HC-One Limited

Roxburgh House (Liverpool)

Inspection report

Roxburgh House Care Home
Roxburgh Street
Bootle
Merseyside
L20 9PS

Tel: 01515257547
Website: www.hc-one.co.uk/homes/roxburgh-house-bootle/

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 3 and 4 February 2016 and was unannounced.

Roxburgh House is a residential care home which offers accommodation and support for up to 38 older people. The single storey building is separated into two areas; a residential care home providing support for up to 23 people and a unit to support up to 15 people with dementia. On the day of inspection there were 37 people using this service.

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.

People we spoke with told us they felt safe living in Roxburgh House and we found that there were adequate numbers of staff on duty to meet people's needs. Staff we spoke with were able to explain different types of abuse, potential signs of abuse and how they would report any concerns. Records showed that staff had completed safeguarding training which helped to support them in maintaining people's safety and wellbeing. We found that staff were recruited in adherence with safe recruitment practices to ensure staff were suitable to work with vulnerable people.

Medicines were kept secure and systems were in place to ensure effective ordering and disposal. Staff had completed medicine training and a medicine policy was available to help guide staff. Medicine administration charts showed that not all medicines were signed for when administered.

We looked at accident and incident reporting within the home and found that incidents were reported and recorded appropriately. Arrangements were in place for checking the environment to ensure it was safe. On the first day of inspection, we looked at the environment and found that there were some repairs required and the manager ensured that these repairs were completed by the second day of inspection to ensure the environment remained safe.

We found the home to be clean and one person told us, "It's very clean, they clean everyday."

Staff had an understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards. We observed staff seeking people's consent before providing them with support. When people were unable to consent, an assessment of their mental capacity was completed in line with the principles of the MCA and care provided in their best interest.

Staff were supported through induction, training, supervisions and appraisals. People living in the home and their relatives told us they felt staff were well trained.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing, such as the GP.

Catering staff we spoke with were able to tell us about most people's dietary needs, however no written information was available in the kitchen to ensure that all people providing meals was aware of each persons dietary needs and preferences. The manager agreed to review this and on the second day of inspection diet notification charts had been created and were available within the kitchen.

We observed the environment of the home and found that the manager had taken steps within the unit for people living with dementia to ensure the environment included orientation signs and aids and which enabled people to be more independent.

People living at the home told us staff were kind and caring and treated them with respect. Relatives we spoke with agreed and staff told us they enjoyed caring for the people living in the home and that it was like an extended family.

We observed relatives visiting throughout both days of the inspection. People we spoke with told us they could have visitors at any time and visitors we spoke with agreed. One visitor told us, "At least one family member comes nearly every day and at different times, we are always made welcome."

Most care files showed that people had been involved in the development of their care plan. Care plans were specific to the individual person and most were detailed and informative. We found however, that not all care plans contained sufficient detail regarding people's needs and some contained inconsistent information. The manager was made aware of these findings and on the second day of inspection, the manager had updated the care plans to include the relevant information.

Not all risk assessments we viewed had been completed accurately. If accurate levels of risk are not identified, people may not receive appropriate care to meet their needs. On the second day of inspection, the risk assessment had been reviewed and accurately reflected the person's level of risk.

Staff we spoke with demonstrated a good knowledge of people's individual care, their needs, choices and preferences.

People told us they enjoyed activities available within the home, such as bingo, music, singing and trips out in the minibus. did exercises, listened to music, sang, went in the garden in the summer and went out in the minibus.

People had access to a complaints procedure and this was displayed on notice boards within the home and was also available within the residents guide which everybody had a copy of in their rooms.

The home had a registered manager in post. People living in the home told us it was run well and relatives told us they felt able to go to the manager with any concerns and were confident they would be listened to and have their concerns addressed.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had. There were processes in place to gather feedback from people and listen to their views.

There were procedures in place to monitor and improve the quality and safety of the service, such as regular audits completed by the manager and operational director.

