Hexon Limited

Rosegarth Residential

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

Overall summary

This inspection took place on 29 April 2015 and was unannounced. We previously visited the service on 17 November 2013 and we found that the registered provider met the regulations we assessed.

The service is registered to provide personal care and accommodation for up to 26 older people, some of whom may have dementia or mental health problems. On the day of the inspection there were 15 people living at the home; fourteen people lived there permanently and one person was having respite care. The home is located in Bridlington, a seaside town in the East Riding of Yorkshire. It is close to the sea front, to local amenities and on good transport routes.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC); they had been registered since 29 April 2014 (although they had previously been registered to manage Rosegarth Residential and another service belonging to the same provider). A registered manager is a person who has registered with the Care Quality

Summary of findings

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 told us that they felt safe living at Rosegarth Residential. Staff had completed training on safeguarding adults from abuse and were able to describe to us the action they would take if they had concerns about someone's safety. They said that they were confident all staff would recognise and report any incidents or allegations of abuse and that concerns would be dealt with effectively by managers.

We observed good interactions between people who lived at the home and staff on the day of the inspection. People told us that staff were caring and compassionate and this was supported by the relatives and health / social care professionals who we spoke with.

People who lived at the home, relatives and social care professionals told us that staff were effective and skilled. Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them.

People were supported to make their own decisions and when they were not able to do so, meetings were held to ensure that decisions were made in the person's best interests. If it was considered that people were being deprived of their liberty, the correct authorisations had been applied for.

Medicines were administered safely by staff and the arrangements for ordering, storage and recording were robust.

We saw that there were sufficient numbers of staff on duty to meet the needs of people who lived at the home and to enable them to spend one to one time with people. New staff had been employed following the home's recruitment and selection policies to ensure that only people considered suitable to work with vulnerable people had been employed.

People's nutritional needs had been assessed and people told us that they were satisfied with the meals provided at the home. People told us that they had ample choice and their special diets were catered for.

There were systems in place to seek feedback from people who lived at the home, relatives, health and social care professionals and staff. People's comments and complaints were responded to appropriately.

People who lived at the home, relatives and staff told us that the home was well managed. The quality audits undertaken by the registered manager were designed to identify any areas of concern or areas that were unsafe, and there were systems in place to ensure that managers and staff reflected on practice and made any necessary improvements.

Summary of findings

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 is safe.

Good

The arrangements in place for the management of medicines were robust and staff had received the appropriate training.

Staff displayed a good understanding of the different types of abuse and were able to explain the action they would take if they observed an incident of abuse or became aware of an abusive situation.

We found that there were sufficient numbers of staff employed to ensure that the needs of the people who lived at the home could be met, and staff had been recruited following robust policies and procedures.

The premises were being maintained in a way that ensured the safety of people who lived, worked or visited the home.

Is the service effective?
The service is effective.

Good

People were supported to make decisions about their care and we found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff told us that they completed induction and on-going training that equipped them with the skills they needed to carry out their role.

People's nutritional needs were assessed and met, and people's special diets were catered for. People had access to health care professionals when required.

Is the service caring?
The service is caring.

Good

People who lived at the home and their relatives told us that staff were caring and we observed positive interactions between people who lived at the home and staff on the day of the inspection.

It was clear that people's individual needs were understood by staff.

We saw that people's privacy and dignity was respected by staff and that people were encouraged to be as independent as possible.

Is the service responsive?
The service is responsive to people's needs.

Good

People's care plans recorded information about their previous lifestyle and the people who were important to them. Their preferences and wishes for care were recorded and these were known by staff.

People told us they were able to take part in their chosen activities.

Summary of findings

There was a complaints procedure in place and people told us that they were confident that any comments or complaints they made would be listened to.

Is the service well-led?

Good

The home is well led.

The service was being managed by a competent registered manager with support from a competent and skilled staff team.

The registered manager carried out a variety of quality audits to promote the safety and well-being of people who lived and worked at the home.

There were sufficient opportunities for people who lived at the home, relatives, staff and care professionals to express their views about the quality of the service provided.

