Albemarle Rest Home Ltd

Albemarle Rest Home

Inspection report

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Leamington Spa
Warwickshire
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Tel: 01926425629

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 5 January 2016 and was unannounced.

The home provides accommodation and personal care for up to 24 older people. Twenty-two people were living at the home at the time of our inspection. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff understood their responsibilities to protect people from harm and were encouraged and supported to raise concerns under the provider's safeguarding and whistleblowing policies. The registered manager assessed risks to people's health and welfare and people's care plans included the actions and equipment needed to minimise the risks.

There were enough staff on duty to meet people's care and social needs. The registered manager checked staff's suitability to provide care during the recruitment process.

The provider's medicines policy included training staff and checking that people received their medicines as prescribed, to ensure people's medicines were administered safely.

People received care from staff who had the skills and experience to meet their needs effectively. Staff read the care plans and new staff shadowed experienced staff until they knew people well and understood their needs and abilities. Staff were supported and encouraged to reflect on their practice and to develop their skills.

The registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). For people with complex needs, their families and other health professionals were involved in making decisions in their best interests.

Risks to people's nutrition were minimised because staff knew about people's individual dietary requirements. People were offered a choice of foods and were supported to eat and drink according to their needs.

People were cared for by kind and compassionate staff who knew them well. Staff knew about people's individual preferences for care and their likes and dislikes. Staff ensured people obtained advice and support from other health professionals to maintain and improve their health and when their health needs changed.

People were supported to spend time in their preferred way and there were opportunities to socialise with

other people who lived at the home and engage in pastimes they enjoyed.

People and their representatives were involved in planning and agreeing how they were cared for and supported. Care was planned to meet people's individual needs and abilities and care plans were regularly reviewed.

People and relatives told us care staff were kind and respected their privacy and dignity. They were confident any complaints would be dealt with promptly and effectively.

The provider's quality monitoring system included regular reviews of people's care plans and checks on medicines management and staff's practice. Staff were guided and supported in their practice by a registered manager they respected.

Improvements were required in making sure people's views were known and taken into account for planned changes and any improvements in the service.

Improvements were required in supporting the registered manager to access relevant management information, to access information about their professional responsibilities, and to keep up to date with changes in the legislation.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff understood their responsibilities to report any concerns about people's safety and to minimise risks to people's health and wellbeing. The registered manager checked staff were suitable to deliver care and there were enough staff to support people safely. Medicines were stored, administered and managed safely.

Is the service effective?

Good

The service was effective. People's needs were met by staff who had appropriate skills and behaviours required to support them. Staff understood their responsibilities in relation to the Mental Capacity Act 2005. The registered manager understood their legal obligations under the Deprivation of Liberty Safeguards. People were supported to maintain a nutritionally balanced diet that met their needs. People were supported to maintain good health and to access other healthcare services when they needed them.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate towards people. Staff knew people well and respected their privacy and dignity. Staff promoted people's independence by supporting them to lead their lives in the way they wanted.

Is the service responsive?

Good

The service was responsive. People and their families were involved in planning and reviewing how they were cared for and supported. Staff knew people's preferences, likes and dislikes. The registered manager took action to resolve complaints to the complainant's satisfaction.

Is the service well-led?

Requires Improvement

The service was not always well led. People were not sufficiently supported or encouraged to share their views of the service and to influence improvements. The provider did not enable the registered manager to access management information, or to access information to support their legal responsibilities, in the provider's absence.

Albemarle Rest 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 inspection took place on 5 January 2016 and was unannounced. The inspection was undertaken by two inspectors 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.

The provider was not able to complete a provider information return (PIR) prior to our inspection, due to their sickness absence. 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. However, the registered manager was able to give us the statistical information we requested during our inspection, but was not able to tell us about the provider's planned improvements

We reviewed the information we held about the service. We looked at information received from relatives and the local authority commissioners and checked whether the registered manager had sent us any statutory notifications. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with nine people who lived at the home and three relatives, one of whom was a regular volunteer activities person. We spoke with four care staff, the registered manager and a director of the home. We observed care and support being delivered in communal areas and we observed how people were supported at lunch time.

