Mr & Mrs T E Dobson

The Bay Tree Residential Home for the Elderly

Inspection report

The Bay Tree
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Tel: 01947880718

Date of inspection visit:
09 November 2016

Date of publication:
16 January 2017

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

This inspection took place on 9 November 2016 and was unannounced.

The Bay Tree Residential Home for the Elderly provides personal care for up to 18 older people, On the day of the inspection there were 12 people living in the home. The service is located in the seaside village of Robin Hoods Bay. The service does not provide nursing care.

The home had 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 was also the registered provider.

Staff were able to tell us what they would do to ensure people were safe and how to refer any concerns to the correct agencies. People told us they felt safe at the home. The registered provider assessed risks for people regarding their health and the environment of the service. Risk management plans were drawn up with people's involvement to ensure they were protected from harm while not having their liberty unnecessarily restricted.

The home had sufficient suitable staff to care for people and staff were safely recruited.

People were protected because the staff managed medicines safely.

Staff had received training to ensure that people received care appropriate for their needs. Staff received supervision to support their professional development.

The registered provider ensured that people were treated with regard to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff understood that people should be consulted about their care and that they should assume that a person had capacity to make decisions. People who did not have capacity to make certain decisions had these made in their best interests in line with the MCA.

People told us they enjoyed the meals and their nutrition and hydration needs were met. People were offered alternatives if they did not like certain menu choices. People's clinical care needs were met in consultation with health care professionals.

People were treated with kindness and compassion. We saw staff had a good rapport with people and treated them with respect. Staff had a good knowledge and understanding of people's needs.

Care plans provided detailed information about people's individual needs and preferences. Records and observations provided evidence that people were supported to feel cared for and listened to. Care plans

were updated when people's needs changed.

People were supported to engage in daily activities they enjoyed. The registered provider and staff understood what was important to people, their personal histories and social networks so that they could support them in the way they preferred.

People told us their complaints were responded to and the results of complaints investigations were clearly recorded. People we spoke with told us that if they had concerns these were addressed directly with the registered provider who responded quickly.

People told us they saw the registered provider and spoke with them every day they were on duty. They asked people how they were and if there were any improvements they could make each day. People gave us examples of when the registered manager had responded quickly to their suggestions.

The registered provider ensured the quality of the service through a system of audits and checks. They sought feedback from people who lived at the home, relatives, visitors and professionals with an interest in the service and acted on this to improve people's quality of care. The registered provider recorded a number of audits and kept records of essential checks such as lift servicing, gas and electrical safety certificate and checks on the safety of water temperatures.

Some of the audits and checks were not written down. Annual appraisals were not always recorded so that staff may not receive the support they needed around this area of their work. We made a recommendation about these areas.

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.

Risks to people's safety were assessed and acted on and risk management plans included how to maximise people's freedom.

People were protected by sufficient staff who were safely recruited.

People were protected by the way the service handled medicines.

People were protected from the risks of acquiring infection because the service had infection control policies and procedures in place which staff acted upon.

Is the service effective?

Good

The service was effective.

People were well cared for and staff understood their care needs.

Staff were supported in their role through training and supervision which gave them the skills to provide appropriate care.

The service met people's health care needs, including their needs in relation to food and drink.

People's capacity to make decisions was assessed in line with the Mental Capacity Act (2005) and their best interests were protected.

Is the service caring?

Good

The service was caring.

People told us that staff were kind and caring and we observed that staff were thoughtful and compassionate.

Staff respected people's privacy and treated them with regard to

their dignity.

Is the service responsive?

Good

People were consulted about their care.

Staff had information about people's likes, dislikes, their lives and interests which supported them to offer personalised care.

People were supported to live their lives in the way they chose.

Is the service well-led?

Requires Improvement

The service was not always well- led.

The registered manager did not keep staff annual appraisal records which meant they could not ensure they effectively supported staff in their professional development.

A quality assurance system was in place to consult with people, monitor the service and inform improvements. However, not all audits were recorded which meant the registered manager may not have all the information required to identify improvements and put these in place.

A registered manager was in place who demonstrated an approachable presence around the home.

The culture was supportive of people who lived at the home and of staff.

The Bay Tree Residential Home for the Elderly

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 9 November 2016 and was carried out by one adult social care inspector. The inspection was unannounced.

