Mr Munundev Gunputh

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

The Inspection took place on 5 January 2016 and was unannounced. At our last inspection on 6 February 2015 we rated the service as Requires Improvement. We found breaches in four regulations relating to staffing, maintenance of equipment, person centred care and medicines administration. There were concerns about the number of adequately trained staff, there was poor management of the prevention of falls and care staff did not maintain equipment. There was a lack of meaningful person centred activities.

The Limes Residential Care Home is a residential care home providing accommodation with personal care for up to 25 elderly people with dementia. At the time of our visit there were 20 people using the service, two of the people were in hospital.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

We found that the provider undertook staff recruitment checks to ensure candidates were safe to employ. Staff received three days induction training and regular supervision sessions. The registered manager now kept a falls matrix and recorded falls and the cause. We saw referrals to the falls clinics. The service risk assessed and identified risks but did not always give staff clear guidelines to manage the risks. Care plans were detailed for some areas of people's support but lacked detail in moving and handling and managing people's behavior.

The environment still was not accessible to people with cognitive impairments. The service had made attempts to sign post uneven floors and orientate people to their rooms but the measures taken were not effective. The environment was not safe as there was broken furniture and environmental hazards that were not being addressed appropriately.

People required greater assessment and attention paid to their adaptive equipment as care staff did not use specific equipment designed for the individual person.

The registered manager had arranged two new activity sessions that people have enjoyed. However were not activities on a regular basis throughout the week to keep people engaged and active.

People we spoke with and relatives spoke highly of the care staff and we saw some caring interaction by the care staff who know peoples likes and dislikes. People who use the service said they felt comfortable complaining to the registered manager who kept a record of complaints made.

The registered manager undertook audits but they were not successful in addressing the environmental issues.

We found overall 2 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We made a recommendation about more frequent auditing of the environment.

You can see what action we told the provider to take at the back of the full version of the 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?

The service was not always safe. The environment was not adequately risk assessed and made safe for people to live in.

Care staff knew the correct procedures to follow if they suspected that abuse had occurred.

The provider assessed the level of staff required to meet the needs of the service and undertook checks to ensure the safe recruitment of staff.

People received their medicines in a timely and appropriate manner.

Requires improvement

Is the service effective?

The service was not always effective. The environment was not adapted to meet the needs of people with cognitive impairments

Care staff were proactive in obtaining health care assistance for people. People received a varied choice of meals and care staff supported them to meet their nutritional needs.

The registered manager understood the requirements of the Mental Capacity Act 2005 and had made appropriate Deprivation of Liberty applications to the statutory body.

Requires improvement

Is the service caring?

The service was caring. The care staff had a good knowledge of the peoples' individual needs in particular if they were agitated and required reassurance.

Care staff respected peoples' dignity and privacy.

Care staff supported people to make end of life plans with their relatives and health care professionals.

Good

Is the service responsive?

The service was not always responsive. The service had put in place two new activities, but people using the service still did not have a variety of meaningful activities throughout the week.

Care staff and people using the service were able to complain and the registered manager recorded and addressed complaints appropriately.

Requires improvement

Is the service well-led?

The service was not always well-led. The registered manager audits the service. However the issues with the environment of the service remained unaddressed.

There was a registered manager in post who understood their role and responsibilities.

Requires improvement

Summary of findings

The registered manager quality assured by sending out surveys on a six monthly basis and reported on the responses.	

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.

This comprehensive inspection took place on 5 January 2016 and was unannounced.The inspection team consisted of an inspector, a specialist advisor occupational therapist and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we 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. They did not return a PIR and we took this into account when we made the judgements in this report. We looked at notifications we had received regarding this service

We spoke with seven people using the service, three relatives and one visiting health and social care professional. We interviewed three care staff and talked with the registered manager.

We looked at seven people's care plan records and six people's medicines records including controlled drug records and administration of medicines. We checked adaptive equipment and observed staff in particular when moving and handling of people and when they assisting people to eat their meals.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe at The Limes Residential Care Home. One person said "I do feel safe here." Another person said "I feel absolutely safe." A relative told us "My mother is definitely safe and secure here." Care staff told us how they would report a safeguarding concern and explained to us what abuse was and how they would recognise possible signs of abuse. One staff member said "I need to follow the [safeguarding adults] procedure." We saw that staff had received training to protect adults from abuse and there were safeguarding protocols for staff to follow and relevant up to date legislation within the safeguarding adults from abuse policy.