Many of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the

experiences of people who could not talk with us.

We reviewed three people's care plans and daily records to see how their care and treatment was planned and delivered. We checked whether staff were recruited safely and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

People and relatives told us they felt safe at the home. One person told us, "Yes I do. I feel safe here, in these surroundings." A relative told us the staff were very conscientious about keeping people safe. They told us, "I can go out of the door and know [Name] is safe."

The provider's policies and procedures ensured staff understood their responsibilities to protect people from harm. There was a poster on the office wall that explained the procedure for reporting any concerns and how to refer any issues to the local safeguarding authority. Care staff told us they knew the signs of abuse and the actions they should take if they were concerned anyone was at risk of harm. A member of care staff told us, "There is no abuse. If I saw bruises on a person I would tell the senior or manager. They would investigate." Records showed the provider's whistleblowing policy was effective. The registered manager had taken prompt and effective disciplinary action in response to staff's concerns about poor practice.

The provider's policy for managing risks included assessments of people's individual needs and abilities. Assessments included risks to people's mobility, nutrition and communication. Where risks were identified, the care plans described the equipment needed and the actions staff should take to support people safely. For example, for one person who stayed in bed, the registered manager had identified they did not always remember to use their call bell. The instructions for staff included checking on the person every half an hour. We saw staff went in and out of the person's room to check whether they needed anything throughout our inspection. The person was also at risk of sore skin so the registered manager had obtained a hospital bed and specialist mattress, and care staff applied topical cream to reduce the risk of the person developing sore skin.

Staff recorded accidents and incidents in people's personal daily records and in an accident and incident log, for the registered manager to review and analyse. Care staff told us they reported accidents to a senior and called the GP or ambulance if needed. A member of care staff told us, "If they fall, I don't move them. I check them and call a senior." Records showed most people fell when they were in their own rooms, when moving around independently. No-one had sustained any serious injuries that the registered manager needed to notify us of.

The registered manager told us they took action when they identified patterns in when, or where, accidents, incidents or falls occurred. The registered manager told us, "Falls analysis in recent years led us to increase staff to ensure the lounge is always staffed. We now have no falls in the lounge, but if people choose to stay in their rooms, it is not without risks." They told us when they had identified an increase in the number of people who fell when getting out of bed independently, the provider had replaced 18 of the 24 beds with profiling beds that can be lowered at night, to minimise the risks of a re-occurrence.

The provider's policy for managing risk included risk assessments of the premises and equipment, which resulted in contracts with specialist service providers. Records included maintenance records for gas boiler safety, the clinical waste disposal unit and for maintenance of the electronically operated bath chair. The

registered manager told us they recorded maintenance issues as they arose and the regular maintenance man made repairs or called in local specialists for electrical and plumbing issues. The registered manager had identified a possible trip hazard in the hallway with black and yellow tape. They told us the maintenance person would attend to it when they returned from holiday the week following our inspection.

The registered manager's actions to minimise risks to people's safety included personal emergency evacuation plans for each person who lived at the home and training for staff in fire safety to ensure they knew what actions to take in an emergency. Care staff told us they were confident they knew what to do in the event of an emergency. One member of care staff told us, "I was shown the fire alarms and we had a practice drill. I know how to get everyone to the collection point." The member of care staff explained how people's individual needs might change in an emergency, for example, one person who was usually independently mobile would need a wheelchair to move to the collection point for speed in an emergency.

People told us there were enough staff to meet their needs and said staff came to their rooms when they rang their bell. One person told us, "I have my bell there on my walking frame – they generally come between five to ten minutes." Relatives told us there was a regular staff team and said, "There are always enough staff. There are always staff in the lounge."

The registered manager checked people's needs and abilities and scored each person's level of dependence to determine how many staff were needed to support people safely and according to their needs. We saw there were enough staff to spend time supporting and engaging with people individually. Care staff told us there were always enough staff to support people effectively, for example, there were always two staff to assist when a person needed assistance to move with the hoist and they had enough time to spend chatting, playing games and supporting people to enjoy their day.