The manager had notified the Care Quality Commission(CQC) of events and incidents that occurred in the home in accordance with our statutory notifications.

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.

People told us they felt safe living in the home and we found adequate numbers of staff on duty to meet people's needs. Staff had a good understanding of safeguarding procedures and how to raise concerns.

Safe recruitment practices were followed to ensure staff were suitable to work with vulnerable people.

Risk assessments of the environment were completed in order to assess risk and maintain people's safety.

Medicines were stored safely and were available when people needed them.

Is the service effective?

Good

The service was effective.

Consent regarding care was recorded for most people and when people were unable to provide consent, mental capacity assessments were completed which were decision specific. DoLS applications were made when required.

Staff received support in their role through induction, training, supervision and appraisals.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing.

People told us the meals were good and they always had a choice.

The manager had taken steps within the unit for people living with dementia to ensure the environment included orientation signs and aids and which enabled people to be more independent.

Is the service caring?

Good

The service was caring.

People living at the home told us staff were kind and caring and treated them with respect and staff we spoke with told us they would be happy for their relatives to live in the home.

We observed people's dignity and privacy being respected by staff during the inspection. Interactions between staff and people living in the home were warm and caring and it was clear that people got along well.

Staff we spoke with were clear how important it was to promote independence and encourage people to participate in their own care.

People we spoke with told us they could have visitors at any time and visitors we spoke with agreed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Most care files showed that people had been involved in the development of their care plan. People were happy with the care they received and their relatives agreed.

Care plans were specific to the individual person and most were detailed and informative. However not all care plans contained sufficient detail regarding people's needs and some contained inconsistent information.

Not all risk assessments we viewed had been completed accurately.
Staff we spoke with demonstrated a good knowledge of people's individual care, their needs, choices and preferences.

People told us they played enjoyed activities available within the home.

People were able to provide feedback regarding the service through regular resident meetings and quality assurance surveys and had access to a complaints procedure.

Is the service well-led?

Good

The service was well-led.

People living in the home told us it was run well and relatives told us they felt able to go to the manager with any concerns and

were confident they would be listened to and have their concerns addressed.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had.

There were processes in place to gather feedback from people and listen to their views, such as resident meetings, quality assurance surveys and staff meetings.

There were procedures in place to monitor and improve the quality and safety of the service, such as regular audits completed by the manager and operational director.

Roxburgh House (Liverpool)

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 3 and 4 February 2016 and was undertaken by an adult social care inspector.

Before our inspection we reviewed the information we held about the home. This included a review of the Provider Information Return (PIR). The PIR 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 looked at the notifications the Care Quality Commission (CQC) had received about the service. We contacted the commissioners of the service to obtain their views, as well as the local safeguarding teams.

During the inspection we spoke with four people living in the home, the registered manager, deputy manager, one member of the kitchen staff, three members of the care staff, three relatives and two visiting health professionals.

We looked at the care files for six people living at the home, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We made general observations, looked around the home, including some people's bedrooms, bathrooms, the dining rooms and lounge.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living in Roxburgh House. One person living in the home told us, "The (staff) are always there to help, they come quickly when I press my buzzer. When I had a fall they all came running." Relatives and staff we spoke with agreed that people received care that helped to maintain their safety and wellbeing.

We spoke with staff about adult safeguarding, what constitutes abuse and how to report concerns. All staff we spoke with were able to explain different types of abuse, potential signs of abuse and how they would report any concerns. Records showed that staff had completed safeguarding training and staff we spoke with confirmed this. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available within the home. This enabled referrals to be made to the relevant organisations. We found that appropriate safeguarding referrals had been made by staff.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for people living in the home. A medicine policy was available for staff and included guidance on areas such as actions to take in the event of a medicine error, self-administration, controlled drugs, safe administration and covert administration of medicines (medicines hidden in food or drink), though this form of administration was not in use at the time of the inspection. Staff told us and records we viewed confirmed, that staff had completed training in relation to safe medicine administration and had their competency assessed each year.

