The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Limetree House

Provider: Limetree Residential Limited

Date of Inspection: 6 February 2025

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider:	Limetree Residential Limited
Responsible Individual:	Mrs Deborah Cecilia Moore
Registered Manager:	Mrs Andrea Walker

Service Profile –
This home is a registered residential care home which provides health and social care for up to 35 residents living with dementia. The home is divided across three floors with access to a lift. There are a range of communal areas throughout the home and residents have access to an outdoor patio area.

2.0 Inspection summary

An unannounced inspection took place on 6 February 2025, from 9.50 am to 5.35 pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 26 October 2023; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection found that safe, effective and compassionate care was delivered to residents and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

Residents who were able to make their wishes known said that living in the home was a good experience. Residents unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

While we found care to be delivered in a safe and compassionate manner, improvements were required to ensure the effectiveness and oversight of the care delivery.

As a result of this inspection ten areas for improvement were assessed as having been addressed by the provider. Other areas for improvement have either been stated again or will be reviewed at the next inspection. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from resident's, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Residents spoken with who were able to make their wishes known provided positive feedback about their experiences living in the home. Comments shared by one resident included; "it's a great place, we all get on well." Those residents who were unable to make their wishes known appeared to be relaxed and comfortable in their surroundings and in their interactions with staff.

Questionnaires returned by residents provided positive feedback about the residents experiences living in the home, residents told us they found the care to be; safe, effective, compassionate and well-led. Some of the comments included, "the staff are more than helpful" and "the staff are always there when I need them."

Relatives spoken with who were visiting at the time of inspection provided positive feedback about the care provided in the home and the staff. Some of the comments shared included; "the staff are great, I could not say a bad word about one. They love my mum which means the world" and "so far it has been excellent, such support from staff. They are so approachable and responsive."

It was observed that residents were able to choose how they spent their day. For example, residents could have a lie in, go to the lounges or remain in their bedroom if this was their preferred choice. Staff were observed offering choices to residents throughout the day which included preferences for getting up, food and drink options, and where and how they wished to spend their time.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of residents. There was evidence of systems in place to manage staffing, and staff's registration with the Northern Ireland Social Care Council (NISCC). The importance of ensuring that the process of registering with NISCC commences without delay following staff commencing employment was discussed with the manager. A discussion took place with the management team to ensure the person in charge for night duty is clearly documented on the duty rota.

It was evident that the deployment of staff at break times resulted in a lack of staff available on one occasion in the home. A discussion took place with the management team regarding the need for a review of these arranagements to ensure there is adequate staff available based on the size and the layout of the home. The management team provided assurances this arrangement would be reviewed to ensure the appropriate deployment of staff across the home at all times.

Staff generally felt the staffing levels were appropriate to meet the needs of the residents. Other comments regarding staffing levels were shared with the management team for review and action as appropriate.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of the residents. Staff were knowledgeable of individual residents' needs, their daily routine wishes and preferences.

Staff were observed to be prompt in recognising residents' needs and any early signs of distress or illness, including those residents who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with residents; they were respectful, understanding and sensitive to residents' needs.

It was observed that staff respected residents' privacy by their actions such as knocking on doors before entering, discussing residents' care in a confidential manner, and by offering personal care to residents discreetly. Staff were also observed offering residents choice in how and where they spent their day or how they wanted to engage socially with others.

At times some residents may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that the management team had implemented a system to manage and review this aspect of care, however there was not always evidence of these being reviewed on a consistent basis. This is discussed further in section 3.3.5. The systems in place to monitor residents with a Deprivation of Liberty Safeguard (DoLS) in place, did not always evidence residents DoLS was in date. Assurances were provided in writing following the inspection that the system has been updated to ensure DoLS are kept under ongoing review.

Examination of care records and discussion with staff confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed. For example, residents were referred to the Trust's Specialist Falls Service, their GP, or for physiotherapy. A sample of post falls records were reviewed, there was evidence of gaps in the completion of the homes own post falls monitoring protocol which took place over a 24 hour period; assurances were provided that this will be discussed with staff and kept under review.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents may need a range of support with meals; this may include simple encouragement through to full assistance from staff and their diet modified.

The dining experience was an opportunity for residents to socialise, music was playing, and the atmosphere was calm, relaxed and unhurried. It was observed that residents were enjoying their meal and their dining experience. A previous area for improvement had been identified to ensure residents were offered choice at mealtimes, there was not evidence of two meal options displayed on the menu and no clear system for offering residents alternative options. This area for improvement has not been met and will be stated for a second time.

Whilst staff were able to identify the residents who required modified diets, staff did not always evidence the correct International Dysphagia Diet Standardisation Initiative (IDDSI) level the resident required, which could result in the resident receiving the wrong diet. No harm came to the resident and assurances were provided by the management team that this would be addressed with staff. The previous area for improvement stated relating to this has not been met and will be stated for a second time.

The importance of engaging with residents was well understood by the manager and staff. Observation confirmed that staff knew and understood residents' preferences and wishes and helped residents to attend communal areas to engage in activities or remain in their bedroom with their chosen activity such as reading, listening to music or waiting for their visitors to come.

Life story work with residents and their families helped to increase staff knowledge of their residents' interests and enabled staff to engage in a more meaningful way with their residents throughout the day.

Staff understood that meaningful activity was not isolated to the planned social events or games. The weekly programme of social events was displayed on the noticeboard advising of future events. Arrangements were in place to meet residents' social, religious and spiritual needs within the home.

Residents' needs were met through a range of individual and group activities such as bingo, board games, arts and crafts or hairdressing.

3.3.3 Management of Care Records

Residents' needs were assessed by a suitably qualified member of staff at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet residents' needs and included any advice or recommendations made by other healthcare professionals.