Care staff told us they had to provide proof of their identity, references and have a 'DBS' check when they started working at the home. The registered manager showed us the records of the checks they made on staff's suitability to work at the home. They requested references from a previous employer, checked staff had the right to work and whether they were known to the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions.

People told us they were supported to take their regular medicines and when they felt they needed pain relieving medicine, it was brought to them straight away. People's medicines were managed safely and only administered by trained staff. Medicines were kept securely in a locked trolley or locked cabinet, where only senior staff could access them. Medicines were delivered by the pharmacy in named blister packs with an accompanying medicines administration record (MAR). The MAR included the name of each medicine, the frequency and time of day it should be taken. The three MARs we looked at were signed by staff and up to date which showed they were administered as prescribed.

A relative told us, "I am totally happy with the medicines management. [Name] has pain relief when she wants it." Records showed that one person declined to take their medicines, which had an impact on their health. A hospital doctor and the person's local GP had both made a decision in the person's best interests and instructed staff to administer the medicine covertly, that is, without their knowledge. The registered manager told us they followed the GP's advice and the person now benefitted from receiving their medicine regularly and their health had improved.

Good

Is the service effective?

Our findings

People told us staff had the right skills to give them the care and support they needed. People told us, "The staff seem well trained" and "The care is excellent for the people who need it."

Care staff told us their induction programme included meeting the people who lived at the home, learning about their needs and dependencies and shadowing experienced staff. A member of the staff told us, "I was shown how to assist each person with dressing and eating and how to use the hoist. I have a certificate for moving and handling". Care staff told us they felt prepared and supported when they started working at the home. We saw staff working together to support people safely and effectively, for example, assisting people to reposition using a specialist belt and ensuring people's walking frames were positioned safely.

Care staff told us they had training in relevant areas, such as, food hygiene, dementia awareness and equality and diversity. One member of care staff told us they were trained and supervised by the district nurse to support people with delegated health care tasks. Care staff told us they had regular opportunities to meet one-to-one with the manager and discussed their training and career development. One member of staff told us they had training in team leading and another member of staff told us they were studying for a nationally recognised diploma in health and social care. Care staff told us, "The manager makes time (for staff)," and "We speak every day." However, two newly recruited staff told us they had not attended formal training sessions, but observed experienced staff.

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.

Care staff understood the principles of the MCA. They understood that the capacity to make decisions depends on the decision being made and that capacity to understand information could fluctuate. One member of care staff told us, "People do decline care. They (people who live with dementia) might shout 'go away'. I go out and come back after five minutes." The guidance for staff in people's care plans included 'prompting' and 'encouraging' people, to make sure people were supported to make their own decisions about their care and support. We saw staff offered assistance and waited for the person to respond, gaining their consent, before they acted. Care staff told us if people were at risk of poor health by declining care or support, they would report this to the senior to make sure that decisions were made in their best interests.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made six applications to the local supervisory body for the authority to deprive people of their liberty. The registered manager had monitored each person's moods and

behaviours and believed they lacked the capacity to understand the risks to themselves and others if they left the home independently. At the time of our inspection one application had been approved and five were in progress.

People told us, "The food is alright – its practical and sensible food" and "The food is good, it's varied and no complaints." A relative told us, "I had lunch here the other day it was very nice."

A member of care staff told us, "We go in and ask every day what they want for lunch. They choose in the morning after breakfast." We saw the menu was displayed in the front hall, however, none of the people we spoke with could remember being asked which of the two meals they would like beforehand. A member of staff told us people often did not remember and sometimes they changed their minds when they saw what other people were eating. The member of staff told us, "If people don't eat their lunch we try something else, or offer a sandwich, cheese on toast, an omelette or soup."

