The Old Rectory

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Inspection report

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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?	Good

Summary of findings

Overall summary

This unannounced inspection took place on 3 and 5 December 2018.

The Old Rectory provides accommodation and personal care for up to 25 people. There were 19 people living in the home at the time of our visit, some of whom were living with dementia.

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

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

There was 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.

People felt safe. They were supported by staff who demonstrated a good understanding of how to safeguard people from experiencing harm or abuse. People had personalised risk assessments which helped minimise risks to their health and well-being.

There were enough staff to meet people's needs and respond flexibly. Recruitment checks were in place and demonstrated that staff employed had satisfactory skills and knowledge needed to care for people. This included carrying out checks to make sure they were safe to work with vulnerable adults.

Medicines were managed safely, and people got their prescribed medicines on time and at the correct dosage. Accidents and incidents were reported, investigated and the learning shared with the staff to reduce the chance of them happening again.

People had thorough pre-assessments which supported their move to the home and identified their needs, abilities and achievable outcomes. Staff received training and received an induction on starting. Staff had supervision which was used as an opportunity to reflect on practice, performance issues and discuss career aspirations.

People were supported to eat a well-balanced diet and could choose from a variety of fresh foods on offer. Where people required extra support at meal times this was provided in line with guidance from health professionals.

People were supported to attend appointments to maintain their health and well-being. Where people's health needs changed there was timely contact with relevant health professionals such as GP, chiropodists and district nurses.

The home was decorated in a way that gave it a homely feel and people liked this. People could move around the home freely and could enjoy spending time with those important to them.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Where people lacked capacity to make particular decisions they were supported by staff who were trained and worked in line with the principles of the Mental Capacity Act 2005.

People were supported by staff who were consistently kind, caring and attentive. Staff knew people and their relatives well which supported natural, easy conversation. People told us they were supported and encouraged to express their views about the care they received and could live their lives how they wished to live them. People's privacy and dignity was supported.

People's care plans were personalised and regularly updated. They included details of people's communication needs and preferences.

There was a wide range of activities supported at the home and in the local community. People had choice about what they participated in and could feedback their thoughts on the activities programme during the resident and relatives' meetings.

Complaints were acknowledged, investigated and resolved in line with the provider's policy. Staff were trained to support people at the end stages of their life and had a good understanding of how to maximise a person's comfort at this time.

The home was well led. There was an open and inclusive culture where everybody's views were sought and considered. Annual surveys were used to find out where people, relatives and staff thought improvements could be made. The home had developed good working relationships with healthcare professionals.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

The Old Rectory

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 unannounced inspection took place on 3 and 5 December 2018. It was carried out by one inspector and one inspector manager on day one and one inspector on day two.

Before the inspection, we requested and received a Provider Information Return (PIR) from the service. This is a form that asks the provider to give some key information about the service, what the service does and improvements they plan to make. We reviewed this information and in addition looked at notifications which the service had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with the local authority quality improvement team to obtain their views about the service.

We spoke with six people and seven relatives. We also spoke with the registered manager, the cook, activity lead, domestic staff and six care workers. We looked at six care records, four Medicine Administration Records (MAR) and spoke with three healthcare professionals including a nurse practitioner, GP and district nurse.

We looked around the service and observed care practices throughout the inspection. We saw three weeks of the staffing rota and the staff training records, and other information about the management of the service. This included accidents and incidents information, medication records, compliments and complaints, equipment checks and quality assurance audits.

We used the Short Observational Framework for Inspection (SOFI). This is a way of observing care to help us understand the experience of people who could not talk with us.

We asked for information to be sent to us following the inspection which was received.

Good

Is the service safe?

Our findings

People were kept safe by staff who had a good understanding of how to safeguard them from harm or abuse. Staff understood the signs that may indicate a person is experiencing harm or abuse. One staff member said signs could include, "A change in their mood, physical presentation or facial expression." People told us that they felt safe living at The Old Rectory. One person said, "I'm well looked after and feel safe." Staff told us that they would feel comfortable raising concerns about colleagues practice. Safeguarding and whistleblowing guidance was displayed in the home's reception.

