Rose Cottage RCH Ltd

Rose Cottage

Inspection report

14 Kipping Lane
Thornton
Bradford
West Yorkshire
BD13 3EL

Tel: 01274833641

Date of inspection visit:
05 April 2017

Date of publication:
11 May 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Rose Cottage is located in the village of Thornton, close to Bradford. It provides accommodation and personal care for up to 16 elderly people at any one time.

The inspection took place on the 5 April 2017 and was unannounced. On the date of the inspection 14 people were living in the home.

A registered manager was not in place. A manager had recently been recruited who was in the process of going through the application process to by the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection in October 2014, we rated the service 'Good' overall. At this inspection, we rated the provider "Requires Improvement" overall. Although we saw some areas of the service had positively developed since the last inspection, such as increased social opportunities and the person centred approach to care, we found issues relating to; a lack of robust risk assessments and lack of evidence of compliance with the Mental Capacity Act. These issues meant we could not rate the service better than 'Requires Improvement,' despite there being a highly person centred approach to care and support and a kind, caring and stable staff team.

People and relatives were highly satisfied with the care and support provided by the home. They praised the personalised and individual approach provided by the staff and management team.

People told us they felt safe and secure living within the home. Safeguarding procedures were in place which were well understood by staff.

Overall, medicines were safely managed. People received their medicines as prescribed. However, protocols were required detailing how and when to give 'as required' medicines.

Risk assessments and updated care plans relating to pressure area care, nutrition and bed rails were not always in place increasing the risk of harm to people.

The premises were warm and homely and suitable for the intended purpose People were able to personalise their rooms. The building and equipment were kept well maintained.

There were enough staff deployed to ensure people received prompt and timely care. Staffing levels were subject to regular review. Safe recruitment procedures were in place.

Staff received a range of training and support relevant to their role. Staff said they felt well supported by the

management of the service.

Improvements were required to ensure the service could evidence it was fully acting within the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) legislation.

People had access to a range of suitably nutritious food including regular snacks. People praised the food and said it was tasty with suitable choice. Charts recording people's food and fluid intake were not always properly completed.

People had access to a range of external health professionals to help ensure their healthcare needs were met.

People and relatives told us staff with very kind and caring. This was confirmed by our observations of care and support. We saw staff knew people very well and provided personalised care and support. All staff, including the management team, showed kindness and compassion towards the people they were caring for.

People were listened to and their views respected by the service.

People's needs were assessed and plans of care put in place which were understood by staff. People's individual and varying needs were taking into account to develop plans of care that met people's emotional and social needs.

People had access to a range of activities which included trips out and maintaining links with the local community.

A system was in place to log, investigate and respond to complaints.

Systems to assess and monitor the service were in place. However, these had not been sufficiently robust as they had failed to prevent some of the shortfalls we identified from occurring, for example, relating to risk assessment processes.

People's views were recorded and used to make positive changes to the service.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people's health and safety were not always thoroughly assessed as skin integrity, nutritional and bed rail risk assessments were not in place.

People told us they felt safe and comfortable living in the home and at ease in the presence of staff.

Staffing levels were safe and suitable to ensure people received safe, prompt and personalised care. Proper recruitment procedures were in place to ensure staff were of suitable character to work with vulnerable people.

The premises was suitable for its purpose, with a warm and homely feel.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were required to ensure the service could evidence it was fully acting within the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs).

People had access to a range of suitable nutritious diet. People praised the food provided by the home.

People had access to a range of external health professionals to help meet their healthcare needs.

Staff received a range of training relevant to their role. Staff said they felt well supported in their role..

Is the service caring?

Good

The service was caring.

People and relatives said staff were very kind, caring and friendly. This was confirmed by our observations of care and support.

There was a person centred approach to care and support. Staff knew people well and gave them choice over their daily routines. People were listened to by staff and their views respected.

Kind and compassionate end of life care was in place.

Is the service responsive?

Good

The service was responsive.

People and relatives praised the care provided by the home. They said that people's individual needs were met. Staff knew people well and the care routines people preferred.

People had access to a range of activities and social opportunities. This included trips out and regular entertainment provided by staff and volunteers.

A system was in place to record, investigate and respond to any complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Although systems to monitor and improve the quality of the service were in place, they had not been sufficiently robust to prevent some of the shortfalls we identified from occurring.

There was a open and inclusive atmosphere within the home. People and relatives praised the way the home was managed. There was a very personalised approach to care and support.

