First For Care Limited

The Old Rectory Care Home

Inspection report

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Warwickshire
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12 August 2016

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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

We inspected this service on 11 and 12 August 2016. The inspection was unannounced.

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 service provides accommodation and personal care for up to 23 older people who may live with dementia. Twenty people were living at the home on the day of our inspection.

People were safe from the risks of harm, because 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 wrote care plans that minimised the identified risks.

There were enough staff on duty to meet people's care and support needs. The registered manager checked staff's suitability to deliver care and support during the recruitment process. The premises were regularly checked to ensure risks to people's safety were minimised. People's medicines were managed, stored and administered safely.

People's needs were met effectively because staff had the necessary skills and experience and received appropriate training and support. Staff understood people's needs and abilities because they worked with experienced staff until they knew people well. Staff were encouraged to reflect on their practice and to develop their skills and knowledge, which improved people's experience of care.

The registered manager understood their responsibility to comply with the requirements of the Deprivation of Liberty Safeguards (DoLS). They had applied to the Supervisory Body for the authority for to restrict people's rights, choices or liberty in their best interests.

People were offered meals that were suitable for their individual dietary needs and met their preferences. They were supported to eat and drink according to their needs. Staff ensured people obtained advice and support from other health professionals to maintain and improve their health.

People were cared for by kind and compassionate staff who knew their individual preferences for care and their likes and dislikes.

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 and updated when people's needs changed.

The provider's quality monitoring system included consulting with people and their relatives to ensure planned improvements were focussed on people's experience.

Quality audits included reviews of people's care plans and checks on medicines management and staff's practice. Accidents, incidents, falls and complaints were investigated and actions taken to minimise the risks of a re-occurrence. Staff were guided and supported in their practice by a registered manager they liked and respected.

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 protect people from the risk of abuse. Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks. The registered manager checked staff's suitability for their role before they started working at the home 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 were cared for and supported by staff who had the skills and training to meet their needs. Staff understood their responsibilities under the Mental Capacity Act 2005. The registered manager understood their responsibilities under the Deprivation of Liberty Safeguards. People were supported to eat and drink enough to maintain a balanced diet that met their preferences. People were referred to other healthcare services when their health needs changed.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate towards people. Staff understood people's preferences, likes and dislikes. Staff promoted people's independence, by supporting them to make their own decisions. Staff knew people well and respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive. People and their families were involved in planning how they were cared for and supported. Staff supported and encouraged people to follow their interests, to take part in social activities and to maintain relationships with the people that were important to them. The registered manager took action to resolve complaints to the complainant's satisfaction.

Is the service well-led?

Good

The service was well-led. People and their relatives were encouraged to share their opinions about the quality of the service. People were involved in planned improvements to the

service. Staff were inspired by the registered manager's leadership, skills and experience to provide a quality service. The registered manager regularly checked people received the care and support they needed.

The Old Rectory Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 11 and 12 August 2016 and was unannounced. The inspection was undertaken by one inspector.

The provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. 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 four people who lived at the home, the provider and registered manager. We spoke with the cook, three care staff, the maintenance and domestic staff. We observed care and support being delivered in communal areas and we observed how people were supported at lunchtime.

Most 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 told us they felt safe because they trusted the staff. People were relaxed and chatted easily with staff, which showed they trusted them. One person told us they had been offered a key for their room, but did not feel the need to lock their room, because there were always staff around.

People were protected from the risks of abuse because the provider's policy and procedures for safeguarding people were known and understood by the staff. Staff attended training in safeguarding and understood their responsibilities to challenge poor practice and to raise any concerns with the manager. Staff told us, "I have no concerns about staff's practice" and "I would challenge any poor practice in private and share with the manager." Records showed the provider had investigated any concerns raised and taken appropriate action to minimise the risks of harm.

The provider's policy for managing risk included assessments of people's individual risks to their health and wellbeing. Where risks were identified, people's care plans described how care staff should minimise them. For example, the registered manager checked risks to people's mobility, communication and nutrition, and described the equipment needed and the actions staff should take to support people safely. One person told us they understood the risks of going out into the local community alone and were happy to go out only with staff or their family. They told us, "The road is very fast and I move more slowly than I used to." They told us they were confident and content to go out into the garden alone whenever they felt like it.