Risks were managed and supported people to stay safe. System and processes were in place and followed consistently by staff. The home had general risks assessments to help make the environment as safe as possible for the people and staff that worked there. These covered areas such as: electrical appliances, hoists and slings, hot water systems and fire safety. People had personal emergency evacuation plans (PEEP) in place. These plans told staff how to support people in the event of an emergency such as a fire. The registered manager told us that staff checked equipment visually before each use. Fire checks indicated the need for emergency lighting refurbishment which the registered manager said they were chasing up. The home had also done individual risk assessments for people living there. This helped ensure that people had the correct equipment and support to minimise risks to their health and well-being. For example, people at risk of developing pressure sores had specialist equipment in place whilst people at risks of falls were encouraged to use their walking frames or had as much support as they required from staff. This helped to keep people safe without them feeling restricted.

The home had enough staff to meet people's needs and regularly reviewed this using a dependency tool. This was used to ensure that staffing levels matched people's needs. Additional staff were put on shift as and when people's needs changed. A staff member said, "I don't feel rushed. I feel I have plenty of time." A relative said, "There are always staff about." The registered manager told us that they do not use agency staff as they wanted to ensure that people are supported by people that know them well.

The home had safe recruitment practices. Checks had taken place to reduce the risk that staff were unsuitable to support vulnerable people. Pre-employment and criminal records checks were undertaken. Records included photo identification, interview records and references which provided evidence of previous conduct. Staff confirmed that they were not asked to support people until all necessary checks had been completed.

Medicines were signed in, stored and administered safely. This included medication that required additional security. People were supported by staff who had the skills, confidence and competence to carry out this task. The temperature of the room where medicines were stored was monitored and was within the acceptable range. Where people were prescribed medicines that they only needed to take occasionally, guidance was in place for staff to follow to ensure those medicines were administered in a consistent way. The home was imminently moving to electronic medication records.

The home was visibly clean and had no malodours. The home had an infection control policy and systems

in place to reduce the risk of cross contamination. There were hand sanitisers and a supply of personal protective equipment around the home. We saw that staff made appropriate use of these and understood their responsibilities in relation to infection control. Domestic staff attended team meetings and said that the home supplied them with all the equipment they needed to do their job. A relative told us, "It is always very clean, it never smells."

Accidents and incidents were logged, and the information audited monthly. This included a review of what had gone well, what had not gone well and what could have been done better. We looked at incident records for the previous two months. This noted several falls. The registered manager said there had been no trend in the location of where these falls had occurred. One person had an increase in falls and mobility aids had been explored whilst another person had an increase in falls which were due to be discussed with the GP on the day of the inspection. The registered manager explained that learning from accidents and incidents was shared with staff in meetings, 1:1's and via the electronic planning systems messaging system. Information was also cascaded to staff via handovers and by the registered manager speaking with people naturally during the course of their work. This approach helped reduce the chance that accidents and incidents would happen again.

Good

Is the service effective?

Our findings

People's needs and choices were assessed and care, treatment and support was provided to achieve effective outcomes. People had pre-assessments which had supported their move to the home. These included people's needs, preferences, abilities and life history. The home ensured that staff had time to read people's care plans so that they could develop a good understanding of people's individual needs. With people's involvement the home had produced 'This is Me' one-page profiles for people's rooms which detailed things such as: 'What I like to be called', 'My communication, eyesight and hearing', 'The carers that know me best are…' and 'Things that I enjoy and like.'

People were supported by staff who had received an induction. This included shadowing more experienced staff and probationary reviews to check that staff had the rights skills and competence. One staff member told us, "This has given me more confidence." Staff were trained to meet people's specific needs. Courses included dementia awareness, diet and nutrition, communication and moving and handling. A staff member who had recently attended moving and handling training said it had taught them the importance of, "Assessing a person's abilities every time you assist them to reposition." Two relatives commented, "I think they are well trained and know what they are doing" and, "From top to bottom the staff are excellent." A person said, "All the staff here are happy and hardworking."

Staff received regular supervision and annual appraisals that were used as an opportunity to reflect on their practice knowledge and to discuss any professional development aspirations they had. One staff member commented, "I have just finished my level three diploma in health and social care and the registered manager approached me to ask if I want to do level 4." Discussions with staff included their understanding of CQC Key Lines of Enquiry (KLOEs), infection control, fire safety, and what made each person living at the home unique.