Prior to our inspection we reviewed all of the information we held about the service. We considered information which had been shared with us by the local authority. We also checked on the notifications the registered provider had sent to us about incidents they are required to inform us about by law. We did not ask for 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 well and improvements they plan to make. Provider information Returns are not always requested in line with inspections, this is particularly the case if inspections need to be rearranged for operational reasons. We gathered the information we needed during the inspection visit.

During the inspection visit we spoke with five people who lived at the service, one visitor, three members of staff and the registered manager. After the inspection visit we spoke with two health and social care professionals. We also spent time observing care in the communal areas of the service.

We looked at all areas of the service, including people's bedrooms with their permission, where this was possible. We looked at the laundry, bathrooms, toilets and the communal areas. We looked at five care records and associated documentation. This included records relating to the management of the service; for example policies and procedures, audits and staff duty rotas. We looked at the recruitment records for three members of staff. We also observed the lunchtime experience and interactions between staff and people

living at the service.

Good

Is the service safe?

Our findings

People told us they felt safe at the service. They felt there were sufficient staff on duty to care for them safely. One person told us, "I have a stand aid which works really well. I can help myself stand if staff are there to support me, which they always are. A visitor told us, "The stand aid has been a good thing. It has helped (my relative) get out of the chair more easily and they assessed how safe it was first." Another person said, "Yes, I feel safe, staff call on me regularly and more often if I am not well." A visitor told us, "When my relative was not well, they arranged the call bell so that they could use if from the chair during the day." They told us this had reassured the person and made them feel safer.

Safeguarding policies and procedures were in place. Staff had received safeguarding of adults and abuse awareness training which was kept up to date. Staff were clear about how to recognise and report any suspicion of abuse. They could correctly tell us who they would approach if they suspected there was the risk of abuse or that abuse had taken place. They understood who would investigate a safeguarding issue and what the service procedure was in relation to safeguarding.

The registered provider, who we refer to throughout this report as the registered manager had kept CQC informed about safeguarding incidents which had taken place in the service. Staff were aware of the whistle blowing policy and knew the processes for taking serious concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively.

We asked the registered manager how they decided on staffing levels. They told us the levels were set according to the number and dependency levels of the people living at the service at any time. The registered manager told us they considered skill mix and experience when drawing up the rota. During the day shifts (8am until 5pm) the registered manager had one senior and two care workers on rota. In the evening (5pm until 10pm) there was a senior and one care worker on duty. There was also a cook, and an activities organiser who worked each week day for three hours in the afternoons. We spoke with staff and they told us there were enough staff on duty at all times to meet people's needs and not feel rushed. Our observations on the day of inspection confirmed there were sufficient staff to care for people safely.

Risk assessments were in place for each person who lived at the service. Risk assessments were included in care plans. Areas such as falls, eating and drinking, sleeping maintaining a safe environment, the use of bed rails and moving and handling were assessed. Risk management plans had been updated when needed to ensure people's current risks had been assessed and plans were in place to minimise these.

Environmental risk assessments were in place and entry to the service was controlled by keypads on the exit doors for people's safety. Health and safety checks were regularly carried out as part of the quality monitoring system and the registered manager told us any required actions were acted upon. They told us about a number of improvements to the environment which had taken place since the last inspection, such as some decorative works. The registered manager had plans in place to further redecorate communal areas and corridors to brighten the service. These plans were not written down. This was not a large service, and the registered manager was also the registered provider of the service, they told us an informal plan

worked well. The service would have benefited from written records in order to clearly evidence the improvements they have made.

We looked at the recruitment records for three staff which showed safe recruitment practices were followed. We found recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS) for each member of staff. DBS checks assist employers in making safer recruitment decisions by ensuring that prospective care workers are not barred from working with certain groups of people. This meant the service had taken steps to reduce the risk of employing unsuitable staff.

Staff told us they had received training in the control of infection and training records confirmed this. They correctly described how to minimise the risk of infection, such as through using the correct aprons and gloves and washing their hands between offering care to people. The service had an infection control policy and procedure which staff told us they followed. This included details of how to manage outbreaks of infection. The laundry room had a washing machine and dryer. Dirty and clean laundry was kept separate to minimise the risk of cross infection.

