Choices Housing Association Limited

Limewood Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 10 September 2018 and was unannounced.

At the last inspection in 2017 we rated the service as requires improvement. At this inspection we found that many improvements had been made, although some improvements were still required to ensure that medicines were consistently safely managed and all people's risk management plans contained accurate and up to date information.

Limewood Nursing and Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Limewood Nursing and Residential Home accommodates up to 59 people over seven 'clusters'. At the time of the inspection, the service supported 57 people.

Limewood nursing and residential home was specifically designed by a team of clinical specialists, architects and designers at the University of Sterling who have been promoting the importance of the design for people living with dementia. The home has seven 'clusters' which are spread across three floors. On the ground floor, there is a high street which was made to replicate the town of Stafford and includes a pub, a picture house, a hairdressing salon and a large area for social activities.

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 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.

Some improvements were required to ensure that medicines were consistently managed safely to ensure that people received their medicines as prescribed. Risk assessments were in place and most were very detailed and specific to each person, to provide staff with the information they need to manage people's risks. However, we have a made a recommendation about ensuring consistency for all risk management plans.

People were protected from the risk of harm and staff were trained to recognise the signs of abuse. There were enough suitably skilled staff to meet people's needs. People were protected from the risk of infection by robust prevention and control measures. Reflective practice and analysis meant lessons were learned when things went wrong.

People's needs were suitably assessed before the moved to the service and staff were inducted and trained. People had their nutritional needs met and there were systems in place to ensure people received consistent care and support. People were supported to have healthier lifestyles by having timely access to

healthcare services and professionals. People had their consent sought in line with the principles of the Mental Capacity Act 2005. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

People received support that was delivered in a caring and compassionate way and people were treated with dignity and respect. People, where possible were consulted about how their care was provided and people's care was regularly reviewed and adapted in accordance with their needs.

The service delivered care that was person centred. Staff knew people very well and they had access to activities. The provider had plans in place to further improve the provision of activities for people. There was a complaints procedure available to people and their relatives and people were supported at the end of their life to have a dignified and comfortable death.

People, relatives and staff felt the management team were approachable and supportive. There were opportunities for all to be involved in the development of the service and feedback was used to make improvements. The registered manager and provider had effective systems in place to monitor the quality and safety of the service and had plans in place to make improvements where these were required.

The service worked in partnership with other organisations to improve outcomes for people. They participated in innovative partnership working schemes to help improve the services provided.

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.

Improvements were required to the way medicines were managed to ensure that people received their medicines as prescribed.

People's risks were assessed and managed but consistency needed to be improved to ensure all risk management plans contained the required information.

People were protected from abuse and there were enough suitably skilled staff to meet people's needs.

People lived in a clean environment and were protected from the risk of infection.

Lessons were learned when things went wrong to make improvements for people who used the service.

Is the service effective?

Good

The service was effective.

People's needs were assessed and care plans were in place to ensure people were supported to meet their needs effectively.

People were supported by suitably trained staff and care was delivered in a consistent way.

People had enough food and drink and were supported to make choices.

People had access to healthcare professionals and had their consent sought.

Is the service caring?

Good

The service was caring.

People were supported by staff that were caring.

People were encouraged to be as independent as possible.

People had their privacy and dignity maintained.

Is the service responsive?

Good

The service was responsive.

People's preferences were considered and people received person-centred care.

People, staff and relatives could make complaints, which were acted on to make improvements.

People were supported to have their end of life wishes met.

Is the service well-led?

Good

People, relatives and staff felt the management team were approachable and supportive. They were given opportunities to provide feedback which was acted upon to make improvements.

The registered manager and provider operated effective systems to monitor the safety and quality of the service provided.

The service worked in partnership with other agencies to continuously learn and improve outcomes for people.

Limewood Nursing and Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 10 September 2018 and was unannounced. The inspection team consisted of two inspectors; one assistant inspector; a specialist advisor who was a nurse with experience of providing nursing care to older people 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 visit, we checked the information we held about the service and provider. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service such as what the service does well and any improvements that they plan to make.

We reviewed other information we held about the service such as notifications. A notification tells us information about important events that by law the provider is required to inform us about. For example; safeguarding concerns, serious injuries and deaths that had occurred at the service. We also considered information we had received from other sources including the public, Healthwatch and commissioners of the service. Healthwatch are the independent national champion for people who use health and social care services. We used this information to help us plan our inspection.

