Care Quality Commission

Rosevilla Residential Home Limited

Rosevilla Residential Home

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 14 November and 20 November 2014 and was an unannounced inspection.

Rosevilla Residential Home can accommodate up to 35 older people. The home provides services for people who are living with dementia. On the day of our inspection 27 people were accommodated at the service

There was a registered manager in place at the home. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that the people who lived at Rosevilla Residential Home felt the care they received was good. Their relatives confirmed that they agreed with this. As far as possible the people who ran the home tried to provide a family atmosphere for the people who lived there and employed and managed staff in way that would promote this.

People were able to exercise choice such as about how they spent their time at Rosevilla Residential Home as well as what they ate at mealtimes. The home was clean and there were systems in place to make sure that people were safe.

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?

Good

The service was safe. Staff had a good knowledge of safeguarding principles and knew what to do if they had concerns. There were sufficient care staff on duty to provide care for the people who lived in the home. Care staff could call on the management and owners of the home if required. Staff were flexible and provided cover for each other so that continuity of care could be maintained.

The registered provider undertook checks to make sure that the people employed by the home were suitable to work there.Medicines were safely stored and administered in the home.

Is the service effective?

Good

The service was effective. The staff were well trained and felt that training was available to them beyond the minimum required to do their job. The home was aware of its obligations under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards associated with it. Staff understood about the need for people to consent to the care they received.

Opinion was divided over food in the home. Some people thought it was good with plenty of choice but other people thought this aspect of the home could be improved. Special dietary needs were catered for. People received good access to health and social care services whilst living in the home.

Is the service caring?

Good

The service was caring. People who lived in the home told us that they felt well looked after. Their relatives confirmed that this was the case. Staff knew about people's preferences and likes and dislikes and used this knowledge to help them provide care.

People could choose how they spent their time in the home but also went out with relatives. There were no routine arrangements for recording the involvement of people and their relatives in care reviews although some of the relatives we spoke with said that they felt they could be involved and were informed about changes.

Is the service responsive?

Good

The home was responsive. People were able to take part in activities organised by the home. Some people thought there should be more activities. The home had made some environmental adjustments for people living with dementia though more were required.

People said they did not have any complaints about the home although they were not always clear about what the formal complaints process was. Care planning was well-documented and up to date.

Is the service well-led?

Good

The home was well-led. The owners of the home took an active interest in it and supported the registered manager and staff. Both they and the registered manager worked alongside care staff delivering care. They arranged for care in the home to be audited so that the registered manager could use this information to monitor and improve the care provided to the people who lived in the home.

Summary of findings

The registered manager also monitored trends in care and implemented changes when this information suggested this was required. Complaints were dealt with promptly. The manager used active supervision to make sure that staff were providing care to the required standard.

Rosevilla Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 14 November 2014 and was unannounced. The inspection team was made up of two inspectors 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 instance services for people living with dementia. A single inspector visited the home for a second day on 20 November 2014 to complete the inspection.

The registered provider had completed a provider information return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The form was not available to us in advance because of a technical difficulty in submitting it but the provider gave us a copy on the first day and we were able to use it to prepare for the second day of our inspection.

We looked at all of the information which the Care Quality Commission already held on the provider. This included previous inspections and from contact around any incidents the provider had to notify us about. We invited the local authority safeguarding, quality assurance and commissioning functions to provide us with any information they held about Rosevilla Residential Home. We also contacted the local branch of Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection we spoke with eight people who used the service and four of their relatives who were visiting them. We talked with the operations director of the company which owns the home as well as the registered manager. We spoke with six members of care staff as well as other staff working in the home. We looked at records including six care files, and five staff records and maintenance documents. We looked around the building on several occasions and talked to people in their bedrooms if they agreed to this. We spoke with two members of community nursing staff as well as a social worker from one of the local authorities which serves the home.

We undertook a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

We asked people if they felt safe in the home. One person said ""The staff are very kind here" and another person told us "My son is happy about me being in here, he knows I'm in safe hands". We saw that people who lived in the home were relaxed when with the staff.

We saw that staff explained to people any concerns about their safety. We saw that one person expressed a wish to go out shopping. Staff advised them that they would need to be accompanied, by either relatives or staff due to their mobility difficulties and the risk of falling. Arrangements were made to discuss how the trip would take place the following week. We checked care planning documentation and saw that risk assessments relating to various hazards were recorded and had been reviewed recently. This meant that care could be adjusted so as to minimise these risks to the people who used the service.