People had individual risk assessments. Each person had risk assessments in place to help keep them safe when receiving support from staff around the home. Risk assessments included moving and handling, risks associated with dementia such as depression and behaviours that might challenge the service. The risk assessments identified the risks but did not always detail clearly how staff should support people to minimise that risk. For example one person was at risk of falls when they were walking around the care home. It stated for "Staff" to "Monitor [them] more often" and "Discourage [them] from going upstairs" – "Avoid stairs if possible". However it was not specific regarding how often the person was to be monitored and there was no support plan about how this action was to be achieved. This persons' care plan also identified that as their mobility reduced they became more agitated and anxious. However it did not record how staff could interact with them to reduce their agitation. This is a risk for the resident, as a new care staff member would not be able to use the care plans and risk assessments to increase their knowledge of how to work with the individual resident in the care home. We found that some care plans did contain relevant support guideline information but the layout and the guidelines written following review was not set out in a clear way or easy to read. We brought this to the attention of the manager who explained they were considering a new format to support care staff to implement the risk assessment guidelines and showed us the proposed document.

We found that although care staff had received moving and handling training they did not use the adaptive equipment in a safe manner. People did not have assessments for individual moving and handling support. For example care staff told us that a medium sling "Suits everyone". This was not correct. Assessment for sling size and type should take place with each person using the wrong sling could result in a fall or pain and discomfort. People did not have named slings. People should have their own individual named sling to avoid cross contamination. Care staff told us most people do not require hoisting support, one person had been hoisted in the past following a discharge from hospital. However the person's care plan and risk assessment did not address use of a hoist. This meant moving and handling could have been unsafe without safe guidelines or assessment.

We observed three people who sat in chairs that were not suitable for their needs. For example one person was in danger of sliding from the chair onto the floor and required re positioning on a regular basis. Two other people lent over and were uncomfortably positioned again care staff re positioned on a regular basis. All three people required chair assessments.

Some people had ensuite toilets in their bedrooms. We saw some toilets had Mowbray movable and height adjustable frames with a built in raised toilet seat, these were not individually assessed for the person's use. One person reported that they did not use a Mowbray toilet frame at their own home before they came to the service but they was getting used to it now. No assessment had taken place for the frame use care staff confirmed, as the equipment came with the room. The frame had splayed legs and can be a tripping hazard. If raised too high for the person there is an increased risk of falls from the toilet. The service should not provide the frame without an assessment. We found peoples' walking frames when not in use, remained in the lounge area together and only two were named. This meant that care staff could be give people the wrong height frame. This could cause discomfort or a fall and is not a safe practice. We brought this to the attention of the registered manager who agreed to address the matter.

This is a breach of Regulation 9 of the Health and Social Act 2008 (Regulated Activities) Regulation 2014.

One person described "I am comfortable here. They come when I call." During the inspection visit we saw the four staff named on the rota present, one of whom was a team leader also the registered manager was available to support if required. Although care staff were busy

Requires improvement

Is the service safe?

throughout the day we observed they responded quickly on most occasions to attend to people. The registered manager explained at night time there were three waking night care staff who positioned themselves throughout the home to monitor people. When someone was restless at night they sat outside the room in the corridor to ensure that people did not try and use the stairs when they had just woken and were tired. Staff said there was usually enough staff except if someone was ill, explaining they don't use agency staff so "they just manage." We asked the registered manager how he calculated staffing needs. He explained they have sufficient staff to meet people's current needs and that they would employ extra staff if people required extra support. The registered manager had recently recruited two permanent staff members to replace staff who had left. We saw people in the communal areas were well supported but we saw some people waiting by their bedroom door for support by care staff throughout the day. It was not clearly stated in the care plans how often people should be monitored and there was no clear designation of tasks to ensure a staff member was allocated to check and support people in their rooms.

Staff files contained copies of references and Disclosure and Barring Service responses. Care staff had completed an application form, notes from interview and documents demonstrated why the service had employed the candidate and whether they held the appropriate knowledge and skills necessary to do the job. All this information meant care staff were considered safe to work with people who used the service.