We spoke with four people who used the service and three visiting relatives. We did this to gain people's views about the care and to check that standards of care were being met. We also spoke with 15 members of care staff, two nurses and the activities coordinator. We spoke with the deputy manager, the registered manager and the quality and compliance manager to help us to understand how the service was managed.

Some people who used the service were not able to speak with us about their care experiences so we observed how the staff interacted with people in communal areas and we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at the care records of eight people who used the service, to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included six staff files, training records, incident reports, medicines administration records and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection improvements were required because some people felt there were not enough staff and not everyone had up-to-date risk assessments and care plans. During this inspection, we found that improvements had been made in these areas though we have made a recommendation to ensure consistency across the whole home.

During this inspection we found some issues which meant that medicines were not always managed safely. One person was prescribed eye drops which were clearly labelled to be discarded four weeks after opening. We found the person was still being administered eye drops over seven weeks after they had been opened. We brought this to the attention of the nurse responsible for administering medicines who immediately to acted to ensure the eye drops were safely discarded and the new stock of eye drops was started. However, prior to our inspection, no-one administering medicines had identified or acted to ensure the person received their eye drops in line with the guidelines for safe administration.

Some medicines were received in boxes from the pharmacy. The service had a weekly system in place to monitor stock control of these medicines. We saw that for some people, the stock numbers were not consistent with the Medicines Administration Records (MARs). We raised this with staff responsible for administration of medication. The staff told us that they were going to introduce a more robust system so that the stock of medicines could be monitored daily. This showed that improvements were needed to ensure stocks were checked and people did not go without their medication.

Despite the issues described above, people told us they received their medicines as prescribed, and that they were administered at the correct times by staff who had been trained in medicines administration. There was an up to date policy and procedure in place. We found that when people required their medicines to be administered covertly, this was done safely with necessary permissions in place. Medicines were stored securely and safely. There were suitable protocols in place to guide staff on when to administer medicines prescribed as 'take only when needed' such as pain relief and creams. The registered manager told us that a community pharmacist had recently completed a full medicines audit at the home. They had identified some areas for improvement and we saw that a detailed action plan was in place to address any issues and the provider had amended their auditing process to make it more robust.

Risks were identified and assessed to help people stay safe. Where people lived with health conditions, detailed and through risk assessments and risk management plans were in place to describe what that meant to the person. These plans gave specific instructions to staff about how to support them with the risks associated with the condition. For example, epilepsy plans detailed what type of seizures the person experienced, possible triggers and how to support the person should a seizure occur. Staff we spoke demonstrated that they understood the plans in place and how to manage the risks to keep people safe.

Risks in relation to skin damage were assessed and monitored. When people had a wound to their skin, a very detailed treatment plan and wound chart were in place and wounds were photographed on a regular basis to support evaluation of the treatment plan. However, we found that one person's treatment plan had

not been updated to reflect a change in how often they needed to be repositioned to help manage the risk of further skin damage. Records showed they had been repositioned as required, but their care and treatment plan did not reflect the change. We discussed this with the nurse who took immediate action to update treatment plan.

Some people had diabetes and we found that the risk assessments and risk management plans were detailed and had been completed in partnership with specialist professionals to ensure that staff had the information they needed to be able to manage and reduce the risks to the person. However, one person's risk management plan was not as detailed as other people's plans that we viewed.

We saw examples of risk management plans that were detailed and specific to the person and their conditions. Staff were aware of the plans in place which meant that risks had been assessed and well managed. However, we saw a small number of examples which did not show the same level of detail.

We recommend that the service ensures that all risk management plans contain up to date information and relevant detail to ensure that staff have the information they need to consistently manage people's risks.

There were enough staff to meet people's needs. One person told us, "If anything happened to me, there would always be someone to go with me to hospital." A relative told us, "There are the same amount of staff on each cluster and there has been a recruitment drive." We observed that people's needs were responded to swiftly and that call bells were answered promptly. Staff told us that they felt that staffing had improved and one member of staff said, "There is enough staff now and the seniors are really good." The registered manager told us they had recruited more staff, including some agency staff as permanent members of staff. They told us and we saw that people's dependency was assessed and reviewed regularly and this information was used, alongside consideration of the layout of the home, to work out how many staff were required to keep people safe and meet their needs on each cluster. Some people required one to one support to keep them safe at certain times and we saw this was provided to them. The people to staff ratio that we saw on inspection exceeded the number recommended by the tool. This showed that sufficient staff were available to support people to stay safe and meet their needs.