People were supported to eat a well-balanced diet. Choices were plated so people could make a visual choice about what they would prefer to eat and drink each day. All food was freshly cooked using local suppliers. One person told us, "The food is very nice. You can have as much or as little as you want." The cook and care staff had a good understanding of people's dietary needs, likes and dislikes. For example, one staff member said, "Some of the ladies don't like soup for supper so they have sandwiches instead." All staff had received food hygiene training and the kitchen had been awarded a five-star food standard rating. Snacks were available to people 24 hours a day.

People could choose where they had their meals whether that be in the dining room, one of the sitting rooms or their own room. Support was provided where required by staff. People's independence was supported by the supply of adapted plates and cutlery where required. Meal times were relaxed and informal. People chatted with each other and staff. One person was observed smiling and singing along to the hymns playing quietly in the background and commenting to another person, "I like this song as I know some of the words to it."

People were supported by staff who understood the importance of working effectively with health and

social care professionals to meet people's needs. A district nurse told us, 'As a team we have worked with The Old Rectory for three and half years. We have found them more than efficient at both reporting incidents to the community nursing team, self-reporting to safeguarding when required and more than prepared to listen and act on advice given in a timely manner. The communications system is effective as the information is cascaded to all relevant staff. They are keen to learn from situations and events as they arise.' A nurse practitioner who visited the home fortnightly commented, "The staff are very pro-active. They keep me up to date. Pro-active is the best way to describe the staff here." A local GP conducted a bi-monthly visit to each person supported by the registered manager. This pro-active approach was used to identify and resolve people's health issues in a timely way to reduce the need for unnecessary hospital admissions.

The home was decorated in a way that gave it a homely feel. Since the previous inspection the home had undergone some changes to the internal layout so that its smaller bedrooms were enlarged to accommodate en-suite facilities. People had memory boxes outside their rooms which helped mark this as their room and celebrated their interests and what they had achieved in their life. People had level access to a safe, enclosed garden which included raised planters, seating, two resident chickens, and opportunity for purposeful walks.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). Records confirmed that each person who required a DoLS had this in place. We found that no authorisations had any conditions attached to them.

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 had the appropriate legal authority and were being met. Our checks confirmed these requirements were being met. Where people were assessed as lacking capacity to make particular decisions staff had involved relevant people when making best interest decisions. Where people had representatives who gave consent on their behalf, consent forms were signed within the scope of the representative's legal authority.

Good

Is the service caring?

Our findings

People were supported by staff who were kind, caring and respectful. One person told us, "I like it here. I've been made to feel welcome since I came." One relative commented that their loved one had, "Turned into a calm and contented person there. It suited [name] so well. [Name] completely blossomed there. They are so kind and caring." Other relatives told us, "They seem to care for everyone", "They interact with [name] very well. Oh yes, they are kind and caring" and, "Everybody is very kind. They are also very good to me."

Staff were attentive to people's needs, for example we saw a staff member checking whether a person wanted the blinds closed as they had noticed that the sun was getting in the person's eyes. Staff conversations with people were natural, respectful and contained appropriate humour. We heard one staff member saying to a person, "How are you [name]? What have you done to the weather?" The person responded, "You come and cheer me up don't you." The staff member supported the person to transfer into their wheelchair and both were heard laughing when the staff member commented, "You're doing well [name]. Take your time. We've landed!"

Staff knew how to support people when they were feeling anxious or upset. One person on respite was becoming unsettled as they were not aware when their relative would come to collect them. When a staff member reminded the person of the day their relative would come the person appeared calmer and expressed, "Oh thank goodness, thank you."

People had been supported to personalise their rooms to reflect their interests, personality, friends and family and what they had achieved in their lives. One person commented, "You can have your room how you want it." A relative said, "We were told we could personalise the room, we have brought in some photos." This helped people to settle in and supported people and staff to get to know each other. A person told us, "The staff are wonderful. They talk to me about when I was a bus driver."