People were listened to and their opinions used to make changes to care and support.

Rose Cottage

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 5 April 2017 and was unannounced.

The inspection was carried out by an 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, in this case the care of older people.

Before the inspection we reviewed the information we held about the service. This included looking at information we had received about the service and statutory notifications we had received from the home. We contacted the local authority safeguarding and commissioning departments to get their views on the service.

The provider submitted a PIR (Provider Information Return). This document gives the provider the opportunity to tell us about their service and any planned improvements. This was completely appropriately and returned to us in a prompt manner.

We used a variety of methods to gather information about people's experiences. During the inspection we spoke with eight people who used the service and four relatives. We spent time observing how people were supported in the communal rooms and looked at four people's care records. We looked at the way people's medicines were managed and looked at other records relating to the management of the service such as maintenance records and meeting notes. We looked at staff files and training records. We looked around the home at a selection of people's bedrooms and the communal areas. We spoke with the cook, five care workers, the deputy manager, the manager and the provider. We also spoke with two health care professionals who visited the home on a regular basis.

Requires Improvement

Is the service safe?

Our findings

We found in some cases, risks to people's health and safety were assessed to reduce the risk of harm. For example, risks associated with falls and moving and handling were assessed and staff had a good understanding of the people they were caring for. We also observed that behind people's bedroom doors there was a copy of risk assessments and a summary of care needs to help provide staff with information to keep people safe. However, we had some concerns over pressure area prevention care, although improvements to the risk assessment process had been made. National Institute for Care and Health Excellence (NICE) guidelines state that pressure ulcers are often preventable. The pressure area audit undertaken by the manager in April 2017 showed 4 out of the 14 people living in the home had pressure sores. We looked at one of these people's care records which showed the person had no skin integrity risk assessment or care plan in place at the time they developed the sore and their current skin care plan did not mention their wound. Although an appropriate referral to health professionals had taken place and equipment sourced, we were concerned that prevention planning had not been in place. We saw another person had developed a pressure sore and although they had pressure area risk assessment in place, this had not been reviewed since February 2016. We spoke with the manager who had recognised that pressure ulcer assessments and care plans had not all been in place or were not up-to-date. They showed us that the deputy manager had recently completed new assessments, which were in the process of being reviewed by manager. We saw one person required regular pressure area relief. Records for this were well completed and showed the person received timely repositioning.

Some people had air mattresses in place to reduce the risk of them developing pressure ulcers. However, care staff did not know the settings mattresses should be on and the settings were not recorded in the individual's care plans. This meant there was a risk the mattresses could be on the wrong setting which would reduce the therapeutic effect and could potentially cause tissue damage rather than prevent it. Moving and handling care plans lacked detail as to the type of sling each person should use.

Some people had nutritional risk assessments in place. However, this was not consistently the case. One person's risk assessment had not been reviewed since February2016. Another person did not have a nutritional risk assessment in place despite losing weight recently. Another person's nutritional care plan did not acknowledge their recent weight loss. There was no information on people's body mass index within their care files to determine whether they were of healthy weight. We raised this with the manager who said they were awaiting training from the district nurses in the use of the Malnutrition Universal Screening tool (MUST), a recognised nutritional risk screening tool.

We also found a lack of bed rail risk assessments for people who had bed rails in situ. Health and Safety Executive Guidance on the safe use of bed rails requires that the risks and benefits of bed rails are considered in order to come to an informed decision over the correct plan of care and that any subsequent equipment put in place is assessed to ensure it is compatible, in working order and safe. We saw this had been identified by the manager and a plan was in place to address.

This was a breach of regulation 12 of the Health and Social Care Act (2008) Regulated Activities 2014

Regulations

People told us they felt safe living in the home. One person said, "I feel safe here, that is why I don't want to leave." Another person said, "The home is safe for everyone, staff make sure that people don't just wander off." A relative told us, "[Relative] is safe here, can't go out unaided and there's good communication between all concerned with my mum's care." People, relatives and staff said they had not seen anything of concern within the home and they would recommend the home to others.

Staff we spoke with understood safeguarding and how to identify and act on any allegations of abuse. This assured us that the correct processes would be followed should a concern be identified. We saw no recent safeguarding incidents had occurred within the service and the service had liaised with the safeguarding authority over any minor concerns.