Staff were knowledgeable about people's individual risks and knew how to support them safely. For example, we saw when staff used equipment to support one person to mobilise, they reassured the person they were safe. Staff explained what they were doing and what the person could do to minimise the risks of injury. Staff were attentive to people's needs and ensured the equipment they needed to mobilise independently was close to hand or brought to them promptly.

Records showed that people's risk assessments were regularly reviewed, but we observed that some staff did not always recognise people's abilities, and offered them support they did not need. The provider told us some staff had worked at the home for many years and were used to a 'risk averse' culture. They told us they were working with staff to change the culture, in accordance with the fundamental standards of care.

The provider was observant of staff, to make sure they followed best practice in managing risk. The provider reminded staff that another person, who was able to understand the risks of walking around independently, should be able to move around the home without staff's support. Staff followed the provider's guidance, and just watched until the person had safely reached their chosen destination.

Staff recorded incidents, accidents and falls in people's daily records, which the registered manager analysed to identify any patterns or any changes in people's abilities. The registered manager acted in accordance with the regulations, and had only needed to notify us of one incident that had resulted in an injury to the person.

The provider's policy for managing risk included regular risk assessments of the premises and emergency plans for untoward incidents. Staff received training in health and safety, first aid and fire safety, to ensure they knew what actions to take in an emergency. The provider had arranged for an external specialist to check their fire safety measures and had followed their recommendations. Records showed there were regular checks of the fire alarm, fire-fighting equipment and fire drills for staff. Care plans included personal emergency evacuation plans, which were matched to the individuals' needs and abilities.

The provider and maintenance staff did a regular 'walk around' of the premises to identify any issues that required attention in the building, the décor, furniture and fixtures. Records showed there were regular checks of the safety of essential supplies, such as water, gas, electricity, and of the lift and hoist. Any issues identified were attended to promptly. For example on the first day of our inspection, there was a dripping pipe under a hand basin and some light bulbs were not working in the lounge. They had had been fixed and replaced on the second day of our inspection.

People told us there were enough staff to support them with their needs. Care plan records showed the registered manager analysed people's physical needs as either low, medium or high dependency, to identify how many staff were needed. During our inspection visit, we saw the needs analysis was effective. There were enough care staff to support everyone with their physical needs and they had time to play board games or to sit and talk with people. Staff told us there were always enough staff on the rota. A member of staff told us, "There are enough staff and if a person is poorly, there are extra staff." The provider and staff told us that one member of staff who lived nearby regularly volunteered to support people to attend hospital visits, if they did not have any family or if a family member was not available to accompany them.

Staff were recruited safely and the provider checked they were of good character before they started working at the home. The provider showed us records of the checks that had been made of staff's suitability for the role. The registered manager had obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions.

People told us they received their medicines when they needed them and in accordance with their GP's prescription. We saw staff took people's medicines to them, reminded people what they were for, and waited to check the person took them before moving away. People who had medicines for pain relief, were asked whether they had any pain and whether they wanted any pain-relieving tablets.

Staff assessed the risks and benefits of people managing their own medicines or applying their own prescribed creams, and promoted people's independence where it was safe to do so. For example, one person told us, "I have cream for my sore leg. It's here in my handbag. I put it on when I want." A member of care staff told us they were confident the person applied the cream when necessary, because the sore skin was visible and they could see whether the cream was applied effectively. They told they would apply the cream for the person if they had sore skin in a less accessible or visible area.

A senior member of care staff showed us how they managed and administered medicines safely. Medicines were kept in a locked cupboard or trolley and only trained staff were responsible for administering them. Medicines were delivered from the pharmacy in colour-coded blister packs, which were marked with the name of the person, the time of day they should be administered and a photo of the person to confirm their identity. Medicines delivered in their original packaging and in liquid format were marked with the person's name and the prescription details and kept in a locked cupboard. Some people were prescribed fortifying drinks to maintain their nutrition and these were also stored and administered in accordance with the medicines policy and procedures.

The medicines administration records (MAR) we looked at were signed and up to date, which showed people's medicines were administered in accordance with their prescriptions. Staff recorded when medicines were not administered and the reason why not. For example, if a person declined to take them or the GP changed their prescription. Records showed when one person declined to take all of their medicines one day, staff had supported the person to visit their GP. The GP was able to re-assure the person about the purpose and importance of taking their medicines to maintain their health. Records showed the visit to the GP had been effective and the person started taking them again.