Rosegarth Residential

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 29 April 2015 and was unannounced. The inspection team consisted of an adult social care (ASC) inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had experience of supporting a variety of people including those with age related concerns, with a learning disability and with mental health concerns.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider, information we had received from the local authority who commissioned a service from the registered provider and information from health and social care professionals. The registered provider submitted a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home. We also received feedback from two social care professionals and a health care professional.

Prior to the inspection we contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they have had with the home. On the day of the inspection we spoke with three people who lived at the home, five members of staff, a relative, a visiting health care professional and the registered manager.

We observed the serving of lunch and looked around communal areas of the home. We also spent time looking at records, which included the care records for two people who lived at the home, the recruitment and training records for two members of staff and records relating to the management of the home.

Good

Is the service safe?

Our findings

We spoke with three people who lived at the home and chatted to others. We asked them if they felt safe and they all told us that they did. They said that this was partly because there were enough staff around to help them at all times. The health care professionals who we spoke with told us that there was always a member of staff to assist them when they visited people at the home.

We checked staff rotas and saw that there were three people on duty each morning, including the deputy manager or senior care worker. There were three staff on duty each afternoon / evening although sometimes one person was not working a full shift. There were two staff on duty overnight. The registered manager was on duty throughout the day from Monday to Friday. Ancillary staff were also employed; there was a cook and a domestic assistant on duty every day. On the day of the inspection we saw that there were sufficient numbers of staff on duty and we noted that everyone we spoke with, including staff and visitors to the home, told us that there were sufficient numbers of staff on duty.

Staff told us that they kept people safe by using safe moving and handling techniques and using the correct equipment, by observing that people were safe, by good communication between staff and by undertaking and following training on safeguarding adults from abuse.

There were safeguarding policies and procedures in place and the manager submitted alerts to the local authority as required. We spoke with the local authority safeguarding adult's team and they told us they currently had no concerns about the home. A social care professional explained a situation to us where staff had been concerned about a person's welfare (due to issues outside of the home) and had made appropriate referrals to the local authority to protect this person from the risk of harm.

Training records evidenced that staff had undertaken training on safeguarding adults from abuse and staff who we spoke with confirmed this. They were able to describe different types of abuse, and were able to tell us what action they would take if they observed an incident of abuse or became aware of an allegation. Staff told us they felt all of their colleagues would recognise inappropriate practice and report it to a senior member of staff. One member of staff told us that they would escalate any concerns to the organisation's headquarters or the Care Quality Commission (CQC) if they felt issues were not being properly addressed at the home. We saw that the whistle blowing policy was discussed with staff during their induction training.

We checked the recruitment records for two new members of staff and saw that the application form recorded the names of two employment referees, a declaration that they did not have a criminal conviction and the person's employment history. Prior to the person commencing work at the home, checks had been undertaken to ensure that they were suitable to work as a care worker, such as references, a Disclosure and Barring Service (DBS) first check and a DBS check. DBS checks identify whether people have committed offences that would prevent them from working in a caring role. We saw that a thorough interview had taken place that was recorded on an interview evaluation form.

We saw care plans included management plans for any behaviour that might cause the person or other people harm. These plans gave staff clear instructions about how to manage the person's behaviour to achieve the most positive outcome, and an explanation for staff about what specific behaviours may mean. There were also risk assessments in place for any identified risks and some of these included a scoring system to show the level of risk. We saw that there were risk assessments in place for topics such as nutrition, tissue viability, pressure area care, moving and handling and the use of a wheelchair, although we noted that the wheelchair risk assessment did not mention the use of a lap belt even though the outcome was 'high risk'. Risk assessments were reviewed by staff each month which meant that staff had up to date information to follow.

We saw that there were policies and procedures in place on the administration of medication, plus good practice guidance from the Royal Pharmaceutical Society on handling medication in social care settings and a homely remedy policy.