Overall, we found, medicines were safely managed. People reported they received appropriate support with medicines in a timely fashion. Medicines were administered by trained senior care workers. We saw medicines were stored safely and securely. We looked at a sample of medicine administration records (MAR) and saw these were well completed indicating people had received their medicines as prescribed. Arrangements were in place to ensure people who were prescribed topical creams, received these at appropriate times. We counted balances of medicines and found in most instances the number of tablets present matched what should have been present if people had received their medicines as prescribed. However, we identified in two cases, the number of sachets of a prescribed laxative did not match what should have been in stock. We raised this with the senior care worker to investigate.

Although staff demonstrated knew people well and when they needed pain relief , the administration of these medicines was not supported by 'as required' protocols to ensure they were offered in a consistent way.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

Where medicines errors had occurred previously, we saw these had been investigated and action taken to prevent a re-occurrence. A low number of medicines errors had occurred within the service.

We found sufficient quantities of staff were deployed to ensure people received safe and prompt care. Staffing levels consisted of three care workers in the morning and two in the afternoon. The manager also assisted at busy times and the home was supported by a cook and cleaner. People told us staffing levels were appropriate. One person said, "Day or night, it don't make no difference, there is always staff." Another person said, "There is more staff all the time" and a third person said, "Always there, lovely girls, all of them." A relative told us, "Never had problems about staffing, even though [relative] is not in the communal areas, staff are always passing by to check on [relative]." Staff also told us there were enough staff deployed and shifts always got covered if there was sickness. We saw staff were present and able to meet people's individual needs and had time to chat with people. Call bells were responded to appropriately. We saw if people were at the end of their life staffing levels were increased, to ensure people had someone with them in their final hours. Staffing levels were regularly reviewed, for example, a query had been raised about staffing levels at night. This had been discussed with all staff before a conclusion reached and amendments made to working practices. Out of hours, a senior member of staff was 'on call' to help ensure management support was always available to staff.

Safe recruitment procedures were in place to ensure staff were of suitable character to work with vulnerable people. This included ensuring applicants completed an application form and attended an interview. Staff were required to complete a disclosure and baring service(DBS) check and have their conduct in previous employment checked. New staff were also subject to a probationary period to help ensure they were suitable to work in the home.

The premises was safely managed and kept well maintained. People told us they were happy with the building and that the environment was always kept clean. Health professionals also told us the home was always clean and odour free. Money had been invested in the building overt recent years to improve the décor and general living environment. There were adequate amounts of communal space for people to spend time, including, a dining room, lounge and conservatory. A pleasant enclosed garden area was also available where people were encouraged to spend time. Bedrooms were well maintained and furnished to a high standard with people who used the service being encouraged to personalise their rooms. Since the last inspection, signage had been put in place throughout the building to assist people living with dementia to navigate safely around the building. Checks on key safety systems such as the gas, electric and fire systems took place and water temperatures were monitored to ensure they remained safe. Equipment such as hoists was regularly serviced and kept in good condition.

Requires Improvement

Is the service effective?

Our findings

During care and support we saw people were asked for their consent before care and support tasks were undertaken. People said staff asked for consent and respected their choices.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

DOLS applications had been made for people the service thought were being deprived of their liberty. We saw one DoLS authorisation was currently in place with others awaiting assessment by the local authority. The authorisation had conditions attached referring to the need to ensure specific mental capacity assessments and best interest decisions were put in place for important decisions, such as, support with medicines management. We saw this condition had not been met as there was a lack of specific mental capacity assessments in this person's and other care plans. Although mental capacity assessments were in place, they were not specific and consisted of a generic checklist with very basic information. Staff had received training in DoLS and the MCA and although we saw staff were acting in people's best interests, there was a lack of documentation to demonstrate the correct process had been followed where important decisions needed to be made. For example, around the provision of bed rails or administration of medicines.

We recommend the provider consults guidance on the Mental Capacity Act (MCA) to improve the quality and relevance of the mental capacity assessments.

People spoke positively about staff who worked at the service. One person said, "The standard of care is good, I can only guess that they are well trained." Another person said, "Staff do their daily work, there is always enough staff and their standard of care is good." A third person said, "Staff seems to know what they are doing" and a fourth told us, "I am very well and I feel very well, it is all because of staff here."

Staff knew people well and their individual needs. There was a low turnover of staff which allowed staff to build up good relationships with people and get to know them. One person said, "Been here long enough, staff know me well."