People received support from safely recruited staff. Staff confirmed that recruitment checks were completed to ensure they were suitable to work with people. We saw staff provided two references. The provider checked to ensure staff were safe to work with vulnerable people through the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions. This meant safe recruitment procedures were being followed in relation to the employment of new staff.

People felt safeguarded from the risk of abuse and harm. One person told us, "There is no reason not to feel safe here". A relative told us, "[Person's name] is really cared for and if there was an incident, I would know straight away. Nothing is kept from me." There was a safeguarding policy in place and staff were able to demonstrate they understood the policy and could tell us how to recognise the signs of abuse. Staff told us that they knew how to report any safeguarding concerns. A staff member told us, "I would report any concerns to senior management and if necessary, other organisations such as the Care Quality Commission (CQC)." Records showed that when an incident had occurred, staff and the registered manager reported incidents to the relevant organisations for the necessary action to be taken.

People were protected from the spread of infection. Staff were observed wearing Personal Protective Equipment (PPE) and had completed infection control training. A staff member told us, "We wear PPE. We use different mop heads and cloths for different tasks and wear gloves and aprons". Gloves and aprons were kept in designated places so that they were easily accessible for staff. The registered manager

completed audits to monitor and maintain standards of hygiene. During the inspection, we observed domestic staff cleaning throughout and we saw that alcohol gel was located at stations throughout the building. This showed that people were protected from the risk of infection and cross contamination.

The registered manager told us how the service had made improvements and how lessons were learned when things went wrong. The service understood its responsibility under The Duty Of Candour (an obligation for providers and managers to be open and transparent with people who use the service). For example, the service had issued letters to relatives of people who had sustained injuries at Limewood. The registered manager also demonstrated that they met with people and their relatives regularly when there was a need to do so. We saw that there had recently been an issue with the temperature of the medicines room which meant that it too hot to safely store some medicines. The provider had taken swift action when they became of the issue to ensure that medicines were stored safely. Additionally, they had taken action to source solutions to stop the same event occurring again. This showed they had learned lessons and made improvements when things had gone wrong.

Good

Is the service effective?

Our findings

At the last inspection, improvements were required because people did not always have specific plans of care for health needs and professional advice was not always recorded in plans of care. At this inspection we found that improvements had been made.

People's assessments identified their needs and choices and care plans were detailed, giving staff guidance on how to deliver people's care. There were individual assessments in place for different aspects of care. For example, one record we looked at gave specific information about a person's nutritional needs and there was detailed guidance for staff to follow in the form of NHS (National Health Service) patient safety literature. Staff could describe people's needs and told us how they supported a person with nutritional supplements to meet these needs. Care plans took account of what was personal to the individual such as religious needs. Reviews were undertaken and we saw changes had been made to care plans to reflect any change in need. This meant that needs were assessed and care plans provided staff with the information they needed to deliver effective support.

People were supported by suitably trained staff. A relative told us, "I don't think there is anything that staff haven't had training on; they seem very knowledgeable using equipment." Staff were observed during the inspection using equipment such as hoists and were competent in doing so. A staff member told us, "I received very professional training and management want you to aim higher." Staff told us that they received a full induction before commencing duties and including showing experienced members of staff. Another staff member said, "We have to shadow for two weeks, then there is loads of training. I am very well trained and I always have refreshers." Staff had completed training and the registered manager showed us how they kept a track of what training staff had received and when they were due to have refresher training. Another staff member said, "Managers will always let us know when training is due and I receive supervisions where I receive feedback." Records confirmed staff had completed training in areas such as manual handling, safeguarding adults and fire safety and we could see that staff received support through regular supervision sessions.

Staff supported people to have a balanced diet. People told us that they enjoyed the food and that they were provided with choice. One person said, "'I think it's very good. I have not turned anything away yet." A relative said, "Food is really, really good and they also tailor it to peoples' needs. When [person's name] could no longer eat solids, they started to puree [food] for them." Another relative told us, "I've never tasted it but it looks nice. There is a nice choice of sandwiches at teatime and a choice of a hot meal. It always looks nice and is presented nicely." We observed food being served from hot trolleys and staff were seen washing their hands before serving meals. People were asked if they required an apron to protect their clothing and each person was offered a choice of two options. People were offered a choice of drinks such as water and juice to accompany their meal. We saw that there was a menu on the dining room wall and staff told us that the menu was rotated every four weeks. There was information in the kitchen area relating to individual dietary requirements and staff could tell us who had specific needs and their food was presented in accordance with individual needs and requirements. This showed that staff clearly understood people's dietary requirements.