We asked staff what they understood by safeguarding. One member of staff was able to describe an example of abuse they had come across in another setting and said "If a resident told me about it I would tell a manager". They were able to identify the sorts of warning signs that they would look out for in relation to abuse – "You can tell if (people's) moods are low by their facial expressions".

Staff told us "I would report any concerns about people's care to senior staff or to the manager", "I would report anything to the manager or someone higher than her". "I'd not think twice, I'd just report it". Other staff said "Its 100% safe here" and "I'd report (abuse) to a senior or manager or the social worker in the care plan".

We saw that outline safeguarding procedures were on display in the office used by staff as well as in other parts of the home. We saw that there was a safeguarding policy available and that this had been tailored to the requirements of the home so as to show the relevant contact details for the local authority in which the home was situated. The procedures were made available to staff in a box file which was available in the staff office.

We asked two of the staff if they understood the meaning of whistleblowing. They explained it correctly as needing to report if they thought something was wrong and nothing was being done about it – one staff member said "I'd report colleagues". They correctly identified the Care Quality Commission as an organisation they might contact. We suggested that the registered manager added the home's whistleblowing policy to this box file so that it would be available to staff. We saw that staff were provided with a staff handbook which included a policy prohibiting staff from entering into private arrangements with people which might lead to accusations of financial abuse.

When we started our inspection it was 7.30 a.m. and we saw that there were two night staff who were completing their shift. We asked what would happen to other people if one person needed the attention of one or both members of staff and they were already providing personal care to someone. We were told that this might mean that that person would have to wait. However because the owners of the business and their families live on the premises they were always available and could be called on if there were difficulties.

People told us that there were sufficient staff on duty. They said, "I think there are just about enough staff to do what needs to be done" and "I like to be in my room and if someone wanders in I buzz the staff who come and remove them, I usually don't have to wait long for them to come".

Relatives also thought that there were enough staff to care for the people living in the home. One said "My (relative) has dementia and doesn't understand what's going on, it's a real shame, but the staff here look after (my relative) very well, nothing is too much trouble for them" and "The staff here are marvellous, I'm delighted with the care here".

We saw that during the day there was one senior carer on duty together with three carers. There were also two cleaners and a cook. We checked staff rotas which were kept in a rotas book as well as displayed in the staff room. This confirmed that this level of staffing had been consistent for some time. During our inspection we also saw that the level of staffing was supported by members of the management team. For example, we saw one director of the company helping to give out drinks to people. Another director was available throughout the day and helped to greet professionals. Another family member took responsibility for making sure that prescriptions were ordered and was available to explain the maintenance arrangements for the home to us in some detail.

Is the service safe?

The registered manager was additional to these numbers. We were told that ancillary staff could also support the care team if this was required and on the day of our inspection a member of domestic staff had substituted in the laundry for someone who was off work sick that day.

Staff told us that whilst they thought there enough staff in the daytime but that the biggest challenge was in "Getting our residents up for breakfast. Getting them up and sorted – encouraging them". They added "There's enough staff on – they (the management) have staff who will cover if staff can't cover their shift" and "Yes – four staff on each shift is all right".

We saw that here was an effective handover routine between the night and day staff. Night staff gave a detailed account of the previous shift and anything that needed to be passed on to the day time staff. Every person living in the home was discussed at this handover which included information about people's moods and any worries or concerns they might have which the day staff should be aware of. Where the night staff thought something should be referred to another agency such as the district nurse they passed this on to the day staff. We saw the day staff passing these referrals on. It was clear to us from this process that staff knew the people who lived in the home well. Staff took care to consider the particular requirements of specific people for example in relation to one person who had just arrived for a short stay and to another who was moving bedroom within the home.

We asked about what would happen if there was an emergency. Staff explained to us that they were able to call on the owners who lived in the building and ultimately could contact the registered manager at home. We saw that there was an emergency evacuation plan and that this included a personal emergency evacuation plan for each person living in the home. All of these had been reviewed in the last four months.

We looked at five staff files to make sure that the registered provider conducted checks to make sure that people employed were suitable to work in the home. We saw that the files included application forms, references, and interview checklists. Disclosure and Barring Service forms were in place which meant that the registered provider could check if an applicant for work had any criminal convictions and assess whether these should prevent someone from working in the home. Staff who had recently been recruited confirmed that these processes had taken place. There was evidence that induction had taken place although some records had not been signed and/or dated. However all the staff we spoke with confirmed that they received induction which included working with another member of staff until they were confident they could work alone.