We found medicines were stored appropriately and the temperatures recorded daily. We looked at people's medicines administration records (MAR) and found records had each person's photograph for identification. The blister packs contained the correct doses of medicines for breakfast, lunch; supper and night time they were colour coded to identify what time of day the medicines was for. There were photos of the different medicines and descriptions to avoid error. The team leader administering could tell us what the medicines were for and we saw them administer someone's medicines appropriately. The service had monitored people's medicines and had referred one person for a medicine review to the GP to reduce their medicine as it made them too drowsy. Another person had medicine given later in the day because they woke late each day. This meant their medicines remained spaced across 24 hours appropriately, however care staff had not written this difference of time administration in the MARS instructions. We found two omissions in recording in the week of inspection and we found some paracetamol was given 'when required' as prescribed to one person, but it was not written on the person's MAR sheet. The care staff stored eye drops correctly in a fridge as the directions required and date opened was clearly marked. We looked at controlled medicines and found detailed recordings and amounts of medicines tallied with recordings. We brought to the attention of the manager the issues we had found who agreed to address them immediately.

Care staff had received infection control training in their induction and there was an infection control policy. Care staff used disposable equipment such as gloves and aprons appropriately. We observed staff wash their hands before administering medicine or serving food. Care staff used disinfectant spray to wipe clean tables and chairs. Floor mops were colour coded to avoid cross contamination. We saw the service looked mostly clean on the day of inspection but noted that some of the toilets were in need of a professional clean. Although toilets had paper towels for hand dying, some toilets did not have toilet roll holders. We noted for example this in a communal toilet used by residents outside the lounge area. Lack of toilet roll holders increases risk of infection by one person to another as they have to pick up the toilet roll to use it. We brought this to the attention of the manager who said he would address this matter.

We found two sharps boxes for the disposal of used needles and syringes left in places people could touch if they were unmonitored for a short time. One box was under a table in the main lounge area and another in an unused open bedroom. We brought this to the attention of the registered manager as an unsafe practice. The staff moved the boxes immediately.

We found a cable ran across a doorway between the lounge and the conservatory. This was a tripping hazard. We told the team leader who removed the cable.

This is a breach of Regulation 15 of the Health and Social Act 2008 (Regulated Activities) Regulation 2014.

Fire risk training was included in staff induction and there was a fire safety policy and procedure. The fire panel certification occurred in November 2015. The service conducted weekly fire alarm tests and conducted a fire drill

Requires improvement

Is the service safe?

every three months when the registered manager observed staff practice. Each person living in the service had a personal emergency evacuation plan. There was a smoking area in the garden that we saw people used to avoid a fire risk in the service. The office diary detailed scheduled The London Fire Service to visit the service at the end of January 2016.

A portable electrical appliance certificate was issued in October 2015 and a gas safety certificate was issued in February 2015.

Requires improvement

Is the service effective?

Our findings

The design of the building was not organised to meet the needs of people who have cognitive impairments. The lounge area was long and narrow and people's chairs were in a line along one side. People faced the inner wall looking at the televisions. This layout did not lend itself to the service looking homely and created difficulties for staff who were unable to stand either side of people sitting in chairs to move and handle them correctly. We saw some moving and handling that was not correct. Staff were lifting incorrectly due to the lack of space between the chairs. The service had made attempts to address the environmental concerns raised at the last inspection but some measures were not effective. For example where the floor sloped on the first floor warning signs were now in place to alert people. However the signs were too high for people to see and take notice.

We found at the last inspection there was nothing to show people to their room. Now people's names were on the bedroom doors to identify their bedroom, however one person had moved on a temporary basis to a different room, their name was on their old bedroom door that they were not currently using. This could have confused the person. Another person's name who was no longer living in the home name was still on their bedroom door. We brought this to the attention of the registered manager who rectified this matter. The conservatory area was a large mostly unused space as it is cold in winter. One activity sessions take place during the week in the conservatory. It is not inviting to look at and requires heating to make it more accessible for people.

Although people were asked if they wished to move to the dining room for lunch it was not inviting or even immediately obvious it was a dining area. The interior décor should support people to understand where they are in the service with clear objects of reference or use of colour scheme and signposting.

Throughout the service there was old furniture that was tired and shabby. There was a chest of drawers in the communal lounge that had three hanging down broken drawer fronts it was a danger to people should they touch it, the front panel would have come away from the chest and fallen. We brought this to the attention of the manager who arranged the removal immediately. The broken chest in the lounge was an example of the lack of care and neglect of people's environment when living in the service.

At the previous inspection we found that a stair gate was a danger to the people using the service. One of the two stair gates had been removed since the last inspection but the remaining one at the top of the stairs was very flimsy and not fit for purpose. This was an unmanaged hazard to people using the stairs. Despite the stair gate the stairs were still accessible to people who might not be safe to use them unaided and although there was a hand rail we noted that it was wrapped in Christmas tinsel decoration so people could not grip it. This was not safe.