Medicines were stored safely in a locked trolley attached to a wall. Controlled drugs were stored separately and administered according to policy and procedure. Medicines were supplied to the service in a Monitored Dosing System (MDS). MDS is a medication storage device designed to simplify the administration of solid oral dose medication. We found appropriate arrangements were in place for the ordering and disposal of all medicines.

We looked at the Medication Administration Records (MAR) for two people. The MARs were accurately completed and medicines were signed for. We also checked a sample of boxed stock levels which tallied with the records kept.

Staff told us they received regular medicine training updates and records confirmed this. This meant that people benefitted from being cared for by staff who were trained in best practice around handling medicine.

Good

Is the service effective?

Our findings

People told us the registered manager was quick to get the doctor or to refer them to another medical specialist if their health required this. A visitor said, "They have organised for an optician to visit, a hearing test and the chiropodist calls regularly." One person said, "They have organised for the district nurse to carry out blood tests. They have a good oversight of that." Another person told us, "I have regular visits from the GP." People said they enjoyed the meals. One person said, "I know I could have something different from the main meal, but I like everything they give me." Another person said, "They know I don't like scampi and so they always ask me what I would like instead." When asked if staff were skilled at their job one person said, "Yes they know what I need." One person mentioned that staff sometimes held on to them a little too firmly. We reported this to the registered manager who told us they would ensure staff were aware of this in order to adapt their care accordingly.

Staff had received induction and training in all areas the registered manager considered mandatory (core training). Staff told us they shadowed other more experienced staff when they were first recruited and only began working with people unsupervised when they were confident and the registered manager felt they were competent. Training was provided through a range of provision; most was face to face in a classroom setting and some was through meetings and informal learning. All staff training was completed and a plan was in place for when this needed to be renewed. The registered manager did not keep a training matrix which would log when training was due to be renewed and what training had been completed in a way which was easy to check. However, we found evidence of training certificates in staff files. All staff who had been working at the service for more than six months had completed NVQ at level two at least and a number of staff had completed level three. In addition to the core training, the registered manager had sourced training in areas such as care for people who were living with dementia and end of life care. Staff also received training during their induction in respecting diversity and treating people with equality. Staff told us this supported them to offer personalised care for people.

Staff told us they received regular supervision and appraisal which they told us supported them to offer appropriate care. They told us and the registered manager confirmed this took place mostly as group supervisions but they would discuss professional development issues with staff on a one to one basis also. Staff told us they met with the registered provider at 11am each morning and this was an opportunity for discussions about people's care, any required changes and to discuss care topics. They told us they found the registered manager was approachable and they often discussed their work informally on a one to one basis each day.

At our last inspection we saw staff supervision records were available however the registered manager was unable to locate these on the day of this inspection visit. The registered manager is also the registered provider, a role they share as a partnership. The other partner was not available on the day of inspection, however it was they who had responsibility for recording formal two monthly staff supervisions. Following the inspection visit, the registered manager sent us three examples of supervision records which had taken place earlier in the year. Staff told us appraisals were carried out annually, however notes of appraisals were not kept and it was difficult to evidence the detail of what these included, though staff told us this covered

areas such as training needs, an evaluation of their progress during the year and areas for improvement.

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. We checked whether the service was working within the principles of the MCA.

People's plans of care showed the principles of the MCA Code of Practice had been used when assessing their ability to make decisions. The service also had a policy and procedure on the MCA and DoLS to protect people. Staff understood the principles of the MCA and DoLS and were able to tell us about the five main principles, for example that they should always assume capacity and support people to make their own decisions. People had signed their consent to receive care, and for photographs to be used to support them with medicines and personal care.

Staff were able to tell us about when a best interests decision may be made and who might be involved in this to protect people. A best interest decision is made when a person does not have the capacity to make a decision for themselves and involves a multidisciplinary team. The registered manager told us, and social care professionals confirmed that the registered manager had applied for a number of DoLS authorisations, and a number had been granted. Other applications had not yet been assessed. Records confirmed these had been applied for and put into place appropriately and decisions had been made in the person's best interests.

People's capacity to make decisions about their care was recorded as well as any support people required to make decisions. For example one care plan stated, "(The person) can make their own decisions, and contribute to the care plan with staff."