There were two medication trolleys (one to store morning medication and one for lunchtime / evening medication) and these were fastened to the wall within a locked cupboard. Creams were stored in a separate cupboard and we saw that the pharmacy provided a body chart to advise staff where on the person's body the cream should be applied. We saw that medication administration record

Good

Is the service safe?

(MAR) charts recorded 'see cream chart' to indicate that the chart in the person's bedroom needed to be signed. There were a small number of gaps in the recording of creams but no gaps in the recording of other medication.

Medication was supplied in a biodose system and we saw that the MAR chart folder included information that described the system. The 'pods' containing the tablets recorded the person's name and the name of the tablet. The 'pods' were colour coded to identify the times that the medication needed to be administered; this reduced the risk of errors occurring.

All staff that administered medication at the home had undertaken appropriate training. We also saw that there had been a recent meeting with senior staff to discuss medication issues. The registered manager told us that this was to make sure staff were clear about their responsibilities in respect of medication administration. A new form had been devised to enable the registered manager to carry out competency checks on staff who administered medication to make sure they remained competent in carrying out this task; two checks had been carried out at the time of this inspection.

We observed the administration of medication and saw that this was carried out safely; the senior staff member did not sign MAR charts until they had seen people take their medication. People were provided with a drink of water so that they could swallow their medication, and the medication trolley was locked when not in use. We also noted that, when a community psychiatric nurse (CPN) had administered a person's medication, they signed the homes MAR chart.

There was a suitable cabinet in place for the storage of controlled drugs (CDs) and a CD record book. We checked a sample of entries in the CD book and the corresponding medication and saw that these balanced. There was evidence in the CD book that records and medication held were audited on a regular basis to ensure accuracy.

We checked MAR charts and saw that each person also had a patient information chart that had been provided by the pharmacy; this included a photograph of the person and described the medication prescribed, the times of administration and any allergies the person had. Two staff had signed to confirm the accuracy any hand written entries made on the MAR charts. We discussed with the registered manager that it would be good practice to have more substantial dividers in between people's MAR charts to make it easier for staff to identify each person's records.

There was an audit trail that ensured the medication prescribed by the person's GP was the same as the medication provided by the pharmacy. There was a protocol in place that described a person's use of 'as and when required' (PRN) medication so that this was clearly understood by staff and recorded accurately.

We noted there was an effective stock control system in place and the deputy manager told us that the date was written on liquid medication to record when it was opened and the date it expired. This was to ensure the medication was not used for longer than stated on the packaging. However, on the day of the inspection we saw that a small number of bottles / packages had not been signed by staff. We checked the records for medicines returned to the pharmacy and saw that these were satisfactory; a specific returns book was being used that recorded details of the medication to be returned.

Audits of the medication system had been carried out in January, March and April 2015. The audit form included a space to record comments and actions that needed to be taken although we noted there was no space for recording when the action had been completed.

We observed that the premises were suitable for the needs of people who lived there. There was a current gas safety certificate in place and bath seats and hoists had been serviced. The fire alarm system had also been serviced in December 2014. The home's handyman carried out weekly or monthly checks on door closers, the fire alarm and emergency lighting. These checks ensured that the premises were maintained in a safe condition to protect the well-being and safety of people who lived and worked at the home.

The registered manager told us in the PIR about some improvements that were being made to the premises. This included improvements to the two bathrooms and on the day of the inspection we saw that there was only one 'wet room' available for use. This meant that people were unable to take a bath if they did not like having a shower. The registered manager told us that the upstairs bathroom could be used but acknowledged that it would need to be tidied first; she assured us that the bath hoist had been

Good

Is the service safe?

maintained and that it would be ready for use by 8 May 2015. The registered manager told us that the second bathroom would be back in use when the new bath hoist arrived; it had been ordered. Although we did not assess infection control on this occasion, we noted that there were no unpleasant odours throughout the premises.

There was a contingency plan in place that included advice for staff on how to deal with disruptions to power, heating and water supplies, severe weather conditions, the breakout of fire and staff disruptions. There were lists of all staff who worked at the home, each person who lived at the home and their mobility needs, people's GPs and information about alternative accommodation. In addition to this, the 'fire' book included an evacuation plan and a personal emergency evacuation plan (PEEP) for each person who lived at the home. This showed that the registered manager had considered how staff would deal with an emergency situation to protect the wellbeing of people who lived at the home.