Medicines were stored securely in locked trolleys, in a locked clinic room. Medicines that required refrigeration were stored within a medicine fridge and the temperature was monitored and recorded daily, as was the room temperature. The stock balance of medicines were checked and recorded at each administration and controlled drugs were checked by two staff twice each day. The stock balance of medicines we checked were accurate.

We looked at people's MAR charts and found that they included information regarding any allergies. This helped to prevent people being given medicines they may be allergic to. MAR charts showed that not all medicines were signed for when administered. For instance, we found that one medicine had not been signed as administered for two nights. After discussion with the manager we found that the person had not received the medicine as they had been sleeping and the medicine was for pain relief. Staff should have indicated this on the MAR chart. The manager agreed to address this with all staff.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility and pressure relief. These assessments were reviewed regularly to ensure any change in people's needs was assessed to allow appropriate measures to be put in place, such as regular weight monitoring or pressure relieving equipment.

We looked at how the home was staffed. On the first day of inspection there was the registered manager, deputy manager, five care staff, two domestic staff, one chef and a kitchen assistant and one person responsible for laundry. Staff were providing support to 37 people living in the home. The manager and deputy rotated to provide on call support to staff out of hours.

We spoke with staff, people living in the home, their relatives and visiting professionals and everyone agreed that there were adequate numbers of staff on duty each day to meet people's needs effectively. People living in the home told us they did not have to wait long to receive care and staff came quickly when they pressed their call bells.

We found that dependency assessments were completed for each resident, however these were not used to decide upon the appropriate numbers of staff required. The manager advised us that they make observations each day, speak to staff and people receiving support and if extra staff were required, they would arrange this. We viewed staff rota's and they reflected consistent numbers of staff were on duty to meet people's needs.

We looked at how staff were recruited within the home. We looked at four personnel files and evidence of application forms, photographic identification, appropriate references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. We found that there was an effective procedure in place to recruit staff.

We looked at accident and incident reporting within the home and found that incidents were reported and recorded appropriately. Staff completed incident forms and these were signed by the manager once reviewed. They included details of any actions taken and any referrals made, such as to the local safeguarding team or CQC. When significant injuries were incurred, the manager completed an incident investigation to look at how recurrence of this could be prevented.

Arrangements were in place for checking the environment to ensure it was safe. A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire. These were held in a file that was easily accessible in the event of an emergency. Risk assessments were also in place which covered tasks and activities within the home, such as using portable room heaters, use of the BBQ, kitchen tasks, cleaning hoists and general moving and handling of equipment. Safety checks of equipment and services had been undertaken, such as weekly fire alarm tests, gas and electrical equipment, hoists and slings, call bells, water temperatures and scales. Staff had access to a list of contact numbers for a variety of services should they need to contact them in the event of an emergency.

On the first day of inspection, we looked at the environment and found that there were some repairs required. For instance, the lock on the electrical cupboard was not working and the lock mechanism had been removed from one door, leaving a hole within the fire door. The manager was made aware of these findings and both were repaired by the second day of inspection. A maintenance person was employed but was off sick, however the provider had another home locally, who provided maintenance support during this time.

There were no concerns raised regarding the cleanliness of the home. One person living in the home told us, "It's very clean, they clean everyday." Staff were observed to wear personal protective equipment when serving meals at lunchtime and a stock of gloves and aprons were available to staff in relevant areas around

the home. Liquid hand soap and paper towels were available in bathrooms in line with infection control guidance, as well as hand sanitiser. Regular internal infection control audits were completed and 100% was achieved in the last audit.

Good

Is the service effective?