People told us that they could express their views about the care and support that they received. One person said, "If I want something all I have to do is ask." People could choose to live their lives how they wanted to, for example we heard a staff member saying to a person, "Did you like your lie in?" and the person responding, "Too true." One person commented, "They let you do your own thing. If they didn't I'd put my foot down." When a staff member asked a person if they would like to read a book they responded, "No, I'd like a snooze" and this was respected by the staff.

People's privacy and dignity was supported. We saw staff knocking on people's doors and asking permission before entering their rooms. Staff said that if people wished to enjoy an intimate relationship they would give them private time in their rooms and help them to stay safe. A staff meeting had included a discussion of examples of how to support people with their dignity with staff concluding that if a person's clothing was not ironed they should not be expected to wear it. A relative told us that their family member was, "Always in her own clothes and they are clean. She has her hair done every week and nails every fortnight. She loves it." The registered manager conducted weekly spot checks to ensure that people received support that demonstrated quality, dignity and respect. Any issues identified were discussed with staff in supervision.

We observed people enjoying visits from people important to them. People were given time and space to spend private and uninterrupted time alone or with their family and friends. A relative said, "We pop in every other day. We can turn up when we want and don't need an appointment." One person told us, "I'm having some quiet time and that's how I like it."

People were encouraged and supported to maintain their independence. Care plans detailed what support they required and what they could do themselves. For example, one person's plan stated, '[Name] is able to choose [name's] own clothes for the day and [name] is able to dress [themselves] with minimal support.' A staff member said, "[Name] likes to wash and dress herself. We just do her back as she finds that more difficult to reach."

Compliments that the home received were logged and were available for people to read in the reception. Feedback had included an email from relatives expressing thanks for hosting their grandson's wedding party which had enabled a person at the home to feel involved with the wedding day. They had written, '[Name] was clearly having a wonderful time and it did us all good to see [name] so happy enjoying the company of family and a few residents with whom [name] is obviously good friends.'

Good

Is the service responsive?

Our findings

People's care plans were detailed and person-centred. They included information about people's needs, preferences, social background, their abilities and people they enjoy visits from. Care plans were updated monthly. Reviews were held with people's involvement alongside those important to them. This was confirmed by a relative who told us, "They regularly update the care plan and give it to me so I can discuss it. They keep in good contact. The registered manager rings me if there are changes."

Staff had been trained to support people with end of life care needs. The home had recently achieved platinum accreditation for their end of life work. Their support at this time also extended to a person's family. One relative said, "I can't praise them highly enough. They were very caring to us as well." Care with people at the end of their lives was led by a senior staff member with support of care staff. A box was placed in people's rooms which contained a variety of items such as a book of poetry, tissues, books and sensory CDs. The home had arranged for a local entertainer to make a CD for a person with end of life care needs as this was their favourite musician. If a person wished to have somebody close by during the last stages of their life the home arranged for staff to provide a sitting rota. Staff played the CD to the person in their final moments. People who had passed away were not forgotten. Staff and people at the home raised a glass to the person at a subsequent meal time and a candle, photo and memory book were placed in reception for people to view and contribute their thoughts.

There was a wide range of activities supported at the home with people able to choose what they wanted to participate in. One person told us, "There is always something to do and sometimes it's good to do nothing like have a sleep. We can do what we like." A staff member was heard saying to a person, "Come along [name] and see what you fancy." The person was later observed playing table tennis with another resident with staff voicing encouragement and taking turns to guess who might win.

One relative said, "There is something interesting going on every day." Other relatives commented, "There are things going on, especially music, which [name] loves. [Name] has been up dancing. It is brilliant" and, "They have such good activities." The head of activities was working with a person's relative to build a collection of music to help their family member feel more relaxed. There had been a trip to the seaside in the summer where people had been supported to paddle in the sea, some of whom had not had the opportunity to do this for several years. Other activities had included knitting, poetry, gardening and supporting an ex-farmer to visit a cattle farm to relive their earlier working life. The head of activities said that the staff at the home were "brilliant and get involved." Relatives were also encouraged to join in with activities. We observed people and relatives enjoying an interactive reminiscence activity where they handled and commented on objects from the past.