Good

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

One member of staff told us that they had recently completed training on safeguarding adults from abuse, MCA and DoLS, and another member of staff told us that seven staff from the home had completed training on DoLS. Discussion with the registered manager evidenced that there was a clear understanding of the principles of the MCA and DoLS, and we saw that some applications for authorisation had been submitted to the local authority. We noted that one person's care plan recorded when the DoLS authorisation would expire; this indicated that the registered manager was aware that DoLS authorisations only lasted for a limited period of time and new applications for authorisation needed to be submitted.

Assessments had been carried out to record a person's capacity to make decisions. When people lacked the capacity to make decisions, we saw that best interest meetings had been held to assist them. Best interest meetings are held when people do not have capacity to make important decisions for themselves; health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf.

On the day of the inspection we saw that people were encouraged to make decisions and that choices were explained to them clearly. Staff told us that they encouraged people to make choices such as about meals and what time to get up and go to bed. One member of staff said, "We always ask the person if they would like to get up" and added that people were given options to help them make a decision. A social care professional told us they had always observed staff to be kind and considerate, and to offer choices.

The registered manager told us that three people who lived at the home had a diagnosis of dementia. Some signage had been provided to assist people living with dementia to find their way around the home, such as signs for the kitchen, toilets and bathrooms. However, some relatives indicated to us that this could be improved. The registered manager told us in the PIR document that they had a meeting with MIND, a mental health charity, in March 2015 to seek advice about lighting, signage and activities that were suitable for people living with dementia. They had also sourced a company that made products to aid people living with dementia, such as memory boxes and signage. They were in the process of purchasing some of these products as they acknowledged that this was an area that required improvement.

We saw that new employees had completed indution training and we viewed the newly introduced induction pack. The topics covered included infection control, the control of substances hazardous to health (COSHH), safeguarding adults from abuse, fire safety, dignity, first aid, accident reporting, health and safety, the key worker system, food hygiene, supervision and appraisal arrangements, care plans, whistle blowing and moving and handling (theory and practical). We noted that one person had commenced work in January 2015; they had completed training on moving handling theory but not the practical training. The new induction pack recorded that staff would undertake practical training during week one of their induction to the home. The training matrix showed that all staff had now completed this training.

Staff confirmed to us that they had completed induction training, and that they had 'shadowed' experienced staff prior to working on the rota unsupervised as part of their induction process.

The registered manager told us that training on moving and handling, fire safety, first aid, infection control and health and safety were considered to be mandatory by the organisation and staff were expected to complete this training every two years. The training matrix recorded that all staff had completed training on fire safety and that the majority of staff had completed training on safeguarding adults from abuse. Most staff had completed training on nutrition / food hygiene, first aid and dementia awareness and some staff had attended training on health and safety, mental health, equality and diversity and end of life care. In addition to this, staff who had responsibility for the administration of medication had attended appropriate training.

Staff who we spoke with felt that they had received appropriate training and that this helped them to meet the needs of people who lived at the home. However, it was

acknowledged by the registered manager that some of this training needed to be updated. They told us that they had recently 'signed up' for three new training courses; diabetes, common health conditions (Level 2) and safe handling of medicines (senior care workers only).

We noted that ten of the sixteen staff (including ancillary staff) had completed a National Vocational Qualification (NVQ) or equivalent at Level 2 or 3. The health care professionals who we spoke with told us that they had found staff to have the skills needed to carry out their roles effectively.

Staff told us that they had appraisal meetings with a manager and that they had the opportunity to discuss any concerns, including their training needs. This made them feel well supported by the registered manager and deputy manager. We saw that there were questions at the bottom of supervision forms; these included, "Do you understand MCA/DoLS?", "Do you understand about safeguarding?" and "Have you had any convictions since your last DBS check?" This provided prompts for managers so that they remembered to discuss these topice with staff at supervision meetings to make sure that staff remained confident in carrying out their roles.