Staff received a range of training and support. Staff we spoke with praised the training provided and said it

gave them the skills needed to undertake the role. New staff without any previous care experience were also enrolled on the Care Certificate. The Care Certificate is a set of standards for social care and health workers. It is designed to equip health and social care support workers with the knowledge and skills they needed to provide safe and compassionate care.

Staff received regular training updates, delivered 'face to face' by an external training provider. These covered topics such as dementia, safeguarding, Mental Capacity Act (MCA), fire safety and safe people handling. We saw training was kept up-to-date. Specialist training was also provided based on assessed need. For example, in 2016, it was identified by the provider staff needed training in behaviours that challenged the service. This training had been sourced and provided to staff. Two staff had recently received "React to Red" pressure ulcer training delivered by local tissue viability nurses. The manager told us the staff who had received this training were due to deliver training to other staff within the home to help improve pressure ulcer prevention awareness.

Staff 'Champions' had been appointed in a number of subjects. Whilst this was in its early stages, some areas had established champions. For example, we spoke with the infection control champion who demonstrated the role was meaningful, describing their responsibilities in the area. Staff told us they felt very supported in their role. They received regular supervision and appraisal which provided a mechanism to assess performance issues and plan their future development.

People we spoke with praised the food provided by the home. One person said, "The food is good, staff give you a menu to select your choice, when it's time for dinner, they come searching for you – if you are not here, they save you some food." Another person said, "We are served good food, staff are always going around offering us snacks." A third person told us, "The food is lovely you can have whatever you want, you can have juice or banana if you need." A fourth person said, "the food is to die for! We are lucky in that way." A relative told us, "Staff are aware of mum's relationship with food, they offer her countless options, if she refuses to eat they try different things and ways to get her to eat something."

People were provided with an appropriate nutritious diet. Fresh food was prepared everyday by a cook. People had access to cereals, toasts or a cooked breakfast in the morning. At lunchtime there was one main option which rotated on a four week menu, with alternatives offered if people did not like the main option. A lighter menu was provided in the evening. Fresh cakes were made on a daily basis with snacks being available several times a day. We spoke with the cook who had a good understanding of the likes and dislikes of the people they were providing for. For example, they knew one person liked fruit cake so had recently made them a fruit cake for their birthday. Dietary sheets were maintained which provided information on people's preferences and any specific dietary needs.

We observed the lunchtime meal and saw it was well presented, it looked appetising and warm:. The dining experience was unrushed and the general atmosphere was calm. When we asked one person how they felt about what they just ate, they said, "It's been perfect", another person said, "I feel very fortunate to live here and have such delicious meals being prepared for me, every single day."

People were regularly weighed and liaison took place with external health professionals over weight loss. However, some people's nutritional care plans required updating when their weight had changed.

Some people had their food and fluid intake recorded to monitor whether they had enough to eat and drink. We saw completion of these charts was of variable quality with staff not always recording when people had been offered food. Fluid intake was also not totalled and there was no target input recorded for individuals. We raised this with the manager who agreed food and fluid intake charts were not well completed and

showed us a new form they planned to introduce to make it easier for staff to complete.

People had access to a range of healthcare professionals such as district nurses, GP's and speech and language therapists. We saw regular liaison took place with health professionals over people's health, although more information on their advice needed translating into care plans. People and relatives we spoke with said the service liaised appropriately with health professionals. Relatives we spoke with said they were always consulted and contacted should people's healthcare needs change. People had a, "This is me" document in place which could be taken to hospital with them to provide hospital staff with information about their care and support needs to help with continuity of care.

Good

Is the service caring?

Our findings

People and relatives we spoke with all praised the staff and said the service was very caring. One person said, "Staff are all very kind, anything I want I just ask and they do it for me – they show respect, they do not bully people or anything like that." Another person said, "Very good members of staff, they do their job very well, plenty of respect, they knock at your door." A third person said, "Lovely staff, they do their best" and a fourth said, "On the whole staff are very good." A relative we spoke with said, "I have got nothing but praise for staff." A health professional we contacted said, "Staff are always friendly and helpful. I have observed staff responding to residents, they appeared patient and good humoured."