Information about advocacy services was available to people and advocates were appointed when needed, though nobody living at the service required an advocate as all had family or friends to act on their behalf.

Needs relating to nutrition and hydration were recorded in people's care plans, and risk assessments and management plans were available. The service used the Malnutrition Universal Screening Tool' (MUST). MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition or obese. It also includes management guidelines which can be used to develop a care plan. People were regularly weighed when they were at risk, and the service had electronic sit on scales so people, who were not able to stand could also be weighed. Staff were able to tell us about people's nutritional needs, for example, how people required their food to be presented and whether people had allergies. People's likes and dislikes were recorded and staff were aware of what these were. People's food and drink choices were recorded in daily notes which could then be referred to for future care planning.

We observed a meal time. Five of the 12 people who lived at the service were eating in the dining room. People received food which was served in good portions and looked appetising. The registered manager told us if there was a meal people did not like the cook would ask whether they would prefer an alternative and people confirmed this. Lunch time was a sociable occasion and people had the opportunity to chat with each other. The dining room was clean and tables were attractively set. We observed staff assisted people

when they required this in a kind way, sitting at the same level with people, talking with them, and supporting them at their own pace. Staff responded to people's preferences. For example one person told staff they preferred not to have chicken that day but preferred only vegetables. People who needed adapted cutlery had this to support them to eat independently. We noted one person spent time walking around the service during meal time and staff told us they offered this person their meal wherever they were in the building, offering different foods to help interest them in eating. This included finger foods which were easy to eat on the go.

Some people took their meals in their rooms. We spoke with most of these people and they all told us that they had made a positive choice to eat in their room and they had visitors and staff who popped in for a chat so they didn't feel lonely. We noted that drinks and snacks were available mid-morning and in the afternoon. People praised the home made cakes and biscuits and told us the staff knew what their preferences were.

The registered manager told us some people had prescriptions for fortified drinks, and they referred people to specialists such as the Speech and Language Therapy Team (SALT) when required, in order to meet people's needs in relation to nutrition.

The registered manager told us how they monitored people's mood and behaviour. Care plans included instructions for staff around recognising changes in behaviour which may, for example be due to changes in physical or mental health needs. Information from care plans, reviews and daily notes was shared with mental health professionals when they were advising staff on individual people's care.

The registered manager told us other medical conditions which required monitoring were managed in consultation with health care professionals. They told us the staff handover between shifts was a useful way of ensuring staff understood any changes in people's care needs and whether there was any involvement or advice to pass on to them from health care professionals. GP and other health care professionals visits were clearly recorded which meant that communications around people's health were easy to monitor. The support guidelines from professionals were written into care plans with people's involvement and consent where relevant.

Staff routinely supported people to attend GP and hospital appointments. Care plans showed people had been seen by a range of health care professionals including GPs, dentists, physiotherapists and district nurses.

Good

Is the service caring?

Our findings

People told us staff were kind and caring. One person told us, "Staff are really helpful and kind." One person told us, "Yes, they are good about privacy. They always knock on my door." Another person said, "You can talk with them if you are bothered about anything." The staff and people we spoke with told us the service encouraged visitors at any reasonable hour and we observed a visitor was greeted by staff in a friendly way. A visitor told us the staff always offered them refreshment and they were made to feel very welcome.

We spent time with people in the communal areas of the service and observed there was a relaxed and caring atmosphere. People were comfortable and happy around staff. Staff gave the impression that they had plenty of time and spoke with people who were sitting so they were on eye level with them. They reassured people with a touch on the arm or hand where this was appropriate. We observed staff talking with people about their lives, who and what mattered to them and significant events. Staff were good at communicating with people, anticipating needs and making people aware of what their choices were. They interacted well with people who were observed to be more withdrawn and included them in conversations. People who were sitting quietly became more animated and smiled when staff were speaking with them and appeared to enjoy the interaction.

Staff understood the importance of respecting people's privacy and dignity and we observed a number of examples where this happened during the day of inspection. We noticed staff knocked on people's doors and waited for a response before entering. When people were being supported with personal care, staff always did this in private, and people's doors were closed to respect their privacy. People were approached discretely with regard to their personal care needs.