We checked the contents of another staff file and found that the provider used appropriate and clear disciplinary procedures where there were performance issues with staff. The registered provider told us that they retained a human resources advisory company to provide these services.

We saw that a senior member of staff was responsible for giving out medicines and wore a red bib whilst doing so in order to identify that this activity was in progress and that they should not be distracted from it. We saw that the temperature of the medicines refrigerator was subject to regular checks to see that it was in the correct range. Making sure that medicines are stored at the correct temperature helps to make sure that they are effective.

Medicines were dispensed from a trolley which was kept in a locked medicines room when not in use. This senior member of staff who was responsible for dispensing medicines came into work earlier than the other day staff in order to start this process. Only staff who had received medicines training were allowed to administer them.

On the provider information return the registered manager told us that there had been a high number of medicines errors in the last twelve months. Once she had taken up post she had instituted measures to reduce this. We saw that this had included colour coding medicines to particular times of day which in turn made it easier to see if a dose was missed. This had reduced the number of errors. However during the inspection we checked on some of the medicines' records and found that two doses of a particular person's medicines had not been signed for. The registered manager instituted an immediate investigation into the circumstances surrounding this and satisfied us that she had identified the cause and taken steps to prevent it happening again.

We saw that the home was clean. We checked the arrangements for the laundry and found that there were

Is the service safe?

robust routines and that sluice washing machines were available. Personal protective equipment was available for staff to use and both soap and antiseptic gel were available from wall dispensers throughout the home.

Is the service effective?

Our findings

We checked five staff files for evidence of training. We saw that training had taken place which included first aid, communication and record keeping, end of life care, health and safety, safeguarding, moving and handling, tissue viability, person-centred care planning, food and fire safety, dignity and nutrition. Staff told us that they thought the training was good and said "You have only got to say and it will be done" and "Training here is good. I feel I've had support to learn. I'm having dementia training in the next few weeks".

We saw that the registered provider kept detailed records which showed any training that was due to take place and training which was planned. The information in these records matched the accounts given to us by staff. We found some evidence that training had recently been completed but not yet entered onto the training records. This was difficult to check because the training record was not marked with the date it had been produced and so we could not identify exactly which period it covered.

We saw promotional material for training opportunities. The registered manager told us that the home took advantage of opportunities for training locally such as through the local social care partnership which helped them to access funding opportunities. The registered provider told us that it was their policy to arrange for new staff to undertake the relevant National Vocational Qualification at level 2 and that all care staff were currently registered to take the equivalent dementia award. The employee handbook included a training policy for staff.

We were told that there were seven people living in the home subject to Deprivation of Liberty Safeguards (DoLS). These are arrangements which apply to people who live in care homes and who do not have the capacity make decisions for themselves. The registered manager showed a good awareness of current developments in relation to these safeguards and knew that they should be applied in a wider set of circumstances following a recent judgement in the courts. The registered manager told us that they received good support from the local community psychiatric nursing team and that the home was used to working closely with social workers where best interest decisions needed to be made. During our inspection we saw that a social worker called at the home to undertake an assessment in respect of DoLS. The registered provider ensured that they exchanged information with the assessor before they left the premises so that they were aware of the current position in relation to the person who had been assessed.

The home did not formally complete mental capacity assessments but did undertake a mental health assessment of its own before referring people to other agencies. Staff were not very familiar with the detail of the arrangements for DoLS but in most instances were able to identify which people were safeguarded and which were not and what this meant for their care.

We looked for evidence that people had consented to the care provided by the home. We did not find written consent by people on their care files. The registered provider told us that when a person was admitted they did not ask for formal consent. Some people were admitted where there had already been a decision made that they could not give such consent. Where there was doubt or concern about a person's capacity to consent an assessment was requested from the relevant agency such as the local authority depending on where the person lived.

We were told that because the capacity to consent needs to be considered in proportion to the gravity of the decision being taken, the home would limit itself only to those care tasks to which it felt the person could consent. Where appropriate advice and an assessment would be sought. We saw from a care file that in one instance a person had been admitted to the home and an assessment and standard authorisation under the DoLS requirement had been authorised within two days. This showed that the registered provider had a good grasp of the principles of the Mental Capacity Act 2005.

When we talked to staff they told us that they used the care plans to find out what people liked. They told us "We would rely on a person's body language and try to pick up body cues to make sure they consented". Another member of staff told us "The more you work with (people who live in the home) the more you get to see their personality and what they do or don't want". If a person refused something important such as personal care the staff told us "If a person gets upset then I would leave them, and go back and suggest it later" and "If (a person) refuses I would report it to the manager. But at the end of the day (people) have got a choice".