Our findings

We looked at staff personnel files to establish how staff were inducted into their job role. Records of a basic induction were seen and staff told us that they completed training, including manual handling training, prior to starting in post. Staff also told us that when they were first employed, they worked with an experienced carer to enable them to get to know the people they would be caring for. The manager told us that any new staff would complete the company's new induction which we viewed and had been updated to include the requirements of the care certificate. The manager told us they planned to ensure all existing staff completed this induction also, however this had not yet commenced.

We looked at ongoing staff training and support. Training records showed that most staff had completed courses the service considered mandatory, such as safeguarding, medicines, fire safety, health and safety, moving and handling, infection control, first aid, nutrition, dignity, mental capacity and DoLS, as well as open minds which was the company's dementia training programme. Most training was completed via e-learning which staff told us was effective and they enjoyed the flexibility it offered. People living in the home and their relatives told us they felt staff were well trained. One person told us, "The (staff) are well trained, they know exactly what to do" and another person told us, "They are well trained and can look after people, if they are ever unsure, they call for an ambulance, you get the help you need." A visiting health professional also told us, "They know what they are doing."

Staff we spoke with told us they felt well supported and were able to raise any issues with the manager or senior staff when required. Staff told us the manager was, "Very supportive" and, "Always there if you need to talk to her." Staff received supervisions and an annual appraisal and records we viewed reflected this. This meant that there was an effective process in place to support staff and enable them to meet people's needs.

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 make 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).

The manager told us they had made three DoLS applications and was in the process of making further applications for relevant people. There were no authorisations in place at the time of the inspection. We looked at one care file which showed that a mental capacity assessment in relation to the DoLS application had been completed. Staff we spoke with told us and records confirmed, that staff had completed training in relation to DoLS and on discussion, they were aware of the applications that had been made for people and why.

Staff we spoke with told us they always asked for people's consent before providing care and we observed this during the visit. For instance, before entering a person's bedroom, providing personal care and providing support at lunch time. Staff told us they ensure people have choice regarding their care and are there to support the person how they want to be supported. Care files we viewed showed that when able, most people signed to show their consent consent in areas such as care planning, information sharing and photography. This however, was not consistent as one care file we viewed did not contain evidence of any consent. On the second day of inspection the manager had discussed this with the person and consent to care planning, photography and information sharing was evident.

When people were unable to provide consent, mental capacity assessments were completed which were decision specific. We viewed completed mental capacity assessments in relation to living in the home and the best interest decision was to apply for a DoLS. Staff told us they had received training in mental capacity and records we viewed reflected this.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, district nurse, social worker, community mental health team, podiatrist, optician and dietician. Visiting health professionals we spoke with told us that staff made appropriate referrals for advice and followed the advice provided in relations to people's care and treatment. The home had access to a "virtual nurse" computer system, which enabled staff to contact nurses for advice when necessary. However this was only available for people registered with G.P's in Sefton, however most people living in the home were registered with G.P's in Liverpool and so this service was not available to them. Staff told us they had a good relationship with the local G.P surgery and regularly contacted them for advice if they had any concerns regarding people's health.

We observed the lunch time meal in one of the dining rooms. People could choose where to eat their meal, either in the dining room, the lounge or in their bedroom. In the dining room people sat together to eat their meal and staff were available at all times to provide support to people when required. There was a relaxed atmosphere with music playing in the background and people were not rushed. There was a menu available and people told us there was always a choice or meals, as well as an alternative if they did not want meals from the menu. Tables were laid with table cloths, napkins and condiments were available on each table. Jugs of juice were available and staff provided people with drinks of tea, coffee and milk during the meal. Staff were available to offer encouragement and support to those people that required it. People were provided with extra dessert on request and staff offered and provided one person with a number of different meal options to encourage their dietary intake.

When asked about the food people told us they had a choice of meals and that staff knew their preferences. Catering staff we spoke with were able to tell us about most people's dietary requirements and told us staff kept them informed. There was however, no written information available in the kitchen to ensure that all people providing meals was aware of each persons dietary needs and preferences. The manager agreed to review this and on the second day of inspection diet notification charts had been created and were available within the kitchen.