When we asked the registered manager how people were placed in the centre of importance they told us they had daily meetings to discuss whether people's needs had changed. Small adjustments in approach were often needed to reduce anxiety or to increase people's comfort. For example staff gave the example of working with one person to reduce their anxiety and support them to access their memories of their younger life through using a photograph album.

The registered manager explained a number of examples where staff had noticed signs which concerned them, such as people appearing in pain, or not eating as well as usual. Staff told us they observed people for signs of pain or distress and acted quickly to alleviate this. Our observations confirmed staff were kind and responsive to people's emotional needs.

Some people had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in place, and these were correctly completed and regularly reviewed to ensure they were in line with people's current wishes.

Staff told us about the way people were cared for in their final days. The registered manager said they worked closely with district nurses to ensure people received the care they needed. Staff emphasised the need for close liaison with palliative care professionals and attentive monitoring to ensure people did not suffer pain. They also spoke about the importance of supporting relatives, the people who lived at the

service when people reached the end of their lives.

Good

Is the service responsive?

Our findings

People told us that staff were responsive to their needs. One person told us, "(The registered manager) visits every morning and we have a chat every day. He deals with any problems that might arise." Another person told us, "There are lots of things going on for people every day downstairs, but I can also entertain myself well with the newspaper and crosswords." Another person said, "Staff often ask how things are going for me and we talk about any changes I might need, such as offering a bit more help if I am not well." A visitor told us they were confident the registered manager would discuss any changes in care which they felt were needed for their relative, and that they were asked for their opinion about the care offered.

Staff told us they focused on promoting people's independence and on what people could do for themselves. One member of staff told us about how they supported people to get dressed, giving people time to do as much as they could, then assisting with areas of difficulty. The service had a stand aid for one person, bathing aids and individually assessed walking aids to enable people to retain the independence they had when moving around the service or bathing.

Reviews focused on wellbeing and any improvements which could be made to people's care. Records were detailed and gave clear information about any changes to people's care needs which were needed. For example, one review record gave details of how a person had been particularly sleepy and that they had called the GP who had suggested a change in medicines which had made an improvement. These monthly updates contained useful and relevant details to assist staff to plan responsive care.

Relevant specialists were consulted for advice at reviews. For example we saw that GPS, district nurses, and physiotherapists had been involved. The registered manager told us about reviewing a person's mental health with appropriate professionals to ensure they were receiving the right service for their needs.

People had identified areas of interest, likes, dislikes and preferences within their care plans. For example one person enjoying caring for their plants, another person enjoyed walking to the local shops. Staff were prompted within care plans to ask people about how they preferred to receive their care. For example, one care plan stated, "(The person) brushes their own hair," and "They have a special adapted hair brush."

People were supported to maintain their preferred routines. For example one plan stated, "(The person) prefers support at 7pm, prefers two pillows and blankets not a duvet." Staff had recorded whether each person wished to be checked or offered a drink during the night, whether the person preferred a lamp to be left on or if they would like an early morning cup of tea.

People's life histories were recorded in detail with their permission, and included information such as previous occupations, hobbies, family and friendships, spiritual needs and preferred ways to spend time. Some people had written their own life histories which were kept on file for staff to read, and included information the person wanted to share with care staff. For one person this included many interesting things they had done in their life and explained a number of their current interests and hobbies. Some people had photographs of family and those people who were important to them which staff told us they often looked

at with the person as it gave them pleasure and reassurance. Staff knew about people's interest and life histories and were enthusiastic about telling us how people they cared for enjoyed spending their time.

People were supported to keep in touch with friends and family. One care plan stated that the person had their own mobile phone, with instructions for staff on how to support them to use this to keep in touch with people.

The registered manager told us that there was a specific activities member of staff who was employed at the service for five days a week for three hours each day. During our inspection visit, the activities organiser visited the home and we saw that people enjoyed making craft items. Staff told us that the activities organiser involved people in art work, musical afternoons, historic and themed days. The registered manager also invited external entertainers into the home, such as a singer who one person told us was, "very good fun." People's engagement in daily activities and whether people had enjoyed these was recorded in daily records. Staff also regularly recorded information about people's wellbeing and any concerns in daily written records. This meant staff had information to help them to offer care which was responsive to people's needs.