Care staff received guidance to ensure people's medicines were administered appropriately. The leaflets that explained the purpose, benefits and side effects of people's medicines were kept in a folder, and staff were able to look on-line for additional guidance. The senior care staff told us only seniors administered medicines and they all knew people very well. Some medicines were only to be 'administered as required' (PRN). The senior told us they looked at the faces and body language of people who were not able to say whether they had any pain and offered them pain relief according to their facial expression. Staff were confident people's PRN medicines were administered appropriately and the provider regularly checked that all medicines were managed and administered safely.

Good

Is the service effective?

Our findings

People told us the staff were very good at supporting them because they understood their needs. One person told us their needs were met because there was a lift to their room, their laundry was done for them, their bed was made and they were not lonely. They told us this was what made living at the home possible and easy for them. Another person who was not able to mobilise independently told us staff had the right skills to use the specialist equipment to support them to mobilise safely. We saw care staff knew people well and supported them appropriately with their physical and social needs.

People received care from staff they were familiar with, who had the skills and knowledge to meet their needs effectively. Most of the staff had worked at the home for over five years, so they knew people well. The registered manager had worked at the home for more than 11 years, so they had a good knowledge of staff's individual skills and experience and how they matched people's needs.

Two staff had been recently recruited. They had both already achieved nationally recognised qualifications in health and social care, which meant they were experienced in supporting people. Their induction to the home included understanding the provider's policies and procedures and learning about people's individual needs and abilities. One recently recruited member of staff told us, "My induction included shadowing and observing how people are cared for. I did morning and evening shifts. I felt prepared." A member of staff told us when new people moved into the home, they read their care plan, so they could get to know them quickly.

The provider kept a record of when staff's training was due and completed, so they could be confident that staff had the right training to meet people's needs. New staff were asked to show their certificates of achievement, which assisted the provider to schedule refresher training. Staff completed training to ensure basic standards of health and safety were met and training specific to the needs of people who lived at the home. For example, staff had training in caring for people at risk of sore skin, for people who lived with dementia and for people who presented challenging behaviour.

Staff told us they were supported to be effective in their practice through regular conversations with their colleagues, at team meetings and at one-to-one meetings with the registered manager. Staff told us, "I have one-to-ones with the manager, whenever I need. I feel supported" and "The manager is good. She is always here." In the PIR, the provider told us all the long-term staff had attended an appraisal meeting with the registered manager to discuss their individual performance and to consider their professional development. Staff were encouraged and supported to apply for more senior roles, with more responsibility.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People told us they made their own decisions about their care and support and staff respected their right to decide. People told us they only received care and support if they wanted it. For example, one person told us they chose whether and when they would have a bath or a shower. Another person told us they chose what household tasks they were involved in, such as, sweeping outside in the garden. Staff told us they had training in the MCA and they understood the requirements of the Act meant they could only deliver care if a person consented.

Staff told us the training was useful. One member of staff told us they had learnt that when a person declined care or support, sometimes it was best to, "Just step away." We saw a notice on the wall in the staff room reminding staff how to support people who declined care. The notice said, "Does it have to happen now? It might be less stressful if you try again later." We saw staff asked people how they wanted to be cared for and supported before they provided care. A member of staff told us, "People have freedom of choice" and "You can't force people, just offer, or distract if they are agitated."

The registered manager understood their responsibilities to comply with the requirements of the Act. They had applied to the supervisory body for the authority to deprive 19 people of their liberty, because their care plans included restrictions that they did not have the capacity to consent to. The decision for the 19 people to live at the home had been made in their best interests by a team of health and social care professionals. Eight applications had been authorised at the time of our inspection. We had not been notified of the approvals, but the provider told us they would send the appropriate statutory notifications to us after our inspection visit.

People's care plans had been recently reviewed and updated, and people had signed to say they agreed with the plan, where they were able to, but they had not always been invited to sign their advance care plans. The registered manager told us they would check whether people had retained the capacity to consent to care, at their next care plan review, and ensure people's right to decide how they were cared for at a later date in their lives was upheld.