Is the service effective?

Consent does not always have to be given in writing for it to be valid. However we suggested that where possible the home obtained written consent to care from the person or their authorised representative perhaps when they first enter the home. We saw that the home had obtained such written consents for those people featured in the social media published on the internet by the home.

We saw evidence that best interest meetings were held when it was necessary to make a decision which affected someone who did not have the capacity to make this for themselves. Where appropriate the service had involved an Independent Mental Capacity Advocate.

Most people were complimentary about the choice and quality of the food in the home. They said "The food is fine in here" and "The food is alright here" and "I like the food here, there's a good choice and enough food for me". Others were more critical about the choice of food "The food here is alright, but it could be better, I think there should be more choice of food, but that's just my opinion". One relative said "My (relative) is used to having a snack meal at lunchtime and the main meal at night, the food I've seen looks good, but I have been bringing pies in the evening for (my relative) to eat as they are looking for more than just a sandwich".

We looked around the kitchen and talked with the cook. Breakfast was being prepared and we saw that there was a choice of cereals, porridge or toast with marmalade as well as tea, coffee or milk to drink. We looked at the menus and saw that a cooked breakfast was available on Saturdays. During the week there was cooked lunch as the main meal of the day with a choice of dishes available. In the evening we saw tea being served. Again this was a hot dish with sandwiches as an option.

We saw that the menu was rotated on a four-weekly basis so as to provide variation. The cook told us that the kitchen was left open at night so that anyone who wanted a snack could ask the staff to prepare it for them. We saw that fruit was readily available and that people were provided with drinks throughout the day. The kitchen had received the highest grade of hygiene rating.

We saw that people could choose to eat where they wanted either in the dining room or in their bedroom. One person told us "I enjoyed my lunch" whilst another told that the food was "all right". One person told us "I eat in my room, there's plenty of choice and the food is good".

We were present whilst lunch was served. Residents were served their lunch in various parts of the home, the majority in the two dining rooms and others in the lounges or their own room. Residents in the two dining rooms were divided between those that needed physical help or constant prompting to eat and those that were more independent. Residents were offered a choice of hot drink of tea or coffee or cold drinks of milk or fruit juice. However the tea was served from a large pot with the milk already mixed. This meant it could not be varied to taste. We raised this with the registered manager and operational manager who agreed to review this practice.

Residents were offered a choice of a main meal of either fish, chips and peas or egg chips and peas. All residents were offered a choice of cream or ice cream with a mince pie for desert. We saw that there was a menu displayed in the dining room and this was kept updated. There were no menus on the tables but we were told that this was because of a temporary difficulty relating to a specific person who was no longer living in the home. We saw that menu cards were being prepared for each individual table. These were attractively designed and included interesting facts about the dish being offered as well as a picture which would help some people to recognise the dish if they were unable to communicate verbally.

We saw that one person had special dietary needs which had been recommended by a speech and language therapist. We checked with the kitchen on two occasions and found that these requirements were known about and that appropriate arrangements had been made.

We saw that health and social care staff from community services visited the home. We spoke with a member of staff from the local authority who told us that they thought the home had a good grasp of requirements in relation to DoLS and made appropriate referrals to them regarding this. A nurse from the local NHS Trust told us that they thought that the home was good and involved them in the care of the people who lived in the home where this was required. One visiting professional told us "I think the staff are very caring and they do what we advise them to do." People were able to access various community medical services and receive care. We were told that people in the home did not generally require care for serious pressure sores.

People who lived in the home and their relatives reported that they were given access to medical help when required. One person told us "I had my hip done and they gave me

Is the service effective?

this set of wheels so I could get about, the physios helped me, now I can't do without it" and another said "I have my exercise plan that the physio gave me and I do my best to do it every day, I'll do some later after my dinner".

One relative told us "My relative has had visits from the doctor and trips to the hospital. They're not in as good a state as they were three months ago, but I've been impressed with how good the care is here". Another relative told us "(My relative) needs their flu jab sorting, which the home is doing now, but they have also arranged for (my relative) to see the optician to make sure they can see properly".

Is the service caring?

Our findings

The people all spoke of the good quality of care in the home. One person said "I'm happy here, I get on well with all the staff and they are very good to me" and another told us "I'm OK here, I like it here, they look after me properly".