People's nutritional risks were understood and managed by staff. For example, one person's risk assessment stated that a person required a soft diet and that the person needed time to eat their food to reduce the risk of choking. We saw staff preparing a soft diet for the person and observed that staff could communicate this person's needs to a new member of staff who was assisting to help meals at that time. We saw guidance in each care plan for how staff should support with fluid intake to reduce the risk of dehydration. A staff member told us, "We use a chart to encourage fluids for each individual but we have a baseline amount for everybody". This demonstrated that staff knew people's individual nutritional risks and acted to reduce the risk of harm.

People had access to suitable healthcare provision. Staff we spoke with demonstrated they understood the health needs of the people they were supporting and therefore could identify when support from a specialist healthcare professional was required. For example, staff told us and records confirmed they had made referrals to Speech and Language Therapy (SaLT) where it had been identified that people had difficulties eating and swallowing. We observed people eating soft and pureed diets and records showed that this followed advice from the relevant healthcare professional.

The service had good links with healthcare professionals such as district nurses and the GP. We observed the Advanced Nurse Practitioner (ANP) from the local GP surgery visiting to support staff and review people's healthcare needs. Staff told us that the GP and ANP visited the service weekly. The registered manager told us that this process enabled the service and the GP surgery to work closely together and reduce the need for GP callouts. A staff member told us, "This system works really well and communication is much improved." This meant people had access to support to maintain their health and well-being.

People had their consent sought by staff, who could demonstrate they understood their responsibilities in line with the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making 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. A staff member said, "I always ask people before I provide help and support and I use the MCA when I am supporting people who cannot make decisions for themselves." We observed staff gained consent from people before supporting them. For example, we saw a member of staff seeking consent from a person before they administered medicines. We saw that people had mental capacity assessments in place and the service took the required action to protect people's rights and to ensure people received the care and support they needed in line with best interests.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that people had restrictions in place to ensure that they were kept safe and that the registered manager had made the relevant applications for a DoLS authorisation. This demonstrated that any restrictions were being made lawfully and people were supported in line with the principles of the MCA.

The design and adaptation of the building met people's needs. The service had received an accreditation in dementia friendly design and the certificate was displayed in the reception area. Living accommodation was split into seven 'clusters', each with its own communal lounges, kitchen and dining area. Communal areas were bright and spacious and people were free to access the areas they chose to. Bedrooms were personalised with people's names and doors were colour matched to the décor in people's rooms to make the premises dementia friendly. Staff told us that some rooms were equipped with assistive technology to promote people's safety. During the inspection, we witnessed an alarm from a sensor mat activate and staff

were seen to immediately respond. This reiterated what staff had told us and that assistive technology was promoting the safety and well-being of people. People had access to a garden area and staff told us that they recently held a garden party and we saw photographs of this to evidence what we were told. The service had a large communal area on the ground floor of the premises called the 'High Street' consisting of a pub, a hairdresser, a snug and a cinema room. We were told by staff that people could use the facilities as they pleased, though we did not see anyone using the facilities during our inspection. We saw pictures and we were told about events that were held at the high street including dementia awareness sessions, movie afternoons and theme days.

Good

Is the service caring?

Our findings

At the last inspection the service was caring. At this inspection we found the service continued to be caring.

People were treated with kindness and compassion. One person told us, "'There's not any of the staff I can say I don't get along with". Another person said, "Staff are respectful". Relatives also told us they believed that people were treated with kindness and that the service was caring. A relative said, "I have watched the care staff and they make sure they have face-to-face contact. They show things to [person's name] so they can understand what is being said and staff pick up on their body language to determine what [person's name] needs." One member of staff told us, "I absolutely love the job. It is so rewarding as I'm supporting vulnerable people. I feel like I have done something for someone". Another staff member said, "Care plans are very useful but the best way is to get to know people by spending time with them". Staff demonstrated a good understanding of people's needs and we observed staff engaging with people and speaking with them in a compassionate way. For example, we observed one person become upset whilst they waited for their relative to visit. Staff approached the person and knelt at their side. Staff spoke with the person in a calming and reassuring manner which helped the person to relax. This showed that people had access to emotional support when they required it.