This is a breach of Regulation 15 of the Health and Social Act 2008 (Regulated Activities) Regulation 2014.

One person said: "I am well looked after. The staff ask me how I am." Another person with complex medical needs told us "If I feel ill, I just have to mention it and they call the district nurse, the doctor or the ambulance." We found the service referred people in a timely manner if there was a medical concern. A visiting health care professional confirmed a proactive approach by the service. Referrals in people's records were to services such as the speech and language therapist for possible swallowing difficulties when someone was not eating well, a referral to the district nurses when someone's skin looked a little pink and they had a high risk of pressure ulcers. We saw people attended routine checks such as the opticians and the chiropodist. There were prefilled transfer forms for hospital admissions in people's files to ensure the medical history was available to hospital staff if an emergency admission occurred. We found stocked first aid boxes and staff had received first aid training.

We found staff received a three day induction training that covered mandatory subjects such as safeguarding adults from abuse, manual handling and infection control. New care staff told us their colleagues and the registered manager had been very supportive and told them about people's needs, they confirmed they read the care plans to know how to support people and gave an example of supporting someone who becomes unsettled at times as the care plan dictated. The staff training matrix showed that some care staff had attending training in dementia care, first aid, food hygiene, health and safety and safe handling in 2015. The registered manager explained the

Is the service effective?

training needs are identified during staff supervision sessions these are scheduled to take place six times a year with a yearly appraisal. We saw supervision sessions had taken place every two months in the two care staff records we looked at.

At the last inspection we made a recommendation that there should be a more varied diet to suit people's preferences. People told us "The food's OK. It's not perfect, but then nothing is." Another person said "The food is stodgy and a bit mushy but I suppose that is for the other people here….If I don't like what's on at lunch time they make me something else." Another person said "I am not a great eater but they try to persuade me to eat what I like." On the day of inspection we saw fresh food in the fridges and fresh ingredients being prepared in the kitchen there was a choice of a fish curry or a sausage casserole. The cook showed us people can have other choices such as vegetarian options if they wish. Care staff asked people each day which meal they would like to have, explaining they give people three choices but the third choice such as cheese pasties or baked beans on toast are not on the menu but verbally suggested. The menu for a four week period did offer choice however presentation was not accessible for people with cognitive impairments to understand.

Care staff gave people the choice of sitting in the dining area or remaining in the lounge. We observed staff supporting people to eat their meals. Staff rushed to prepare people for lunch time and did not spend time talking to people to explain clearly what was taking place. However once food was served they spent time with people that required support and did encourage people to eat. We saw one person's food reheated when they had to leave their meal and return. We observed staff explained to people what they were eating. Portion sizes looked plentiful and people who wanted to change their mind were able to do so. The cook explained they always cooked more than required in case people decided they wanted other choices when they saw the meal served. We saw people had a variety of drinks to maintain hydration throughout the day.

There was a list of special diets in the office including allergy information detailing foods to avoid for certain people such as shellfish and highlighting dietary requirements such as a diabetic or soft diet. Both the kitchen staff and care staff could tell us what dietary requirements people needed and this information was in people's care plans.

One person's file contained their weight records monitored on a monthly basis. When records showed a significant weight loss a Malnutrition Universal Screening Tool (MUST) assessment was undertaken. The service kept nutritional and fluid charts for people assessed at risk nutritional to monitor food intake. The registered manager explained they always recorded what people chose to eat and monitored if they were not eating well referring to an appropriate agency showing us a recent example of a person referred to the GP.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

The registered manager demonstrated he had submitted Deprivation of Liberty Safeguards (DoLS) applications to the supervisory body. We looked at a sample of the applications and they were appropriate applications. The manager was able to describe people's circumstances that would lead to consideration of a DoLS application. Care staff were not always able to tell us about MCA and DoLS although one care staff said it was about supporting people who wanted to go out by themselves but were not safe to do so. Care staff explained they had received training but it was some years ago, we saw this was evident from the training matrix. There was a MCA and DoLS policy available for care staff to reference and a poster in the office giving accessible information regarding mental capacity assessments. We raised the care staff lack of a comprehensive understanding of the MCA and DoLS with the registered manager who showed us that the need for refresher training had been noted at the staff meeting in November 2015 and he was in the process addressing this matter.

Requires improvement

Is the service effective?