We observed the environment of the home and found that the manager had taken steps within the unit for people living with dementia, towards the environment being appropriate to assist people with orientation and safety. For instance, there were pictorial signs on bathrooms, arrows on the wall with pictures of a toilet, directing people to the nearest bathroom, photographs of people on their bedroom doors and memory boxes next to their door, though not all of these had been filled. Bathroom doors were different colours to other doors in an attempt to promote people's independence. There was an enclosed garden with a seating

area, enabling people to enjoy the outside whilst maintaining their safety. In all areas of the home, not just in areas specifically for people with dementia, doors contained numbers and door knockers to resemble front doors. The manager told us they planned to further develop areas of the home to make them more "dementia friendly."

Good

Is the service caring?

Our findings

People living at the home told us staff were kind and caring and treated them with respect. One person told us, "They are the best" and another person told us, "I wouldn't want to live anywhere else, we get on like a house on fire." Relatives we spoke with agreed and described the care staff as, "Marvellous," "Wonderful," "Very caring" and "Like a family." A visiting health professional told us they observed, "Caring relationships" between staff and people living in Roxburgh House. Staff told us they enjoyed caring for the people living in the home and that it was like an extended family. All staff we spoke with told us they would be happy for their relatives to live in the home.

We observed people's dignity and privacy being respected by staff in a number of ways during the inspection, such as staff knocking on people's door before entering their rooms and referring to people by their preferred name. Personal care activities were carried out in private and people did not have to wait long if they needed support. People were given plenty of time to eat their meals; they were not rushed in any way. Interactions between staff and people living in the home were warm and caring and it was clear that people got along well. Staff we spoke with were able to share examples of how they maintained people's dignity, such as making sure doors and curtains were closed when supporting people with personal care. Records we viewed showed that most staff had completed dignity training as well as 'kindness in care' training.

Most care plans we viewed showed that people and their families had been involved in the creation of care plans. The care plans we viewed reflected that people were encouraged to maintain their independence on a daily basis and had a separate care plan on "Promoting independence" within their care files. Staff we spoke with were clear how important it was to promote independence and encourage people to participate in their own care. We found on discussion, that staff knew the people they were caring for well, including their needs and preferences. People we spoke with agreed and one person told us, "The staff know me well, the (staff) take me christmas shopping and I enjoy that."

Care files were stored securely in order to maintain people's confidentiality.

The manager told us that nobody living in the home at the time of the inspection, had any particular cultural needs. People attended the local church for coffee mornings and a member of clergy from the local church came to visit the home each Sunday.

We found that one care file we viewed contained a detailed and personalised end of life care plan for an individual. It was clear that the person had been able to express their wishes and staff had recorded details such as where the person would like to receive care at the end of their life, which undertakers they wanted to be contacted when the time came and even what music the person wanted to be played at their funeral. This enabled staff to ensure the person received the support they wanted when they were no longer able to inform people of their wishes.

We observed relatives visiting throughout both days of the inspection. The manager told us there were no

restrictions in visiting, encouraging relationships to be maintained. People we spoke with told us they could have visitors at any time and visitors we spoke with agreed. One visitor told us, "At least one family member comes nearly every day and at different times, we are always made welcome."

For people who had no family or friends to represent them, contact details for a local advocacy service were available and were on display within the home for people to access. There was nobody in the home receiving advocacy services at the time of the inspection.

Requires Improvement

Is the service responsive?

Our findings

We looked at how people were involved in their care planning. Most care files contained a record of involvement in developing the plan of care, signed by the person living in the home or their relative. One person's care file we viewed, however, did not evidence that the person or their relatives had been involved. By the second day of the inspection, the manager had discussed the existing care plan with the person and had evidenced this within the care file.