At lunch time we saw people were encouraged and supported to eat in the dining room, which made lunch into a social occasion, and there was a choice of main meals. Some people chose to eat in the lounge and some people chose to eat in their own rooms. People who chose to eat in their rooms told us, "Food is usually hot when we get it," and "They will try and make me something else if I don't like what they bring me." People were supported to eat at their own pace and were not rushed. We saw one person had a plate 'guard' to stop food going off the edge of the plate, which made it easier for them to eat independently. One person, who needed assistance to eat, was supported by a member of staff who sat beside them and explained what was on the fork before they offered it.

Staff knew and understood people's specific dietary requirements. Care plans identified people's food likes, dislikes and any allergies. In the kitchen we saw staff had made a note of people's specific dietary requirement, such as diabetic diets. A member of care staff told us, [Name] and [Name] are diabetic. They have different puddings and separate diabetic biscuits. No one needs pureed or mashed meals. No one has any identified cultural dietary needs". The main meals were delivered by a specialist catering supplier and were planned to deliver a nutritionally balanced diet. At tea time people were offered hot and cold snacks prepared by staff. The senior in charge of ordering the meals told us they varied the menu according to people's known preferences and watching how well they ate different dishes.

Care staff weighed people regularly and monitored how much people ate and drank. A member of care staff told us, "If a person is not eating well we speak to the GP." Records showed one person who had chosen to eat only a limited range of foods had been referred to the GP because their choices created risks to their nutrition.

People told us they were supported to maintain their health and they were happy with the arrangements in place. During our inspection an additional member of care staff had been allocated to the shift, so that one member of care staff was able to accompany one person to attend an appointment at a clinic. One person told us, "There is no problem with them getting a GP, an optician, a dentist or anyone else if you need one. They are excellent here." Care plans included records of visits and advice from other health professionals, such as the GPs, dentists and chiropodists. Care staff told us they felt well informed because they shared information about people's appetites, moods and behaviours at shift handover.

Good

Is the service caring?

Our findings

People and relatives told us the staff were caring. One person told us, "They look after me, they are kind and patient." A relative said, "I can tell you [Name] is happy because the staff are so kind and helpful."

Care staff told us meeting people's individual needs and making people happy was their main purpose. A member of care staff told us, "They are very special for me, (like my grandparents). They need hugging and I dance with them. I dance with [Name] and she loves it."

Staff recognised people's diverse needs and supported them accordingly. For example, staff knew who liked to spend time in their rooms, who liked to socialise and who had visitors and how often they came. We saw that people were relaxed in staff's company and staff knew them well. For example, a member of care staff told us, "[Name] likes to help with clearing up the dishes," and we saw this person clearing the tables after lunch.

A relative told us, "The staff are very good, very helpful, very kind, very conscientious. Staff know clothes are important to [Name] and they are always folded and put away neatly." People's care plans included a brief life history, which included their culture, religion and important family relationships. Relatives told us staff supported people to celebrate important events in their lives. We saw staff had prepared a birthday cake for one person who was celebrating their birthday on the day of our inspection.

Relatives told us they could visit whenever they liked and always felt welcome. One relative said, "I come several times a week at different times of the day. I spend a few hours here. They always offer me a cup of tea and a biscuit. They are very friendly and welcoming."

People and relatives told us they were involved in planning their care, which meant they received the care and support they wanted. One person told us, "I have a copy of my care plan in my drawer – I am very involved in the planning of my care." A relative told us "They keep me fully informed. We know always what is going on and if [Name] has needed to go to hospital."

People told us staff supported them to lead their lives in the way they preferred, which encouraged their independence. People told us, "I look after myself. I believe in doing things for myself" and "I get myself washed and dressed but they will do anything to help you." Care staff told us people made their own decisions about their daily lives and followed their own preferred routines. A member of care staff told us, "Some people stay up late and we have a chat and watch a movie. Then we have a cup of tea about 9pm."

People told us care staff treated them with respect and supported them to maintain their dignity. One person told us, "I have no concerns with them helping me. They treat me with dignity and respect my privacy." We saw staff spoke discretely when offering to support people with personal care. Staff kept people's personal information and records in the office where only staff could access them.

Good

Is the service responsive?

Our findings

People told us staff responded to their needs appropriately. One person told us, "They are all very good. They know me well and they know what I like." A relative told us, "They all know what they are doing and act swiftly when required."