People were supported to eat and drink enough to maintain a balanced diet. People told us the food was very good and they always had a choice. One person told us, "I can have toast and eggs for breakfast, but I like toast and jam. The jam is lovely - lovely flavour." They told us there was a choice of hot meals at lunchtime and sandwiches and snacks at tea and supper time. Another person told us they knew the cook and had told them what they liked to eat. A member of staff told us, "There is always enough food and we can ask for anything."

The cook told us, "The manager tells me about people's needs and allergies and I go out and introduce myself and ask people what they like. I ask them every day." They showed us their 'cook's book' of the choices offered and made. They told us they knew about people's dietary needs related to their health conditions and cultural preferences. For example, no one who currently lived at the home had requested halal, or gluten-free, meals, but the cook was confident they could cater for any specific requirements.

Staff knew people's dietary needs, for example, who needed a soft diet, and who was at risk of poor nutrition. At lunchtime, we saw people who needed assistance to eat were supported by staff in a relaxed manner, at a pace that suited the person. We saw people who needed a soft diet were served meals of an appropriate texture to enable them to eat. Staff watched to check whether people ate well. They offered

assistance with cutting up food, and offered alternative foods if people did not appear to be enjoying their meal. We saw staff offered people a choice of drinks throughout both days of our inspection.

People were supported to maintain a healthy diet. People were regularly weighed and care staff recorded whether people ate well, so they could monitor their appetites and nutritional intake. Records showed that when one person was at risk of gaining weight, the manager and cook had a conversation with them about amending their diet to reduce the amount of calories they ate. People who were at risk of poor nutrition were referred to other health professionals, such as dieticians and speech and language specialists. Staff followed the healthcare professionals' advice and recorded when people were offered nutritional drinks to supplement their diet.

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People were supported to maintain their health. Records showed people were referred to healthcare professionals, such as opticians, dentists GPs and nurses, when their health changed. Staff kept a record of the healthcare professionals' appointments and visits, and shared information at handover. Staff were knowledgeable about people's individual medical conditions and knew the signs to look out for that a person might be at risk of ill health. The registered manager was a nurse, so was skilled at identifying signs of ill health that required medical attention from a nurse or GP.

Good

Is the service caring?

Our findings

People told us they were happy living at the home because the staff were kind and thoughtful. One person told us, "I can tell you, we are looked after." Staff told us they liked working at the home and the manager was caring. Staff said, "I love working here" and "I have never enjoyed working so much as I do here. It's so relaxed. The staff are lovely, easy going, and help each other out."

Staff had established good caring relationships with people and knew them well. Staff offered friendship by sitting and talking with people about subjects that interested them. We saw one person appreciated staff's running commentary on a television programme they were watching together. Staff were assigned as keyworkers to people they got on well with, to make sure their individual needs were understood. A member of staff told us, "I'm [Name's] keyworker because we have a connection and a bond from a previous period in their lives." The provider told us, "Our male cook has befriended some of the gentlemen here and talks sport and reminisces with them about their working lives."

Staff understood people and supported them with kindness and compassion. Staff offered physical assurance by touching people's arms or hands when talking to them, which promoted their wellbeing. Staff understood that some people were unable to communicate verbally, but they understood people's needs through their body language and facial expression. Staff crouched down when talking to people, held their hands and maintained eye contact with them.

When one person showed signs of agitation, a member of staff told them the time, reminded them of the time lunch would be ready and offered to accompany them into the garden for a walk. The person decided they were happy where they were, declined the offer and settled into their chair. Another member of staff told us, "I can calm people when they are agitated. I ask, 'would you like a cup of tea'."

People were happy to talk with us about their everyday lives, but they were not all able to tell us how they were involved in agreeing their care plan, because of their complex needs. However, their care plans recorded how people and their representatives had been asked about how they would like to be cared for and supported. Care plans included a section entitled, 'My life story', which included the person's religion, culture, occupation, family and significant events. Staff told us this helped them to understand the person and to get to know them as an individual. A member of staff told us, "It's nice to sit and chat with people. It's nice to hear what they have to say."

Staff recognised and respected people's diverse needs and promoted their independence, for example, how and where they liked to spend their time. One person told us about their preferred habits and routine for the day and we saw staff supported them to maintain them. Staff said, "We know people's preferences for washing and their favourite clothes, for example."