People's independence was promoted. We saw staff supporting a person to drink from a beaker cup independently. The person asked for reassurance and guidance and staff were observed telling the person that they were 'doing it right' and gave praise and encouragement. This helped the person to be more confident in using the cup independently.

People's communication needs were assessed and met. Care plans used pictures and simple language so that people could be involved in their care planning if they wished. People were given the opportunity to participate in discussion and conversation and records we saw ascertained people's most appropriate form of communication. The registered manager told us that they supported a person whose first language was not English and that staff would assess the person's non-verbal communication when required to help determine how the person was feeling. We observed this person speaking in her first language and staff were seen responding in a calm manner that reassured the person.

People had their privacy and dignity respected. A staff member told us, "I give people the time that they need. I shut doors and curtains when I am supporting someone and I use a towel to cover people over to maintain dignity". People could spend time in their rooms as they wished and we saw that staff knocked on people's doors to seek permission before entering.

Good

Is the service responsive?

Our findings

At the last inspection the service was responsive. At this inspection, we found the service continued to be responsive.

People were supported to receive personalised care. Staff knew people well including their preferences. A relative told us, "I was encouraged to write [person's name] life story and include pictures so staff could see how [person's name] lived before they came to Limewood". A staff member said, "The care plans are very good as it helps us to learn what the person likes and dislikes and it helps me provide better care". People's diverse needs were assessed and considered including their religion and sexuality. We saw that people were supported to follow their religion if this was required. One person had specific cultural needs and we saw these were assessed and catered for. Staff were observed delivering personalised support. For example, we observed the staff member talking to a new member of staff describing the dietary preferences of a person at breakfast time. Care plans contained detailed, personalised information such as 'all about me and my life' and my 'personal story' and considered preferences such as whether people preferred to bathe or shower; times that people like to get up and go to bed and choices of clothing. This meant that staff had access to the information they needed to provide personalised care.

The service had an activities coordinator and we were told that there were activities for people to participate in. One person said, "There is a lot of entertainment, competitions and what we have here is nice but I would like to be able to play cards. I would also like to get a newspaper." We told the registered manager about this request and they told us they would arrange for the person to have a daily newspaper, as some people already accessed a daily newspaper at their request. A member of staff told us that there were activities available and the service, "did a good job". The activities coordinator was new to the role and told us, "I've been spending some time getting to know people and what they like. Some like one to one time for a hand massage, just a chat or even just to hold hands." They showed us the planned activities which included visits from external entertainers including an artist, trips to the local café, fundraisers and events. The service also had a 'high street' which consisted of a pub, a hairdresser and a large space for social activities. During our inspection we did not observe any planned activities taking place nor did we observe anyone utilising the facilities. We discussed this with the registered manager who told us, "We have been focusing on getting the care right. Activities is something we are going to work on". We saw that a new activities coordinator had been employed who was keen to increase people's opportunities and provide personalised support which meant there plans in place to further improve activities provision.

People and relatives understood how to make a complaint. One person said, "There are a number of senior people here and they would be who I would choose if I needed to make a complaint." A relative said, "It is about bringing issues to the staff and management and giving them the opportunity to do something about them." Staff told us that they knew there was a complaints policy in place and that they had a handover of information if a complaint had been made so they were fully aware of any learning or changes required in response to complaints investigations. There was a suitable complaints policy and procedure in place which was accessible to people. When complaints had been made, we saw they had been recorded and dealt with in line with the policy and procedure so that issues were listened to and action was taken to make

improvements if they were required.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. We saw a white dove on a blue background was displayed on a person's door if they were nearing the end of their life. This helped make staff and visitors aware that the person was receiving end of life care to allow sensitivity and privacy. We saw the symbol had been left on a person's door after they had passed away, as a mark of respect. The home was in the final stages of applying for The National Gold Standards Framework (GSF) which helps doctors, nurses and care assistants provide the highest possible standard of care for all people who may be in the last years of life. At the time of our inspection this had not been awarded to the home but the management team were confident that it would be awarded and provided us with a folder of evidence which showed the work and dedication staff and management had completed towards achieving the award.

Good

Is the service well-led?

Our findings

At the last inspection improvements were required to the monitoring of quality and safety within the home. At this inspection, we found that improvements had been made.