Relatives we spoke with told us they were kept informed of any changes to their loved one's health and wellbeing, though not all had seen the recorded plan of care. One relative told us, "I viewed the care plan when [relative] first came to the home but have not seen it since. I am happy with the care and don't have any concerns." All care plans were reviewed regularly and most care files showed that people had been involved in a number of reviews. Although not every file we viewed reflected that people were involved in each review, all people we spoke with were happy with the care they received.

Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily verbal handovers between staff and through viewing people's care files. One staff member told us, "We get kept informed of people's needs, we have handover every day and I never assume, always ask." Senior staff also completed written handover sheets, including information such as GP visits, appointed first aid trained staff on duty, person holding the medicine key during that day and any changes in peoples needs.

We viewed a number of care files that contained a pre admission assessment; this ensured the service was aware of people's needs and that they could be met effectively from admission.

We observed care plans in areas such as personal care, mobility, nutrition, physical health, safety, promoting independence, social needs, medicines and skin integrity. Short term care plans were also utilised when a person's needs changed on a temporary basis, such as if they developed an infection or were taking a short course of antibiotics.

Care plans were specific to the individual person and most were detailed and informative. We found however, that not all care plans contained sufficient detail regarding people's needs. For instance, one personal care plan advised that the person required support and encouragement from one staff member, but no detail was available regarding what support the staff were required to provide or what the person could do for themselves. Another person's care file contained a wound chart which stated they were using pressure relieving equipment, but did not describe what that equipment was and this was not reflected within the skin integrity care plan. This meant that staff may not have access to sufficient information to meet people's needs effectively. The manager was made aware of these findings and on the second day of inspection, the manager had updated the care plans to include the relevant information.

Although the care plans we viewed were reviewed regularly, they did not always contain consistent information throughout the care file regarding people's needs. For instance, one care file contained an

assessment which stated a person could be incontinent and required support when accessing the toilet, however other, more recent assessments within the care file reflected that the person was continent and could access the toilet independently. The manager told us that the person's ability had improved since living in the home and was now independent. The manager agreed to ensure the care file was reviewed to ensure it contained accurate and consistent information to enable staff to meet people's current needs.

One care filed contained a risk assessment regarding a persons skin integrity which had been completed inaccurately. This led to an incorrect level of risk being identified as "at risk" when the person was "at high risk." If accurate levels of risk are not identified, people may not receive appropriate care to meet their needs. The manager was made aware of this and advised us that there were no concerns regarding the person's skin integrity and that they would review the risk assessment. On the second day of inspection, the risk assessment had been reviewed and accurately reflected the person's level of risk. There were no additional measures needed to support the person despite this change as effective measures were already in place.

We found that when people were diagnosed with a specific medical condition, their files included information and guidance regarding the condition to ensure staff were aware of the illness and how to support the person. For example, one care file included printed information regarding heart failure, what it was, what symptoms people may experience, treatments available and actions to take in specific circumstances.

Staff we spoke with demonstrated a good knowledge of people's individual care, their needs, choices and preferences. Care files we viewed included information on people's preferences. This included how people liked to spend their day and their preferred routines, any particular likes or dislikes in relation to meals and drinks, activities people enjoy taking part in and information on what is important to each person. Care files contained life histories for people which enabled staff to get to know people, understand their experiences and backgrounds and provide support based on their preferences.

We asked people to tell us about the social aspects of the home. People told us they played bingo, did exercises, listened to music, sang, went in the garden in the summer and went out in the mini bus to places like Southport and a local farm which they enjoyed, particularly the nanny goats. During the two days of inspection, we observed activities taking place such as a quiz, bingo with prizes, karaoke and general discussions between groups of residents and staff.

An activities co-ordinator was employed by the home but was not in work on the first day of inspection, however staff ensured that activities were provided throughout the day. A notice board within the home advertised activities available within the home and contained photographs of recent activities that had taken place, such as horses visiting the home and a pyjama party to raise funds. Outside entertainers were also booked to visit regularly, such as the sefton opera and a singer.