Staff understood the importance of respecting people's privacy and promoting their dignity. For example, people's care plans explained exactly how much support they needed to maintain their personal hygiene and the things they could do for themselves. One person told us they could lock their bedroom door if they

wanted to, which showed the management and staff understood their right to privacy. People's personal information and records were kept in the office so only staff could access them.

Good

Is the service responsive?

Our findings

People told us they were cared for and supported in the way they wanted. They told us staff understood them and knew their likes, dislikes and preferences, because they talked about how they wanted to be supported every day. One person told us staff responded to their needs, because they were living life in the way they wanted. A senior member of care staff told us, "There are no set tasks, it's just responding to people's needs."

Staff told us they were empowered to deliver person-centred care and household jobs took second place to spending time with people. Staff told us, "You treat people like you would treat your own parents" and "I think about how I would like to be treated in years to come." People's care plans had recently been reviewed and revised, and were now entitled 'Support plans', which promoted a change in culture from 'looking after' to 'enabling people to live their lives'. A member of staff told us, "People have freedom of choice."

One person told us they liked to keep busy with household tasks, as they would have done in their own home. They told us, "Mr B (the provider) brought me a dustpan and brush this morning, because I want to get the cobwebs out of the birdhouse (gazebo)." They told us they planned to clean the outside tables and chairs when they had the energy. They told us which rooms they liked to spend different times of day in and where they ate their lunch. During our inspection, we saw staff supported the person with the routine they had described.

People were supported by staff's willingness and ability to engage their interests. A member of staff told us, "There are things to do - crafts, manicures, a bit of pampering." A poster in the lounge reminded people that staff organised regular art and craft sessions and an external person ran regular physical exercise classes.

One person showed us their art therapy book and told us they enjoyed this because they were no longer able to hold knitting needles to knit. They told us they used to love sewing, but had not brought their sewing machine with them because sewing required manual dexterity and concentration they no longer had. The registered manager told us a member of staff had recently brought their own sewing machine and a part finished garment to the home and the person had given them a 'sewing lesson'. They told us the member of staff had benefited from the advice, but the person had benefited more by being able to share their knowledge and skills with someone who was genuinely interested in learning from them.

Most people were not able to tell us about their hobbies and interests, due to their complex needs. However, we saw staff had contributed their ideas for engaging pastimes and they made opportunities for people to enjoy their day. During our inspection, we saw staff spent time encouraging people to take an interest in their surroundings, to experience smells and textures or to take part in social pastimes, according to their abilities. Staff sat with people and discussed subjects that interested them. Staff offered people hand cream and encouraged them to appreciate the fresh smell and the sensation on their hands.

Staff encouraged people to play dominoes, skittles and other throwing games, that helped maintain their physical strength and concentration. People who did not want to join in watched the games with interest.

During the afternoon, we saw one member of staff encouraged people with constant feedback on their achievement with praise, applause and laughter. People responded to their feedback with a renewed concentration when it was their turn. A member of staff told us, "People like the 'Fizzical Fun' classes too. They enjoy it, it gets them moving."

People were supported to maintain relationships that were important to them. We saw people's families and friends were welcome to visit and several people told us they went out with their families regularly. A member of staff told us that one person did not have any family, but they did have an advocate to represent their interests and to support them in making decisions.

People's care plans and life histories included their religious and cultural identities and preferences, and whether they continued with their traditions and practices, where this was known. Some people were not able to express their preferences. The registered manager had arranged for a weekly religious celebration and supper to enable people to come together and celebrate, whatever their religion. A member of care staff told us, "We have Holy Communion with the Deaconess and a buffet supper in the evening. People seem to enjoy the hymn singing whatever their religious beliefs."

People's daily records included information about how they had spent their day, their moods, appetites, whether anything was 'unusual' and if visits from other health professionals were booked or had taken place. Care plans and risks assessments were regularly reviewed and updated when people's needs changed. Staff told us they felt well informed about changes in people's needs.

People told us they had no complaints, but were confident any complaints would be taken seriously and resolved promptly. We saw when one person complained about the light in the lounge, the provider listened intently to the person and replaced the light bulb the same day. The provider's complaints policy was displayed in the entrance hall with a locked box, where anyone could raise a complaint anonymously if they preferred. The provider had not received any formal, written complaints. We had not received any negative comments or concerns from relatives or healthcare professionals. The local authority commissioners told us they had no concerns or complaints about people's care.