We observed care and support and saw staff spoke warmly to people and treated them in a kind and compassionate manner. Staff used verbal and non-verbal communication methods such as hugging people to make them feel appreciated. We saw staff comforted people that became distressed. One relative said, "Staff are very attentive, the manager is always checking Mum and the owner was giving my Mum a cuddle when she was upset." We saw the risk of social isolation was considered, one person who was deemed at risk had been able to move rooms downstairs to increase their social interaction. It was evident that staff knew people very well and their individual likes, dislikes and preferences. For example, staff knew what food people liked and how they took their drinks. This was possible due to the small size of the home and low turnover of staff, which allowed strong relationships to develop. Staff talked to people about subjects they were interested in and provided companionship. Information on people's life history had been obtained as well as people's likes, dislikes and preferences to help develop personalised plans of care for people. A relative said of staff, "They get to know people very very well." Staff described the home and its residents as, "Like a family" and demonstrated good caring values when we spoke with them.

There was a person centred approach to care and support with people in control of the daily routines. For example, when we arrived at 8am, most people were still in bed and got up at various times throughout the morning dependant on their individual preferences. We saw the cook was happy to prepare breakfast for people at any time in the morning and people could choose whether to take breakfast in the dining room or their bedrooms. People reported their choices were respected, for example, in terms of their daily regimes. One person said, "I get up when I like" and another said, "I do everything for myself, I go to bed whenever I want, we practically do anything we like in that respect." A relative told us their relative liked to stay up past midnight and staff respected this and provided companionship late into the evening. Throughout the inspection we saw people were listened to and their views and preferences respected. All levels of staff including the manager and the provider demonstrated they valued the views of people who used the service. More formal mechanisms were also in place to listen to people. This included annual surveys, review meetings and resident and family meetings.

People and relatives told us the service got the balance right between offering support and promoting independence. One person said, "I look after myself, do everything, if I need staff for anything, I go seek them out" and another person said, "I could do anything, would like to do things but because of my age, staff support me." Independence was considered in care planning and people were encouraged to do tasks for themselves wherever possible.

We looked at whether the service complied with the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Our observations of care, review of records and discussion with the manager, staff, people and visitors demonstrated that discrimination was not a feature of the service.

End of life care planning took place where appropriate. We saw this involved health professionals and families and future wishes were recorded. Relatives we spoke with confirmed they had been involved in end of life care discussions. One relative said, "We had care plan review recently, we discussed end of life plan." Another relative praised the end of life care provided at the home telling us their relative received 1-1 staff care at the end of their life and that "the standard of care meant a lot for [relative] and us as a family."

Good

Is the service responsive?

Our findings

People and relatives all praised the care and support provided by the service and said it met people's individual needs. One person said, "In terms of staff and the quality of care they give, I couldn't have it any other way."

People's needs were assessed prior to admission to the service and clear and person centred care plans developed when the person moved into the home. These covered areas such as personal care, continence, medicines, emotional and social needs. Care plans had goals and outcomes which were monitored at care plan reviews. We saw there was good quick reference information in people's bedrooms stating how people preferred to be supported. This was very person centred, for example, considering when to play music to ensure the person was relaxed. We saw people's individual and varying needs were taken into account. For example, due to their condition, one person had specific emotional and social needs and we saw the service had worked with external health professionals to develop and deliver a personalised plan which met the person's individual needs.

A handover took place twice a day between shifts of staff to pass key information on people's needs. This was a key mechanism to ensure responsive care. We observed the morning handover and found it to be detailed and person centred.

Regular care plan reviews took place with people and their relatives to ensure the service responded to people's changing needs. People and relatives said they felt involved in their care and support. One person said, "Staff are always there to help, staff consult you on any matter."

The provider sent a regular newsletter to relatives to informing them of events occurring within the service, including changes to the building, the activities that had taken place and whether residents had enjoyed these. A relative told us they felt very involved saying, "Management always kept me on the loop, sending me emails photos, surveys and meeting invites" and another relative told us, "I feel well informed about what's going on, I received a questionnaire asking me to comment on things, management is very approachable."

During observations of care and support we saw people looked clean and well-presented indicating their personal care needs were met by the service. Staff we spoke with had a good understanding the care and needs of residents providing us with assurance that care plans were followed.

People were provided with a range of activities and social opportunities. Overall, people praised the activities available. One person said, "I mostly watch telly, go out for my newspaper or go have some lunch at the pub or somebody will take me to do some shopping." A relative said, "When [relative] was well she enjoyed many activities such as pub lunches and boat trips – as Mum was kind of lonely upstairs, staff suggested to move her downstairs where she will receive more attention." We saw people were encouraged to go out with staff, for example, to the shop or for a walk. Regular organised outings also took place. For example, a boat trip was organised twice a year, regular trips out for meals and live music were arranged as well as summer, Christmas and Easter events. We saw good relationships had been established with families

and volunteers had assisted with outings. A volunteer also visited the home twice a month to provide musical entertainment. Links were maintained with the local community, for example, choirs and a local nursery had visited the home to provide people with interaction and stimulation. On a daily basis, staff spent time with people engaging in activities such as jigsaws, games and arts and crafts.