We looked at processes in place to gather feedback from people and listen to their views. The service had developed a "Resident of the day" system, which involved a different allocated resident every day and included a review of their care plan, deep clean of their room, but also a meeting with the manager to discuss whether the person was happy with their care and any feedback they wanted to share. We also viewed records from regular resident meetings which provided people with the opportunity to share their views regarding the service and any changes they would like, such as meals and activities. The manager told us they regularly advertise relative meetings, however people tended not to attend. There was however, an open door policy and relatives told us they could approach the manager at any time if they had concerns. One relative we spoke with told us the manager was arranging a coffee morning which they hoped to attend.

The manager confirmed this and told us they hoped to invite guest speakers, such as someone from the Alzheimer's Society.

Quality assurance surveys were also provided to people and the responses we viewed were mainly positive regarding the service. Where comments had been made that the manager had acted on, the actions taken were recorded.

People told us they had choice as to how they spent their day, such as where to eat their meals, whether to sit in lounges, whether to join in activities or spend time in their rooms. Care files evidenced people's choice with regards to their daily routines, such as when to go to bed or get up of a morning. One care plan reflected that a person regularly liked to lie in of a morning and staff were to respect that. All staff we spoke with told us they always ensured people had choices, whether it be regarding a meal, who they want to support them with personal care, what they want to wear or when they want a cup of tea. It was also clear that staff considered Roxburgh House the residents' home, not just their place of work.

People had access to call bells in their rooms to enable them to call for staff support when required.

People had access to a complaints procedure and this was displayed on notice boards within the home and was also available within the residents guide which everybody had a copy of in their rooms. People we spoke with told us they had never had to make a complaint, but knew how to raise concerns should they need to and would be comfortable doing so. People told us they were sure staff would listen to their concerns.

Good

Is the service well-led?

Our findings

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was positive. People living in the home told us it was run well and relatives told us they felt able to go to the manager with any concerns and were confident they would be listened to and have their concerns addressed. Staff told us they were well supported by the management team and described the manager as, "Very supportive" and told us the manager was, "Always there if you need to talk" and that "I can always turn to [manager] for support."

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had. Having a whistle blowing policy helps to promote an open culture within the home. Staff told us they were encouraged to share their views regarding the service.

We looked at processes in place to gather feedback from people and listen to their views. As well as resident meetings and quality assurance surveys, there were also regular staff meetings held to ensure views were gathered from staff. Records we viewed showed that staff meetings took place every few months and covered areas such as medicine management, DoLS and support that people required. Staff feedback sheets were also viewed, offering staff views on what the service did well and any areas they felt could be improved.

The manager also told us about daily "flash" meetings that were held with heads of departments within the home, such as catering, maintenance, housekeeping, administration, care and activities staff. This provided an opportunity to communicate any necessary information and ensure all staff had relevant knowledge to support them in their roles and meets people's needs.

During the visit we looked at how the manager and provider ensured the quality and safety of the service provided. The operational director undertook monthly unannounced visits to the home and completed audits in areas such as resident care, the environment, staffing, dining experiences, weight monitoring, staff training, incidence of pressure sores and oversight of audits completed by the registered manager.

The manager completed a monthly quality report for the provider, which reported on areas such as hospital admissions, rate of infections, use of bed rails, any significant weight loss or gain for people and any pressure sores developed. This helped to ensure that the provider had an oversight of the quality of the service.

We viewed completed audits which included areas such as medicines, care plans, catering, health and safety, infection control, falls, fire safety and first aid. We discussed with the manager the tool used to audit care files and they agreed this could be further developed to ensure consistency of information is also reviewed. Any required actions were recorded and signed off when completed. This meant that systems were in place to monitor the quality and safety of the service.

The manager had notified the Care Quality Commission(CQC)of events and incidents that occurred in the

home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding Roxburgh House.