Good

Is the service well-led?

Our findings

People told us they were happy with the quality of the service, because they received the care and support they wanted. They told us any concerns or issues they raised were dealt with promptly. People were invited to discuss the service and any changes in the home and the way it was run. Records of recent meetings with people showed they had discussed the weather, changes in people living at the home, new care staff, the new cook and outings and events.

The provider sought people's views of the service through surveys and by observing how people were supported and cared for during their regular visits to the service. The most recent survey had not yet been analysed, but the provider had visited the home more frequently in the past few months to see for themselves, what worked well, and what needed to change. They had re-written the questions for the next survey of people and relatives, in line with the fundamental standards, to make sure people's views reflected how the service met the regulations.

The provider told us they had learnt from their experience following an inspection at one of their other homes, that they needed to be more proactive at monitoring the quality of the service. They told us, "It's important to be here. I learnt a lot from the other inspections. I am now more hands-on, more visible. I am here to steer, to meet and greet, solve problems on the spot." We saw this approach was effective for people who lived at the home. People greeted the provider like a trusted friend and were happy to share information with them and ask for support from them.

Staff told us they had regular team meetings with the registered manager and that the provider had attended the latest meeting. Records showed staff usually discussed training, people's needs and any changes that were made and planned. At the latest meeting they had discussed the actions they would take to support people during hot weather, new policies and procedures and the fundamental standards of care. Staff had been invited to fill in a questionnaire demonstrating how they knew they delivered a service that was safe, effective, caring, responsive and well-led. Staff had completed 20 questionnaires just before our inspection. The provider told us they had not yet analysed the responses, but, at first sight, it was a 'good' response, which gave them assurance that staff understood their purpose to put people at the heart of the service.

The home was well-led. Staff told us they were happy with the way the service was run and they enjoyed their work. They told us all the staff were caring and worked well as a team. Staff said, "The manager is a nice person, very caring" and "The manager listens and changes things. They nip any problems in the bud." The registered manager's leadership at the home was clearly effective and appreciated by the staff, because staff turnover was very low. Only two staff had left the home in several years, one for retirement and one for personal reasons.

The provider included staff in planned changes. Staff told us they expected to meet with the provider more frequently in the future, particularly because the registered manager was due to retire within weeks and they would have to get used to a change in the leadership of the home. The provider planned the new manager's

induction to include a handover from the registered manager about the day-to-day running of the home, and for the provider to explain their vision, values, policies and procedures and the legal obligations of a manager.

The registered manager understood their legal responsibilities. They usually sent us statutory notifications about important events at the home, in accordance with their legal obligations. However, they had overlooked notifying us when the supervisory body had authorised them to deprive eight people of their liberty to keep them safe, as stated in the PIR. The registered manager told us they would send the statutory notifications to us after the inspection.

The registered manager and provider conducted regular audits of the quality of the service. They checked people's care plans were complete, regularly reviewed and up to date and checked that medicines were administered safely. Where issues were identified, actions were agreed and taken. For example, a recent audit of medicines identified that MARs sheets for medicines that arrived outside of the usual monthly delivery from the pharmacist, were hand written and should be counter-signed on receipt by a second member of staff, because there was no electronic verification of delivery by a pharmacist.

The provider had audited the staff files to check they contained documentary evidence that their suitability for their role had been thoroughly checked, before they started working at the home. Where gaps in the documentary evidence were identified, staff had been asked to bring in copies of the supporting evidence.

The cook showed us their kitchen-cleaning schedule, which included daily, weekly and monthly tasks and the records of their checks of the temperatures of fridges, freezers and food deliveries. The records were in the kitchen for the registered manager to check that the cook understood and followed good hygiene practice and guidance to store and prepare food safely.

The maintenance person showed us records of the weekly and monthly checks they made of the water supply from each tap and shower head in the home. They told us if there were any issues of fixtures or fittings being beyond repair, they only had to tell the provider, who would arrange for replacement items to be purchased straight away. The maintenance person told us the provider had agreed a rolling programme of refurbishments to make sure the home remained a safe and comfortable place to live.