We saw there were robust systems in place to ensure that staff were aware of people's up to date care needs. A communication book and handover sheet were being used to record information each day; this included updated information about each person who lived at the home. The registered manager told us that most staff worked twelve hour shifts so there were two handover meetings each day. However, a small number of staff did not work twelve hour shifts and the senior person on duty met with them when they arrived on shift to update them. The information shared at handover meetings ensured that all staff were clear about people's up to date needs.

Health care professionals told us that staff asked for advice appropriately and followed that advice as far as they could. They said that they were knowledgeable about people's needs. People who lived at the home told us that they had good access to GP's, dentists and other health care professionals. There was a record of any contact people had with health care professionals; this included the date, the reason for the visit / contact and the outcome. We saw advice received from health care professionals had been incorporated into care plans. In addition to this, we saw that information had been shared with health care professionals. For example, a person's GP had been told that they now had a DoLS authorisation in place. Details of hospital appointments and the outcome of tests / examinations were also retained with people's care records. This meant that staff had easy access to information about people's health care needs.

People had patient passports in place; these are documents that people can take to hospital appointments and admissions with them when they are unable to verbally communicate their needs to hospital staff. They include details of the person's physical and emotional health care needs. This meant that hospital staff would have access to information about the person's individual needs.

We observed the lunchtime experience and saw that the meal looked nutritious and appetising. People told us there were "Good choices on the menu" and if they did not like any of the choices there was always something else they could order. We spoke with the cook who told us that they sometimes prepared up to five different meals for people. They described to us how they knew people's likes and dislikes and any special dietary requirements. The cook told us that they were currently undertaking training on the care and management of Diabetes, which would help them to meet the nutritional needs of people with this condition. They also told us that the people who currently lived at the home were able to understand the menu on display, but that they would obtain picture cards to assist people with dementia if this were needed.

The cook told us that there was a four week rota in operation and they were in the process of amending the menu to reflect the warmer weather.

We saw care plans included a nutritional assessment that recorded the person's special dietary needs and risk assessments in respect of eating and drinking. One person's care plan recorded, "(Name) can eat finger foods otherwise needs assistance from staff." Another person's care plan recorded, "Staff to offer (name) plenty of snacks when she is awake and also plenty of fluids. (Name) likes tea with milk and two sugars and orange cordial as well as Fortisips. Weigh weekly." When nutrition had been identified as an area of concern, charts were used to monitor food and fluid intake. We noted that accurate records were kept of fluid intake and that people were also weighed as part of nutritional screening.

Good

Is the service effective?

We saw staff assisted people to eat their meals and noted that this was unhurried and carried out with a caring approach. There had been a survey specifically about food provision in April 2014 and it was planned for this to be repeated.

The home had achieved a rating of 5 following a food hygiene inspection; this is the highest score available.

Good

Is the service caring?

Our findings

People told us that staff were caring and responsive and that their care was centred around their individual needs. People described staff as caring, warm and understanding; one person said, "They look after us really well" and another said, "It's a good place to stay." We observed that relationships between people who lived at the home and staff were positive. People used first names which created a friendly, informal atmosphere.

Staff told us that they felt they were a good team of staff and that everyone really cared about the people who they supported. Staff told us that some people did not have family so they ensured that people received birthday and Christmas presents, and everyone in the home received an Easter present.

A health care professional told us they found staff to be helpful and that they had "No issues at all" with the care provided. They said they had observed that "Staff really care." This was supported by social care professionals who we spoke with.

Care plans included information for staff on how people's dignity should be maintained and people told us that they were treated with dignity and respect at all times. Staff explained to us how they respected people's dignity, such as knocking on doors before entering and taking care to promote a person's privacy when assisting them with personal care. Most people had a single bedroom and this enabled them to spend time on their own if they wished to do so. The registered manager told us in the PIR that they were introducing a staff 'Dignity and Respect' monitoring audit that would help measure staff skills and identify areas where they could improve.