Care staff told us they ask people's permission before they offered support. Care staff explained that if people refused their medicine they came back in 30 minutes, explained the benefits and tried again. One member of care staff member told us "I need to respect them and give choice" another care staff member said they offered choice, giving an example of asking if a person would prefer a shower or wash, or showing people a choice of clothes from their wardrobe.

Good

Is the service caring?

Our findings

One person told us “They look after me. They are very nice people.” Another person said: “The staff are caring. When I have trouble, they do all the things I need. I feel they are doing their best. Everything is as perfect as it could be. They keep an eye on you when they know something is wrong.” Another person told us “I am well cared for. They do not neglect me. The people here are fantastic.” A relative of a person told us “I usually come unannounced and my mother always seems to be clean, well fed and happy within her-self. They show a lot of respect for the patients. They are kind and considerate and always have time for people. Nothing seems to be a problem.” Another relative said people are “Looked after with kindness.”

We observed staff interaction was mostly kind and reassuring. However, some interactions were brief and lacked warmth, in particular at busy times. We observed that the people liked the care staff and visibly improved their communication and eye contact when talking to them. The care staff had a good knowledge of the people’s individual needs in particular if they were agitated. One person clearly responded well to the reassurance of care staff stroking their head. Care staff were aware of this and spent time sitting with the person, this was commented on by a relative who said “staff are tactile with [x] who likes this.”

We observed staff entering residents’ bedrooms and always knocking and checking it was ok to enter. Care staff asked people if they minded a visitor coming in to see them. Care staff supported people to maintain their dignity in their dress, we observed staff adjusting people’s clothing and suggesting tactfully people might like to change soiled clothing. People looked comfortably and appropriately dressed.Some relatives said that the manager had met with their relative and them and assessed people’s care needs prior to moving into the service. Relatives explained they were asked about what [x] liked, might need and their habits. They described their relative was shown the room they could have and when their relative moved into the service they brought all of their personal items. Other relatives told us care staff asked about their relative’s likes and dislikes when people first moved to the service.

A person who preferred culturally specific food told us “If they don’t know how to do what I like they ask my family how to prepare it.” Care staff supported people with their diverse needs, the service catered for one person’s halal diet. The service respected other people’s dietary preferences, for example one person did not eat beef and did not eat meat on specific days of the week. A relative told us the care staff supported their relative in Friday prayers. One member of care staff spoke the same European language as a person, we observed that this helped settle and reassure the person. Our visit took place in early January and we noted there had been a Christmas party with carol singing and the service had some Christmas decorations. Another person who was very attached to their pet was supported to live in the service and bring their pet with them. This was important to the person’s sense of well- being and the service recognised this.

The service had a gender specific care policy that recognised some people would have a gender preference when supported with personal care. We saw some people had made this choice for cultural or personal preference reasons. The service respected and facilitated this choice.

People had end of life plans in their care plans. For example we saw that the family and a multidisciplinary team were involved with one person’s end of life plan and reviews there was a Do not Resuscitate (DNR) in place with the person’s wishes. We saw another care plan for one person who has a life limiting illness they had an end of life plan and a DNR document. There was evidence of a hospice being involved in their care and recorded visits.

Requires improvement

Is the service responsive?

Our findings

People told us: "The staff are very helpful and they try to work round what I want. They do their best to help me do what I want to do." But they added: "I love to sing but I don't get the chance to sing here. I can sing to myself." This person was tearful by the singing in a story telling activity. However we did not see a care staff respond to them. Another person told us "I only watch TV but that suits me." Another person said "I sit and watch telly. Sometimes I play cards,"

At the last inspection we found there were few person centred activities for people to enjoy. On the day of the visit the service had arranged story telling activity. The facilitator engaged with people and played music, asked questions and sung songs with the people. The facilitator included songs from other cultures, so most residents were included. There was a transformation in the lounge as many people who were passive and uninterested previously joined in, singing or clapping or just opened their eyes. The facilitator also played card games to increase reading, memorising and communication skills. We observed that most of the residents really enjoyed this interaction. The service had also arranged an art therapy group each week a relative said "[X] has just started to do art therapy. I am pleased more stuff is being done."

However whilst acknowledging some new activities had been organised there was still not planned daily activities and the lounge where most people sat did not have interesting activities to do and people sat passively. There were three televisions playing different stations spaced along the inner lounge walls this was overwhelming and not necessarily engaging. There was a whiteboard that had information about planned activities and meals but it was not in place people would see unless they went into the dining room. Also the writing was not clear and could not have been read or understood by people with even mild cognitive impairment. We did not see an activity schedule that advertised or provided daily activities. There was no activity co-ordinator employed or specified care staff member to undertake sessions with people.