People spoke well of the staff and how they were cared for. "The staff here are smashing, I get on well with all of them" and "The staff here are all good" and "The staff care for me very well". One person added "The staff here are excellent, I have no regrets about coming in here".

Their relatives were equally complimentary. "I am delighted with the care here, the staff are absolutely marvellous, their attitudes are very good". Another relative said "The care here is excellent, I've heard bad stories about these places (care homes) but this is good. What could you better this with? I don't think you could" and "The staff are very good here".

Staff demonstrated a good knowledge of the people who lived in the home and used this to inform the way they provided personal care. For example in the dining room at lunchtime staff helped people to their seats and the lunch service was calm and relaxed. There were frequent examples of staff reassuring people who were anxious or confused and escorting them back by the hand to their seats. Staff engaged with people in an informal, but respectful way. If people became agitated from time to time the staff reassured, pacified and calmed them by using an appropriate tone of voice and manner. There was one minor incident of conflict between people during the lunchtime observation which was handled calmly and efficiently by the staff in the dining room.

Staff gave examples of how they provided support for someone. This included allowing the person to undertake tasks for themselves such as those parts of personal care and hygiene they were able to whilst providing support for those areas they were not. One member of staff told us about a person who had lost their mobility. They realised that this person would have to use a wheelchair and a hoist and were concerned that the person would be frightened. They said that they realised that it was important that they explained things to the person. This was an example of how staff used their knowledge of the people who lived in the home to inform the care they provided.

Because staff knew people's likes, dislikes and preferences as well as their backgrounds this meant that they could chat and converse with people in a friendly manner. For example we saw that this meant that when two members of staff were supporting a person to walk down the corridor they were able to reassure the person by chatting to them. We heard staff engaging with people in languages other than English where both they and the staff shared some common cultural experience or background.

People were offered some choices throughout the day, such as of different menus at mealtimes. People told us they could get up and go to bed as they wished. They said "I'm short of nothing, I feel settled in here, I eat in my room mostly, there's plenty of choice and good food" and "I can do anything I want here, I'm as independent as I want to be". Another person told us "I have anxiety, and prefer to stay in my room, I can go out, but I prefer to stay here and watch my own TV" and another person said "I can stay in bed in the morning if I want to, but I tend to want to get up".

People told us about going out of the home accompanied either by relatives or staff. One person said "My family take me out, my daughter and my nephew both have cars and we go out sometimes" and another said "I get out to the hospital and the physio with my daughter, she takes me". One person told us "They are really good here; the owner took me to the doctors in his car".

Relatives spoke of being able to visit the home at any time. One said "I am able to visit whenever I like, they invite me to meals and they keep me informed about (my relative's) care" and another confirmed "I can visit when I like".

We asked people and their relatives if they knew about or were involved in care planning in the home. One relative told us they usually saw the care plan when their relative's social worker visited every two months". Another old us "I come for all the reviews" and a third said "They talk to me about my relative's care and keep me informed about what's going on,

However we did not find any evidence that the people who lived in the home or their representatives were routinely involved in reviews of care plans or were informed when they were updated and reviewed monthly. The registered provider told us that this was sometimes difficult because some people's families did not wish this level of involvement. The registered provider told us "If a person's family does not want involvement then we make that

Is the service caring?

person part of our family". The registered manager told us that she was considering introducing an email system so that information about care plan changes could be routinely sent to people's families or their representatives. We saw from the care files that some people in the home had access to advocacy services when required.

We saw that people could make choices in the home such as to where and how they spent their time. We were told that one person now preferred not to spend time in the lounge because it could be noisy. We saw that staff responded to people in a way that was caring. For example one person asked if he could go to his bedroom but needed to be shown where it was. A member of staff showed him the way and accompanied him, chatting pleasantly about what was on the television.

Relatives spoke highly of the care provided in the home. They told us "I've never had a problem with it, never found fault with it though the last six months have been up and down". A concern was expressed about the use of incontinence pads. One relative felt that these were only changed after the period they were supposed to last for rather than when they were actually wet. They told us that they thought that this meant that sometimes their relative smelt of urine and that the incontinence pads were not changed frequently enough". We brought this comment to the attention of the registered manager who agreed to look into it.

One person told us "I'm very happy here" whilst his relative described him as "a changed man". Another person told us that when they had arrived they had eaten very little but now they were beginning to eat more as they became more familiar with the place. Another person was asked by their visitor if they wanted to stay in the home and they replied "Yes – I would".