A system was in place to log, investigate and respond to complaints. These were audited and analysed to look for any trends. We saw a low number of complaints had been received about the service and where they had action had been taken to investigate and reduce the likelihood of a re-occurrence. A significant number of compliments had also been received, and these were logged so the service knew where it exceeded expectations. People and relatives said they were aware of how to raise any concerns. They said they were very satisfied with the service, and said the manager dealt with any minor concerns appropriately. One relative said, "I don't have any concerns, if I had, I know I can approach anyone member of staff."

Requires Improvement

Is the service well-led?

Our findings

Whilst we identified some very good person centred practice within the home, particularly to meet people's social and emotional needs, there was a lack of using recognised guidance to develop robust risk assessment processes in areas such as pressure area care and nutrition and a lack of evidence the service was working to the Mental Capacity Act code of practice and Deprivation of Liberty Safeguards. The manager recognised some care plans and risk assessments processes needed improving and said this had suffered during the period when there had been no manager in place. Although we saw a plan was now in place to address these areas, the shortfalls should have been prevented from occurring through the operation of robust systems of quality assurance.

Systems to assess and monitor the service had recently been improved. For example, audits were now taking place in areas such as medication, pressure area care, DoLS, weights, staff files and care plans. An action plan had also been developed and the manager was committed to continuous improvement of the service.

The manager completed a weekly report which was submitted to the provider to inform them of how the service was operating and of any significant events. The provider also undertook regular visits to the home in order to make their own assessment of the service, with a different focus being made on each visit. We saw this approach included spending time with people and to ensure people were happy and content within the home. We saw issues were identified from these visits, for example, the need to update care plans.

Incidents and accidents were logged, investigated and where appropriate measures put in place to learn from them and improve the service. We saw a low number of incidents had occurred within the service.

A registered manager was not in place. However, a manager had been recruited in January 2017 and was going through the process to be registered with the Commission. The manager was 'hands on' and worked two care shifts a week which allowed them to experience how staff worked and develop good relationships with people using the service. A relative told us they had some concerns during the period whilst a manager had not been in place, but things had now improved. We saw the manager was supported by the provider who was involved in supporting the home and its residents. We found the management team and provider demonstrated good caring values and a desire to provide high quality and personalised care.

People and relatives praised the way the service was run. One person said, "The ladies running the home are quite good, easy-going approach," and another person said "Managers are doing particularly good." A third person said, "Manager is very friendly, very nice, very approachable." People and relatives all praised the overall quality of the home and in particular the person centred approach and homely atmosphere. One person said, "The atmosphere in the care home is easy-going, I can recommend this home to anyone because the staff here look after you, you can talk to staff anytime" and another person said, "The mood in the home is great, if you want a home, then this is a good one, I have advised a lot of my friends to come and live here." A relative said, "The atmosphere never changes for residents since there is always the same members of staff, I know everyone by name and they acknowledge me." Another relative said, "The home is

well managed, always have been since my mum started staying here."

Staff all told us morale was good and they enjoyed working at the service. One staff member said, "Love working here", Another staff member said it was, "Like a family." Staff said the team worked very well together. For example, if someone was sick, other staff always covered because of their dedication to the people who used the service. Staff said the manager was approachable and they were able to go to them with any problems.

People's feedback was regularly sought and used to make improvements to the service. Resident and family meetings were regularly held, we looked at recent meeting minutes which showed topics such as trips, menu's and building work were regularly discussed. One relative said, "It was good to be part of the residents meeting, it was an open meeting to discuss what we wanted, been informed about the changes in the home, activities and menu options." Annual quality surveys were also conducted to obtain feedback from people and relatives on an anonymous basis. We looked at the results from the most recent survey which were overwhelmingly positive. For example, comments included: "Very pleased with Rose Cottage, excellent choice of meals provided. Snacks between meals catered for." We saw feedback was used to improve the service, for example, a 'You asked and we delivered' poster by the door showed the changes made as a result of people's feedback.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (1) (2a)Care was not always provided in a safe way as the risks to the health and safety of service users of receiving care were not always assessed.