A social care professional told us that the home now had a 'quiet' room which enabled people to spend time on their own if they wished, and also provided somewhere for people to see visitors in private.

Staff told us that they asked people what they required assistance with and what they could manage themselves, to promote their independence. One member of staff told us, "We only do what they cannot do for themselves."

We saw that care plans included information about each person's specific support needs, and information about a person's life history in a form called "Getting to know you." This included details of a person's hobbies and interests, their family relationships and their likes and dislikes. This helped staff to understand the person and provide more individualised care. We saw that documents recorded specific information about how people wished to be supported with personal care, such as, "(Name) likes to be washed in Baylis and Harding products, and Pearls soap for hands and face."

Staff told us that, because they knew people well, they were able to recognise changes in their behaviour that indicated they were unwell, or were unhappy, even when they were not able to verbalise this. They gave us some specific examples. On the day of the inspection we observed a person who had needs that challenged the service. We saw that staff assisted them in a caring and supportive manner so that they remained safe from harm.

When there had been a change in a person's care needs, we saw that the appropriate people had been informed. This included their family and friends, and any health or social care professionals involved in the person's care. This ensured that all of the relevant people were kept up to date about the person's general health and well-being.

Good

Is the service responsive?

Our findings

We saw a variety of activities taking place on the day of the inspection and that these were tailored to the person's individual interests and skills. There was a list of activities on the notice board and people told us they took part in singing, dancing and bingo, and went out shopping. We also saw that staff had time to sit and chat to people who did not want to take part in activities. A social care professional told us that staff had enabled one person who was admitted to the home to continue with their usual social activities.

We saw that staff supported people to keep regular contact with relatives and friends and to develop appropriate relationships within the home. One person said, "I still do some of the things I did at home" and another said, "I get to go shopping." Relatives and friends told us that they were able to visit the home at any time of the day as long as it was a 'reasonable' time. A member of staff told us that people could use the home's telephone to contact family and friends.

We saw in care plans that people's needs had been assessed when they were first admitted to the home. Assessments had been undertaken on nutrition, tissue viability and mobility so that a person's level of dependency could be identified. This information had been used to develop care plans that reflected people's individual abilities and needs. Care plans were reviewed each month; this meant that people's care needs were continually updated to ensure they received appropriate care.

We saw that care plans also included information about people's individual ways of communicating and how staff would be able to understand the person's needs when they were not able to verbalise these. One person's care plan recorded, "(Name)'s communication is quite limited. She will tell you that she isn't comfortable by grabbing or nipping you, not verbally."

We overheard conversations between people who lived at the home and staff and it was clear that staff knew people well, including their likes and dislikes and their individual preferences for care.

None of the people who lived at the home who we spoke with had felt the need to make a complaint. They all said that, if they had any concerns, they felt able to talk to a member of staff or the manager "Without worrying."

We saw that the complaints procedure was displayed in various areas of the home, including people's bedrooms, and that it was also included in the service user guide. We checked the complaints procedure and saw that this included the contact details for CQC (should someone wish to take their concerns further) and a review sheet that recorded the details of any complaints made. One formal complaint had been made to the home during the previous twelve months and the records showed that this had been dealt with satisfactorily, including staff having supervision meetings to discuss the concerns raised and disciplinary action being taken. We noted that any concerns raised by people had also been recorded and these included information about how they had been resolved.

We saw numerous thank you cards with positive messages displayed on the notice board.

We saw that 'resident' meetings were held; the most recent one had been in April 2015. Minutes evidenced that people were asked if they had any concerns. One person commented that the garden looked better "Now it had been tended". People were asked if they had any suggestions for outings and their suggestions were recorded. We saw that previous 'resident' meetings were held in January and February 2015 and the minutes evidenced that people were always invited to make suggestions.

Relatives and a health care professional told us that they were happy to approach the manager or staff with any concerns and were confident that their concerns would be taken seriously and acted on. Everyone who we spoke with told us they would not hesitate to speak with a manager or senior member of staff.