There was a garden that was well kept and accessible and two people used the garden during our visit. One person told us "I look after the fish in the pond. I don't want to do anything else." Another person told us "I would like to use a computer but I haven't asked about that." We noted one person had a new laptop to enable them to access a group they could no longer attend in the community. The service had made some improvements and had begun to offer meaningful activities however there was still room for further work to ensure people were engaged undertaking activities they want to do and care staff members would benefit from training in managing appropriate person centred activities for people.

Although some of the rooms were personalised we found many of the bedrooms were not. A few contained the personal effects of people but many did not. The bedrooms were plain and their walls were mostly bare. Many curtains did not hang properly on their rails. Some of the smaller rooms contained a freestanding washbasin, making them appear institutional and not at all homely. The rooms conveyed a general air of neglect. We saw a damaged radiator casing and broken tiles in two communal shower rooms. Corridors were very narrow, the walls uniformly painted in muted colours and handrails of wood, making them hard to see. There was no 'signposting' of different areas and facilities by colour to make it easier for residents to find their way around. There are coloured sheets with residents' names on bedroom doors, but no photos or personal objects of reference to help people find their room.

Care plans had a brief history of each person and described people's care needs, identifying likes and dislikes. The service reviewed care records and updated monthly. Some areas of care planning was not detailed such as moving and handling and did not provide sufficient detail to support care staff to provide a person centred care.

This is a breach of Regulation 9 of the Health and Social Act 2008 (Regulated Activities) Regulation 2014.

Relatives told us they feel able to make complaints if necessary and had a good response from the registered manager when they had raised concerns. We saw there was a complaints policy. The registered manager explained he had an open door policy and showed us records of complaints made, how the service addressed the issue and the outcomes.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager in post who was familiar with his role and responsibilities. People said "I see the manager and I can ask him if I have any problems." Also "The manager is approachable and responds if I ask for something. He seems nice." The daughter of one person said: "The staff are very approachable, especially the manager. He seems to make an effort to make sure everything is OK. He doesn't wait for me to raise any issues with him, he double checks with me."

We found the registered manager was 'hands on', working closely with the care staff. A relative told us "The manager is compassionate he sets the standard of care." Care staff said the manager is helpful and supportive. Care staff described good team work and said "They are like a family" and "Colleagues are helpful all the time". Care staff described how they shared information by discussing with the manager during informal handovers. Care staff record people's appointments in the diary, we saw examples such as neurology appointments and review dates. Care staff read this when they go on duty. Care staff explained they talk a lot while they work and information share information informally as well as formally. We saw two staff meetings records. Meetings occurred once every two months subjects covered were MCA and DoLS, the key working system and activities.

Residents meetings had occurred in June and December 2015 items on the agenda were activities such as the Christmas Party and service issues. There were no relatives meetings held. The registered manager explained he meets with family members on an individual basis. Relatives spoken with all had spoken with the registered manager and found him approachable raising issues when they need to.

We found the registered manager audit's medicines on a weekly basis, the omissions we found were from the week of inspection and the audit had not taken place yet for that week. The pharmacist also audited. The registered manager audited monthly looking at a range of activities within the service such as care plan recordings, ensuring kitchen staff made fridge temperature recordings and that COSSH items are stored appropriately. There was a peer review in August 2015. At the last inspection we found the registered manager had not recorded and analysed falls appropriately. The registered manager now records falls on a falls matrix. The matrix showed all falls and factors causing the falls and actions taken. We saw from people's records the service had made referrals to the falls clinic. However we found the audits had not addressed the environment concerns such as the unsafe stair gate and broken furniture as such audits undertaken were not effective.

A family questionnaire was circulated to quality assure the service given to people using the service. After the inspection the registered manager sent us The Limes Residential Care Home Quality Assurance –Winter 2015 -2016 Report. This contained responses both written and verbal from users of the service and their relatives. Some of the areas covered included staff friendliness, telephone response times; and conclusions and recommendations. This showed that the service was encouraging feedback from users of the service.

We recommend that the service undertakes a weekly audit to identify and address environmental issues within the service.

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 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 (1)(2)3(a)(b)** **The provided must ensure people receive person centred care and treatment**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 (1)(a)(c)(d)(e)(f)** **The provider must ensure premises and equipment are well maintained and fit for purpose.**