week. The dogs very friendly." It was apparent that this activity provided stimulation and meaningful engagement for people who were living with dementia.

Whilst people could access the garden, their access to local towns was limited unless visitors took them out. One person told us, "My friends come and visit me but not very often. I miss going out." Another person told us, "My deepest friend comes three times a year and take me to theirs. Although I'm old I'm not gaga. It can be difficult to have conversations with some of the others who live here. I would love to go out more."

We also observed that the activity person asked several people if they would like to take a walk around the garden. Everyone declined this. After this the activity person sat with three people and engaged them in a ball throwing game.

There was no physical stimulation such as interactive tactile activities or textured surfaces around the home for people that would have provided them with something to do during the day when organised activities were not happening.

We recommend that the provider reviews individual hobbies and interests and look at ways and means these could be implemented and people supported to participate.

People said that staff were attentive and responsive to their needs. One person told us, "If you ask for something, they (staff) get it as soon as they can." People told us they were happy and comfortable with their rooms and one that we were invited to view was attractively decorated with some personal touches including photographs and memorabilia. They told us, "As you can see my rooms very comfortable."

Most people were encouraged to spend their days in the lounge areas, where they were attended to by staff. People told us that there were no restrictions and that routines were flexible. One person told us, "I can get up or go to bed when I like." Another person told us, "We eat what we want. This is my home, I'm happy here." A third person told us, "We have our own sinks in our bedrooms. If you want fresh air you can open the window. There are no rules here." There were no restrictions when relatives or friends could visit the home. Relatives felt welcomed by staff when they came to visit. One told us, "They make me feel welcome."

Assessments were carried out before people moved into the home and then reviewed once the person had settled into the home. The information recorded included people's personal details, medical history, mental health and current care and support needs. Details of health and social care professionals involved in supporting the person such as their doctor or care manager were recorded. Other information about people's medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were also recorded. This information was used to develop care and support in accordance to people's needs to ensure staff had up to date information. For example, arrangements had been made for one person to be seen by a dietician when staff identified that they had lost weight for two consecutive months. As a result, the person was prescribed food supplements and their weight monitoring was increased from monthly to fortnightly.

Staff told us that they completed a handover sheet after each shift which relayed changes to people's needs. We looked at these sheets and saw, for example information related to a change in medication, healthcare appointments and messages to staff. Daily records were also completed to record support provided to each person; however they were very task orientated. For example X had

Requires improvement

Is the service responsive?

a cup of tea; X had three sandwiches with eggs for supper and a cup of black tea. There was no information about interactions, activities or mood. This showed us that although there was up to date information about the support provided, the information was not person centered.

People were provided with the necessary equipment to assist with their care and support needs such as wheelchairs, walking frames and hoists. People and relatives confirmed they were involved in the planning and delivery of their care. Care records were reviewed regularly and any healthcare visits, treatment given and instructions to staff were noted. Information was also recorded if any changes had happened such as: wound care, falls, medicines, incidents, accidents and dietary needs.

We reviewed documentation of a resident's meeting held in December 2014 where issues in regards to food and activities were discussed. There was no record of actions taken. We also reviewed notes from a relatives meeting held in June 2015. Information was recorded about relatives opinion about the care their relatives were receiving, comments included "Staff are very caring towards his wife and she is doing activities.", "X is very happy at The Limes, he is happy with the staff, loves the food and his cup of tea."

People told us they knew what to do if they needed to make a complaint. People we spoke with felt able to express concerns or would complain without hesitation if they were worried about anything. One person said that if they were unhappy, "I would speak to management but I've no complaints." Another person told us, "We used to have one staff who was a bit sharp. I told her, watch how you speak. She was better after that. I'm the sort to speak up." One relative said that no one had explained to them who they should talk to if they were unhappy with the service provided. We saw that information was provided in written form and not in pictorial or other formats which may assist people who have dementia or sensory disabilities to make an informed choice. Staff told us that they were aware of the complaints policy and procedure as well as the whistle blowing policy. Staff we spoke with knew what to do if someone approached them with a concern or complaint. There have been no complaints received in the last 12 months.