The lounges had books, magazines and jigsaws for people to use. Staff told us that for people who spent time on their own they visited them in their rooms for a chat and to prevent them from feeling isolated. We spoke with a person who chose to spend their day in their room and they confirmed that staff did often check that they were okay and whether they needed anything.

The registered manager told us that people went out with relatives and friends and in the warmer months they went out for short trips and to local events. Staff told us they made sure people were dressed as they wished and were ready for these trips when they took place.

Consultation with people about their preferences took place informally on a one to one basis with people who lived at the service. The registered manager did not hold meetings for people who lived at The Bay Tree; however, as this was a smaller service, the registered manager told us they had time to speak with everyone individually each day about how the service was meeting their needs.

People told us they would feel confident telling the staff if they had any concerns and felt that these would be taken seriously. We saw that the service had a complaints procedure and staff told us this was followed. One person told us, "I would go to the manager if there was a problem and they would listen."

Requires Improvement

Is the service well-led?

Our findings

People were positive about the registered manager. One person told us, "I see [them] every day and we always have a chat." Another person told us "I have never had any problems, and [the registered manager] is very thoughtful and kind."

The home had a registered manager in place. They told us that they visited each person to speak with them every day. They asked how they were feeling and GP visits or appointments would sometimes result from these discussions. They also asked about what people had planned for the day and if there was anything they could do to support people to do what they preferred. Any concerns or comments were acted on immediately. The registered manager told us they had ample time to see every person who lived at the home and give them one to one attention. Daily notes contained very detailed accounts of all interactions with people so that staff had the information they needed to offer appropriate care and support.

The registered manager carried out a number of written audits. Care plans were reviewed each month and we saw that the controlled drugs and other medicines which were stored in bottles and boxes were reviewed every week. The registered manager also told us that the blister pack medicines and records were checked each week, though these checks were not recorded. They recorded water temperatures checks, and records for the maintenance and safety of the lift and portable appliance tests were carried out. The service also had a record of the gas safety and electrical wiring safety certificate. Maintenance work which was required in the home was recorded in a diary which highlighted when tradespeople were due to visit. Following the inspection the registered manager sent us a more formal record of required maintenance jobs which had been identified and ticked as complete. Regular formal audits for such areas as infection control practice or people's satisfaction with their care, meals and activities were not regularly carried out, though the registered manager, people we spoke with and staff told us this took place informally

Staff annual appraisals were not recorded though both the registered manager and staff told us these took place informally. Though staff told us that they felt well supported in their role and that they received formal two monthly supervision and support with their professional development there was a risk that without records, appraisals may lack structure and clarity.

We recommend that the registered manager consults best practice advice around the recording of staff annual appraisals to improve the way they offer professional and developmental support for staff. Also to improve the formal recording of audits to evidence where required improvements have been identified and completed.

The registered manager carried out regular daily walks around the building where they identified any issues, and spoke with people and staff. The registered manager told us that this supported them to be visible around the home and to pick up on things which needed attention.

People told us that they had suggested changes which had been listened to and put in place by the

registered manager. For example, people told us they had expressed their preferences for meals, entertainment and activities and these had been listened to and put in place. A visitor told us that the registered manager regularly asked them what they could do to improve things, but that they couldn't think of anything which could be improved.

Staff told us that the manager was open and positive with them, and that they felt supported in their role. They had daily staff meetings which gave them information and guidance to care for the people who lived at the home and to offer them the opportunity to raise any issues and share good practice. Staff told us they had detailed handovers and that they read the daily records which gave them important information about each person's care. We saw detailed handover records to confirm this.

Staff understood the scope and limits of their roles and responsibilities which they told us helped the home to run smoothly. They knew who to go to for support and when to refer to the registered manager. They told us that mistakes were acknowledged and acted on in an atmosphere of support. The registered manager and staff consistently reflected the culture, values and ethos of the home. This placed people at the heart of care.

With the exception of DoLS notifications, other notifications had been sent to the Care Quality Commission (CQC) by the registered manager as required. The registered manager had worked alongside the local authority to apply for DoLS authorisations but had not been aware of the requirement to send a notification to CQC for each DoLS authorisation which had been granted. As soon as we pointed this out to the registered manager they sent us the notifications without delay.