The home had recognised how much people enjoyed the regular visits from a pet therapy group and had bought several interactive pet animals for people to look after including cats and dogs. One person fondly told us about their interactive pet which they had named after a pet that they had when they were younger. The registered manager had purchased a collar and a name tag for this person's interactive pet which further personalised it for them.

People were supported to continue enjoying activities that they had done before moving to the home and be as active as possible. For example, one person continued to have their newspaper delivered from the local newsagent and another person was supported to get their haircut at their favourite barbers. Some activities had given people the opportunity to engage with and contribute to their community. For example, people at the home had made Christmas decorations which had been added to a local church's Christmas tree and other people had been supported to join in with the village Remembrance Day parade. A screen in reception showed photos of recent events so that people could remember these and look forward to the next one. One relative said, "My [relative] spent three years sat in a chair. Since [relative] has been here [relative] has been moving around using [relative's] frame."

The service met the requirements of the Accessible Information Standard (AIS). The Accessible Information Standard is a law which requires providers to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. The service had considered ways to make sure people had access to the information they needed in a way they could understand it, to comply with AIS. People's care plans detailed their communication preferences and needs. We observed staff using these when interacting with people. Communication, health and hospital passports were in place. These passports were used to share communication needs with others, for example new staff and professionals.

The home had a complaints policy and procedure that was displayed in the reception. People and relatives told us they knew who to speak to should they have any concerns or a complaint and felt they would be listened to. Complaints were acknowledged, investigated and resolved in line with the provider's policy.

Good

Is the service well-led?

Our findings

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. The registered manager used to be the home's deputy manager before being promoted to their current position.

The registered manager was highly thought of. Relative comments included, "The manager is so calm, reassuring and confident and that feeds down to the staff", "I am impressed with the manager" and, "The manager seems very competent and experienced and has a sense of humour which is very necessary." A staff member told us, "I can talk to the manager about anything. I feel very supported here." Another staff member said, "You can talk to management or staff about anything. Everyone is approachable. It's a chilled, laid back atmosphere." The registered manager based herself on the ground floor to be available for people, relatives and staff.

Staff got on with each other and told us they enjoyed working at the home. Staff comments included, "I absolutely love my job. It's a great place to work", "All the seniors are fantastic", "Here we work as a whole team. Everyone. I love it here" and, "There is not a day that I come in and don't want to be here."

The registered manager demonstrated a good understanding of when they were required to notify CQC or the local authority safeguarding team of particular events or incidents, for example a police incident or allegation of abuse. Notifications and referrals had been actioned as required.

Staff told us that the management recognised when they had worked well. This included an employee of the year award voted on by people and staff. Records confirmed that good practice was acknowledged. One staff member's file noted, '[Name's] cooking and baking is excellent. Works hard in the kitchen and is an important member of the team." One staff member had been praised at a staff team meeting for 'always being cheerful and happy' and hardworking. On occasions where it had been identified staff needed to improve their practice this was discussed with them and goals set. This was then monitored to ensure the necessary improvements were achieved. Staff who had experienced poor health and were off sick had received flowers and a get well soon card from management.

People had regular, scheduled residents' meetings. Relatives also participated in these. The most recent meeting had included discussion about end of life care accreditation, community trips, the garden and Christmas activities. One resident had commented about portion sizes which had resulted in these being adjusted to their satisfaction. A relative told us, "I have felt completely involved." A staff member said, "If I have ideas the management listen. They got me a trolley to take around evening drinks as I felt it was safer than using a tray." People, relatives and staff were kept up to date via the home's monthly newsletter that advised people of past events, upcoming activities and new staff. People had copies of the newsletter delivered to their rooms.

The registered manager was focused on continually improving their skills and learning. They did this by participating in monthly meetings with other registered managers to discuss current issues and best practice, attending conferences, including a recent one on sexuality and consent in care homes, and reading leading care industry publications. The registered manager told us that they felt supported by operations manager and the owner who visited weekly and was "very good at listening and taking things on board."

The home carried out a range of audits to help maintain the quality of the service. This included internal and external consultant quality monitoring, auditing of care plans, call bell response times and medication records.

The home had established and maintained good working relationships with other agencies. A local GP who had worked with the registered manager for two years said, "The home has never been run so well. We work closely together. The home is run like a well-oiled machine."