There was a registered manager in post who knew people, staff and the service well. The registered manager understood their responsibilities and was supported by the provider to deliver what was required. Notifications were received promptly of incidents that occurred at the service, which is required by law. These may include incidents such as alleged abuse and serious injuries. The registered manager was open and transparent in sharing information about these incidents.

People and relatives knew the registered manager and felt they were approachable and supportive. A relative said, "The registered manager is accessible and approachable. The only time I can't get her is, for example, when she's doing changeover but she'll always ring me back." Another relative said, "The other night I asked something and [the registered manager] sorted it out for me." Staff felt well supported by the registered manager and the wider management team. Staff comments included, "I love it here. The management are friendly and approachable I've not got any issues with them at all" and "You can offload to [the registered manager] if you need to. She is great. Very approachable." An agency staff member said, "I love it here. I've been before and I come quite regularly, even though I have to travel quite a way, I come because I like it here. I am considering coming to work here permanently." The registered manager was visible throughout the service and we saw they were well known by people and staff. They told us they spent time doing a 'walk around' each day and participated in handovers to help promote a positive and inclusive culture and staff confirmed this. There was an open and inclusive atmosphere where staff worked together to achieve good outcomes for people. A staff member said, "I like coming to work because I enjoy putting a smile on people's faces."

The registered manager and provider had effective systems in place to monitor quality and safety. Regular audits took place including checks of premises, infection control and a falls and incident analysis to ensure that any issues were identified and action taken to make improvements. For example, the incident review and analysis identified that one person had sustained an injury due to banging their bed rails. Bed rail protectors were then implemented to reduce the risk of a further injury being sustained. In another example, a person became anxious when being supported to move using a mechanical hoist. Their care plan and safer handling plan was reviewed and updated to ensure that staff were aware of this risk factor and to reduce the likelihood a similar incident occurring again.

People, relatives and staff were encouraged to be engaged and involved in the development of the service. A relative said, "They are having sessions with relatives and residents about the food." The registered manager told us that some families had communicated "niggles" about the choices of food available to people. In response to this, the registered manager and resource manager worked together to arrange food taster sessions for people and families to be more involved in the menu planning. This was confirmed in a "You said, we did" table which was displayed in reception areas and communicated the responses to any issued raised in an annual family service. There were also regular family meetings and a family forum which was

head by a relative of a former resident who has continued to be involved in supporting family engagement at the home.

The registered manager told us they were actively working on new ways to increase people's involvement and engagement. Most people had dementia and 'resident's meetings' had not been successful in supporting people to have meaningful involvement. The registered manager recognised this and showed us they were working on developing a simple survey and feedback cards which included pictures and symbols to help people communicate what they were happy or unhappy with. The registered manager hoped this would generate more valuable feedback from people who used the service and would increase their involvement. There were plans in place to trail this method of gathering feedback from people.
Staff also told us they felt involved in the development of the service and that their feedback was listened to. A staff survey showed that staff feedback had been gathered and listened to. For example, some staff communicated in the survey that more checks needed to be carried out to ensure that all staff were completing the work required. The registered manager then increased the management handovers including introducing a specific housekeeping handover, to give them more thorough oversight of what was happening in the home and to allow to pick up any areas requiring improvement. This showed that people's feedback was listened to and responded to in order to improve the quality and safety of service provided.

The service worked well in partnership with a range of other agencies to help improve outcomes for people. The provider had developed a 'Dementia Hub', located at Limewood Nursing Home, which provided advice and support for anyone affected by dementia. A relative said, "We have this dementia friendly programme and it's being run to help people to understand what dementia is and how to help." This provided a valuable source of support and education for people who lived at Limewood Nursing Home and their families. Some relatives had struggled to understand the communication issues or behaviours their loved one had developed since living with dementia and the dementia hub had delivered awareness session to help people with this. The dementia outreach manager told us, "We go out into the community too and help relatives to cope. We are now taking up with the police and local authorities and other units who are all taking on dementia training." This showed how the provider had worked with other organisations in the wider community and increase their knowledge and understanding of living with dementia.

Alongside this, the service had worked in partnership with the local police to introduce the 'Herbert Protocol'. This is an initiative which had been developed to allow agencies to work together to keep people with Dementia safe and well supported. If a person were to leave Limewood Nursing Home un-escorted and had a vulnerability, a named contacted within the police would be available to coordinate a search for the person. This showed how the service had worked with other agencies to develop innovative ways of keeping people safe and well supported.