Requires improvement

Is the service well-led?

Our findings

Policies and procedures were in place for staff to follow to help ensure safe and appropriate care was provided to people. However, all those we sampled were out of date and did not reflect current legislation and guidance. The provider told us that she was aware that the policies and procedures needed to be updated and had subscribed to an external organisation who would be supplying these in the future.

It was clear that staff and management did not have a clear working knowledge of the current changes in legislation to protect people's rights and freedom and that staff did not always follow best practices which put people at risk of harm. For example staff did not always use the correct techniques when assisting or supporting people to move from one part of the home to another. Staff also used unauthorised and restrictive practices to prevent people from falling over.

When discussing our findings with the provider and manager they confirmed that they did not have a copy of CQC's Guidance for Providers on meeting the regulations and the Fundamental Standards and that all guidance in place referred to old regulations. This meant that staff did not have access to up to date information about current legislation.

We reviewed the quality assurance systems in place to monitor the management of medicines, basic information was recorded; however there was no record of information or action taken when reviewing the systems. We reviewed daily medication checks carried out by staff on individual service user's medicine records, staff signed to indicate they had checked the record but there was no information recorded about what was found.

The manager's Quality Assurance report identified issues relating to the staff file audits, information was recorded but there was no recording of action taken. Monthly audits were carried out which covered areas including health and safety, clinical governance, medicines, facilities, care records and an additional medicines audit conducted by an external agency. However again there was no information about action taken. This meant that although systems were in place there were no systematic arrangements to ensure action was taken to correct any issues or to monitor any actions taken.

The lack of good governance was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were involved in how the service was run in a number of ways such as daily conversations with staff, the provider and residents meetings. Relatives told us there were 'relatives' meetings where they could discuss suggestions or raise concerns about the service. We noted from minutes of a relatives meeting held in June 2015 they discussed issues regarding the service. For example comments on the care provided were discussed.

People and staff said that the manager and provider were approachable and open to suggestions. One person pointed to the provider and said, "She is very nice. She's the very top one and talks to everyone." Another person said of the provider, "She is very honest." A third person said of the manager, "She is good."

Staff told us there were regular staff meetings where they were encouraged to provide their comments about the service and care provided. Staff also could discuss their views of the service and their role during their supervisions and felt supported by the management. A member of staff said of the management, "Its fine, very good. The manager keeps an eye on us. We are good as a team." Another member of staff told us, "The owner is very good, you can speak to her, she's lovely with the residents and she's not afraid to get her hands dirty. The manager is very new and different to the owner. We are getting used to the changes and different ways. We have to change with the times."

The manager had been in post since February 2015. They told us that this was their first position as a manager. We discussed with the manager how she ensured that she maintained her knowledge so that the home was well-led. She said, "I have NVQ levels 2, 3 and 4. I'm moving and handling qualified, have a train the trainer qualification. I'm doing my leadership in management level 5. I have to complete this by June 2016. I was an assessor but gave that up."

The manager said that their biggest achievement since being at the home was "Changes to medicines, care plans are 70% better and I have a good team of staff. They are reliable, teamwork that's what it's all about." She also said that she had arranged for a gardener and that she was going to arrange a barbeque.

Requires improvement

Is the service well-led?

The manager said that she was fully supported by the provider. She said, “The owner is very supportive. If I ring her she is there straight away. I wouldn’t be here otherwise.”

We asked the manager about the aims and vision for the home. She said, “It’s a lovely home. I’ve changed the plastic table cloths to material. Change takes time. I want staff to work as a team. I’ve got good staff now. We provide care to people who are frail, elderly and have dementia.” One member of staff said that the aim of the service was, “To give good quality care and meet all needs.” This meant that staff were aware of the aims of the organisation and were working within their ethos.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider failed to have systems and arrangements in place to protect people from the risk of harm.** **Regulation 12 (1) (2) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered provider failed to carry out procedures effectively, immediately upon becoming aware of, any allegation or evidence of such abuse.** **Regulation 13 (1) (3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered provider failed to gain appropriate consent in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.** **Regulation 11 (1)(2) (3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider had not ensured good governance in the home.**