Care planning was centred on the individual and care plans were regularly reviewed and updated when people's risks and needs changed. Relatives told us they were involved in care planning and knew about recent changes. One relative told us, "[Name's] care plan is reviewed with me every year. [Name] is always involved." A relative told us that changes to their relation's needs resulted in changes to the care plan. For example, the relative used to take their relation to hospital and clinic appointments on their own, but now staff accompanied them.

Care plans included information about people's previous interests, hobbies and preferred activities and stated where and how people currently liked to spend their time. One care plan we reviewed was marked, "Used to draw, paint and garden," but now "Prefers own company, to watch TV in own room and having hair done." The person had recently restated their right to privacy during a feedback session with the manager. The manager had asked staff to re-arrange their cleaning schedules accordingly. For example, staff agreed to only clean the person's room while they were at the hairdressers, to minimise disruption to the person's privacy.

Records showed staff spent time with this person in one-to-one activities of their choice in their own room, for example, by giving the person nail care and an opportunity to 'chat' privately. A member of care staff told us, "We ask people if they would like nail care. They choose the colour. We brush people's hair and encourage them to brush their own hair to keep them moving and supple. We show clothes so they can choose the colour to wear."

Group activities were arranged to encourage people to take an interest in their surroundings and to stimulate memories. Care staff told us, "I can put on music and they sing along or dance," and "We play skittles and do puzzles with people so they don't get bored." Many people were not able to articulate their preferences for how they spent their time, but we saw they chose to spend time in the lounge and joined in various activities. During the morning, staff set up a game of armchair skittles and invited everyone to have a turn. We saw people watched intently and became animated when it was their turn. For example, one person, who lived with dementia, and who had been watching the game in silence, declared loudly, "I'll hit it right in the middle," just before they rolled the ball.

At lunchtime we heard one person singing to music playing in the background. The activities volunteer told us, "I come and play bingo every week and I am the music man and play games fortnightly. People who don't or can't play bingo watch and get a lucky dip prize. We type the numbers in large print on a long strip to assist recognition." Another person told us they enjoyed the 'music man's' visit because, "He does singing and brings song sheets with him."

People told us they had no complaints, but if they did they would report them to the staff or manager. A relative told us, "I would be comfortable to complain. If you raise a complaint it is dealt with. I have previously complained in writing and verbally. It always works." The registered manager showed us one complaint that had been received in the previous 12 months. Records included details of the registered manager's investigation and the outcome, and the action taken to resolve it.

Requires Improvement

Is the service well-led?

Our findings

People told us they were happy living at the home, but some people felt they did not have a say in the way the service was run. . One relative told us they had chosen the home because it had been recommended to them. Another relative told us, "I know [Name] is in good hands."

Improvements were required in communication. People were not always encouraged to make their views known. None of the people or relatives we spoke with could remember taking part in a quality assurance survey recently. Relatives told us, "I haven't had a survey for a while" and "I have not been sent a survey to complete since [Name] has been here over the last year." Records showed the registered manager had adopted a personalised approach to asking for feedback about the quality of the service. Care plans included the outcome of one-to-one conversations they had held with people during October 2015. The conversations included asking people whether they felt safe, well cared for and respected and whether there were appropriate activities and opportunities to be involved in making decisions about the service, which corresponds to the questions we ask about a service.

The registered manager explained how they had responded to individual comments about the service, but they had not analysed responses in total to identify improvements needed across the service. The registered manager had not informed people about their collective opinion, so people did not know what difference these made to planned improvements to the service, for example, using 'you told us' and 'we did'. No-one we spoke with was able to describe how they had any input in changes and developments at the home.

One relative told us they felt, "Communication is so strong and clear there is no need for formal feedback. We have plenty of informal conversations", but not everyone was of the same opinion. No-one was able to give an example of when they had expressed a view and it was acted on. One relative told us, "They used to have residents' meetings but not lately." People told us they were not aware of any residents' meetings and relatives told us they had not been invited to meetings. There was no formal opportunity for people who lived at the home to have a voice in decisions that affected them, such as, redecoration and refurbishment schemes, changes in the catering arrangements or staff recruitment.