Good

Is the service well-led?

Our findings

The registered manager told us that the atmosphere of the home was homely and friendly. Staff told us they and the service was 'well led' and they enjoyed working for the organisation. One member of staff described the home as having a "Relaxed atmosphere. Everyone gets on with and looks after each other – there's a family atmosphere." They said that the registered manager was "Only a phone call away" if she was not at work and added "I can't fault the manager." Another member of staff said, "We all get along together – we are a good team." We spoke with a new care worker who had commenced work in January 2015. They told us that they had been welcomed by other staff and had been supported to become part of the team.

A social care professional told us that the home always seemed calm and organised, and that they were always kept informed about people's well-being, for example, if they were admitted to hospital. They said they usually spoke with the registered manager or deputy manager when they telephoned or visited the home, and that they were professional and skilled. They added that the managers and staff asked for advice appropriately, and followed it.

The registered manager carried out a variety of audits to monitor that systems in place at the home were being adhered to by staff. This included audits on the medication system, infection control and accidents and incidents. The manager told us that she had a long discussion with the deputy manager about infection control and they decided that they needed to devise a more robust audit. We saw this on the day of the inspection and noted that it would provide a thorough audit of the cleanliness of the home and the prevention and control of infection.

Any accidents or incidents had been recorded in detail and we noted that a monthly analysis was being carried out by the registered manager to monitor whether any patterns were emerging and if any additional action needed to be taken. The records evidenced that action had been taken following this analysis; one monthly entry recorded "Staff to do extra checks during the night" and another entry recorded the contact that had been made with the falls team.

We saw that a survey had been distributed to people who lived at the home in February 2015 and that seven people had responded. The returned surveys had been collated and analysed. Two people mentioned that their bedrooms were not always at a suitable temperature and there was a note to record that a plumber had been contacted to make the necessary repairs. One person had asked for a small area of garden so that they could grow vegetables and this had been arranged.

Surveys had been distributed to relatives and six had been returned. Comments included, "Management had got things done when needed", "Good atmosphere", "Good food and plenty" and "Gardens and exterior of building poor."

Surveys had been distributed to health and social care professionals in January 2015 and two had been returned. The responses to questions were rated from one to five and all responses seen were mostly scored as four or five; these were positive responses. Topics included communication from managers, the outcome of any issues raised, levels of staff support and staff interaction with people who lived at the home. The only area that scored less than four or five was the environment, which scored 3. We noted that there was a maintenance programme in place that included plans to improve the appearance of the premises.

The most recent staff survey was in August 2014. Staff suggested that people needed more activities to be made available and said that the conservatory became too hot in the Summer. The registered manager told us in the PIR that this was being addressed and was a priority in the maintenance plan.

Staff told us that they attended meetings and that they could raise issues and ask questions. We saw the minutes of a staff meeting held in March 2015. These recorded, "Cleaners and night staff will be getting a new cleaning schedule and hopefully this will ensure nothing is missed and things are kept up with." Questions raised by staff were recorded in the minutes and also any decisions made. For example, staff raised that if they came on duty during a twelve hour shift they did not always get a 'handover'. It was agreed that the deputy manager would inform all seniors of the importance of 'handover' meetings. At a previous staff meeting the topics discussed were activities, key worker roles, senior care worker roles, fluid charts, turning charts and 'cream' charts; it was recorded that this

Good

Is the service well-led?

was going to be discussed further with all staff during supervision meetings. Staff also told us that any learning from incidents that had occurred at the home would be discussed at supervision meetings and staff meetings.

Relative's meetings were no longer held at the home. The registered manager told us that some relatives had found it difficult to attend these so individual meetings had been held with relatives. One relative had told staff that they "Could not believe" how much her mum had improved in the short time she had been at Rosegarth Residential. Staff took this opportunity to tell relatives about people's current well-being and to ask if they had any concerns.

We asked the registered manager if there were any staff incentive schemes. We were told there were no incentives but staff were taken out by the registered provider each Christmas as a 'thank you' and that this was appreciated by staff.