Residents care records were held confidentially.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the residents' needs. Care staff recorded regular evaluations about the delivery of care. Residents, where possible, were involved in planning their own care and the details of care plans were shared with residents' relatives, if this was appropriate.

3.3.4 Quality and Management of Residents' Environment

The home was warm and welcoming. It was generally clean and tidy and residents' bedrooms were personalised with items important to the resident. Communal areas were suitably furnished and were comfortable and set-up for residents to socialise.

There was evidence of call bell leads missing from a number of residents bedrooms, the management team provided assurances in writing following the inspection confirming that care plans and risk assessments for call bell leads have been reviewed were appropriate.

There was evidence of wear and tear to some of the ground floor area, for example; the wood-work and paintwork. The management team submitted a rolling refurbishment plan to RQIA outlining the proposed timescales for the works to be completed over the coming year.

There was evidence the laundry door was not securely locked, this was addressed immediately. Assurances were provided in writing following the inspection that a system has been implemented by the management team to complete checks to ensure this is securely locked at all times. The laundry room was observed as unorganised with no clear system for the management of laundry. The management team provided assurances this had been reviewed and a system implemented.

A bathroom downstairs was observed as being used to store clean laundry. A discussion took place with the management team and assurances were provided in writing following the inspection confirming this had been reverted back to it's original stated purpose following the inspection.

There was evidence across the home of deficits with infection prevention control (IPC) measures, for example; towels were stored in communal bathrooms, wet wipes were stored for communal use and personal protective equipment (PPE) was not stored appropriately. An area for improvement was identified.

A number of commodes were identified as requiring replaced. The management team provided assurances a review of commodes had taken place and those requiring replaced had been ordered.

The domestic trolley was observed as left unattended on a number of occasions throughout the inspection. This was addressed by the management team. An area for improvement was identified.

3.3.5 Quality of Management Systems

There has been a change in the management of the home since the last inspection, Mrs Andrea Walker has been the Manager in this home since 16 December 2024 and is currently progressing her application to become registered as manager with RQIA.

Residents, relatives and staff commented positively about the management team and described them as supportive, approachable and able to provide guidance.

Review of a sample of records evidenced that systems have been implemented for reviewing the quality of care, other services and staff practices. However, there was not always evidence of these audits completed consistently, for example; restrictive practice audits. A discussion took place with the management team to ensure these audits are completed consistently and are signed off when completed and actions taken if required. There was evidence that the management team responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	1*	7*

* the total number of areas for improvement includes three standards that have been stated for second time and three standards that have been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Monique McCreery, Deputy Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 14 (2) (c) **Stated:** First time **To be completed by:** 6 February 2025	The Registered Person shall ensure that the cleaning trolley is stored securely at all times/supervised when in use. Ref: 3.3.4
	Response by registered person detailing the actions taken: New carry case purchased for COSHH items which is carried at all times when in use by domestic staff and not left on the trolley.
Action required to ensure compliance with the Residential Care Homes Minimum Standards (version 1.1 Aug 2021)	
Area for improvement 1 **Ref:** Standard 12.3 **Stated:** Second time **To be completed by:** 13 February 2025	The Registered Person shall ensure that systems are in place to inform the residents of the daily menu choices to support them to avail of the choices. Ref: 3.3.2
	Response by registered person detailing the actions taken: Staff will ensure that the two choices are detailed on the menu board in the dining area. Staff have also included a daily check to be completed in the "pause file" documenting that all residents are told what the two choices are for each mealtime.
Area for improvement 2 **Ref:** Standard 12.10 **Stated:** Second time **To be completed by:** 6 February 2025	The Registered Person shall ensure that staff are aware of IDDSI terminology regarding individual IDDSI levels for food and fluids. Ref: 3.3.2
	Response by registered person detailing the actions taken: All staff are fully aware of who is on a special diet and indeed have signed a form to say they have read and understood that they are fully aware of who is on a special diet and what that diet entails. As explained to the inspector, the staff member who was asked felt put on the spot and panicked saying the wrong diet. Deputy manager asked all staff after inspection who was on a special diet and what it entailed and all staff fully aware of any resident on special diet.

Area for improvement 3 **Ref:** Standard 23.4 **Stated:** Second time **To be completed by:** 6 February 2025	The Registered Person shall ensure staff are trained to appropriately identify IDDSI levels in relation to food and fluids for each individuals assessed need. Ref: 3.3.2
	Response by registered person detailing the actions taken: All appropriate staff have received this training previously, however, we have booked this training for all staff and this is booked for May 2025
Area for improvement 4 **Ref:** Standard 23.6 **Stated:** First time **To be completed by:** 26 November 2023	The registered person shall review the recording of staff training to ensure that it clearly evidences staff compliance with mandatory training. Ref: 2.0
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 5 **Ref:** Standard 6.2 **Stated:** First time **To be completed by:** 17 January 2024	The Registered Person shall ensure that care plans contain sufficient resident specific detail to direct care, when medicines are prescribed for use 'when required' for the management of distressed reactions. Ref: 2.0
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 6 **Ref:** Standard 32 **Stated:** First time **To be completed by:**	The Registered Person shall review the systems in place to ensure that expired and/or unlabelled medicines are immediately removed from stock. Ref: 2.0

17 January 2024	**Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**
Area for improvement 7 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 13 February 2025	The Registered Person shall review the environment to ensure good Infection Prevention and Control measures are in place. This is with specific reference to the appropriate storage of PPE, towels and wet wipes. Ref: 3.3.4
	Response by registered person detailing the actions taken: Spot checks are being carried out by the manager. All communal bathrooms now have new enclosed storage for such items

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