Improvements were required in leadership of the service. There was no system for the registered manager, or other named person, to speak on the provider's behalf in their absence. For example, prior to our inspection, the provider had not been able to supply the information we requested in the provider information return (PIR) as they had been absent. The registered manager had gathered the statistical information we requested, but they had not been confident to explain what improvements the provider had planned. The registered manager did not feel able to speak on their behalf. The provider had not made provision, or contingency plans, for how information requests should be managed in their unforeseen absence. The registered manager did not have access to all the management information in the provider's absence.

There was no on-site facility for the registered manager to access our website and to keep up to date with the latest requirements, except from the provider's office, which was locked in their absence. The registered

manager had not notified us of two important events, as required by the Regulations. The local supervisory body had authorised them to deprive a person of their liberty two months prior to our inspection, but the registered manager had not realised they should have notified us of the authorisation. A complaint they had received from staff had been dealt with effectively through the provider's disciplinary process, but the registered manager had not referred the allegation of abuse to the local safeguarding team, which could put other people outside of the home at risk of abuse in the future.

Improvements were required in the on-going management of risks. People told us the premises were looked after and told us the ground floor lounge had recently been redecorated. The provider's risk assessments had resulted in maintenance and servicing contracts for essential services, and a full time handyman was employed to attend to issues as they arose, such as keeping floor coverings in good repair. However, there was no clearly articulated, formal process for proactively checking the premises for new or emerging risks.

When we told the registered manager a window on the landing opened wider than we would have expected, which posed a risk to people, they assured us they would take action to ensure the opening gap was reduced in line with the latest health and safety recommendations. We identified a build-up of lime scale around taps in some bedrooms, some cracked tiles in a shower room and a bath seat that was not clean underneath. The registered manager told us these issues would be attended to immediately, but they could have been prevented by a regular, proactive risk assessment of the home.

Improvements were required in the support available for staff to attend training sessions. Records showed formal staff training was inconsistent and unrelated to their seniority or length of service. The registered manager told us that, apart from staff's initial induction training, "Staff do training in their own time. It's their choice, it advances them." The registered manager told us staff did not get paid for training time if they had to attend outside of their allocated shift and "It depends if I can take a staff member off the floor." The registered manager was not able to insist staff attended training in their own time, which meant they could observe staff's practice, but could not be assured that all staff had a professional understanding of their role.

The registered manager told us their plans to review staff's training, included reviewing the Care Certificate to assess the possibility of incorporating it into new staff's induction programme. The Care Certificate was launched in April 2015 and replaced the previous Common Induction Standards (in social care) and the National Minimum Training Standards (in health). The Care Certificate will help new members of staff to develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care.

The registered manager conducted regular audits of staff's practice and record keeping. For example, they checked people's care plans were regularly reviewed and up to date and medicines were managed and administered safely. Records showed the registered manager checked staff signed to say medicines had been administered as prescribed, or had explained why it was not administered. The registered manager checked some, but not all, boxed medicines were accurately recorded when received and administered. In two of the records we looked at, the actual amount of medicines did not match the amount calculated as remaining in the boxes. The registered manager told us they would ask the senior care staff to conduct a full medicines audit following our inspection.

Staff told us they were happy working at the home and they appreciated the registered manager's management style and hands on approach. A member of care staff told us the manager and senior staff observed their practice and checked they carried out their role as expected. They told us, "The senior checks people's rooms and tells us if we have forgotten anything." Staff told us they had regular team meetings to,

"Share good practice", because "The manager doesn't want any mistakes." The registered manager told us they talked about people's needs and gave reminders about staff's practice, for example, "Remember to close the windows at dusk or if it rains." The registered manager told us, "If staff don't attend, I share my notes of the meeting." Care staff told us the manager was very good and said, "It's good teamwork. It works." Another member of care staff told us, "The manager and senior are lovely. It feels like family. It's important to feel happy at work."