One member of staff had recently been provided with training in dignity arranged by the home with the local council. They had covered topics such as affording people choice over what to wear and the importance of responding to call bells promptly. They told us "It was a refresher and it opened my eyes".

There was no keyworker system in the home. A keyworker system means that each person has a designated member of staff who takes responsibility for them as an individual The manager told us that this was because she preferred all the staff to take responsibility for all of the people who lived there. We asked staff to tell us about how they care for people who lived in the home and how they made sure that they had the person's consent to any care they provided. They told us "Some residents don't communicate with you but you can tell whether they are happy or sad by their expressions". They gave examples of how they would support someone. This included allowing people to undertake tasks for themselves such as those parts of personal care and hygiene they were able to whilst providing support for those areas they could not manage independently.

We asked staff how they would respond if someone did not want to do something such as get up out of bed. They said "We would ask them". Another member of care staff said "We talk with (people) and tell them what we are doing so that we can be sure that they are happy with it."

We undertook a SOFI in the lounge of the home in the afternoon. We found that staff responded to people who were sitting watching the television helping them to prepare for the teatime meal which was about to be served in the dining room.

Is the service responsive?

Our findings

There are a number of ways in which the physical environment of a home could be adapted to better support and respond to people living with dementia. We saw that the home had recently had new lighting installed which we were told was significantly brighter than had been there previously. This could help people to find their way more easily by making things more easily identifiable.

We saw that the registered provider had installed memory boxes by each bedroom door. Memory boxes can be personalised with important pictures or objects from a person's life and this may provide memory stimulation and recognition of home. Some of these boxes contained familiar items but others still needed to be filled. Some people's bedrooms' doors were decorated in such a way as to distinguish them from one another. Not all the décor in the home would assist in distinguishing one area from another in this way. However on more than one occasion we heard staff reassuring and reminding people about where their bedroom was by describing where it was in the home. They repeated this and the door number so that the person could try and remember it whilst they helped them to go there.

The registered provider told us about a recent visit to a care exhibition and how she planned to introduce more opportunities for offer people tactile experiences, for example, with different surfaces they could touch. We saw that in some parts of the home decoration had been varied to help people to orient themselves although this did not extend to the corridors which were hard to distinguish from one another. The registered manager understood the part that environment played in providing a home for people living with dementia.

The home had a programme of weekly activities displayed on notice boards throughout the home but none of the published activities for the day of our inspection could be seen taking place. One resident commented that there should be more going on in the home to stimulate residents saying "I'd like to see more activities going on, otherwise I just doss about". Most people said they spent their day either in the lounges or their own rooms. One person said "I like watching the news and doing a few little jobs in my room" another said "I do get out sometimes, but mostly I spend my time in this lounge". A third person said "I'm short of nothing in my room so I like to stay in here".

We saw that some people were actively watching television in one lounge whilst other people used a second lounge which was brightly decorated and benefited from a very sunny aspect. Although there were no structured activities taking place during our inspection we saw photographic evidence of a number of activities which had taken place in recent weeks. These included carpet games, craft work, and chair-based activities such as Zumba fitness and Sonos which combined musical participation with other sensory influences such as smell. Relatives told us "I think they do a really good job" and "It's lovely. They have a lot of activities. Connect 4, tombola. There's always something going on".

The home used Facebook social media in order to encourage the involvement of relatives and friends. When we looked at this we saw it showed some of the recent activities held with people which included baking, entertainment and bringing small animals into the home for people to pet. The registered manager had recently gained the agreement of the registered provider to purchase two laptop computers which she planned to use to allow people to look up items of interest to them such as where they had lived and sports they used to play or watch. The registered manager was arranging to have sports television channels installed so that people could follow their favourite sports teams. We were told that there were plans to designate a member of staff as an activities coordinator.

Most people had few complaints about the home and the care they receive, but when they did have concerns they said the staff and managers in the home were approachable and keen to rectify any issues raised with them. One said "If I have any worries I would go to (the registered manager), I know she would sort things out for me". One relative said, "if I have any concerns I talk to (the registered manager). The home is very co-operative and handles things well". A third relative said "If I am worried about anything I talk to the staff and they sort it out".

Other people said they would contact their family or their social worker if they had concerns. However another person said "If I had any worries I would tell my daughter, who would contact the social worker, I don't know who to talk to here, I don't know who is in charge". Another relative told us "I don't really know how to make a complaint but I assume I would talk to the registered manager".

When we looked at the complaints file we saw that it contained two complaints by people who lived in the

Is the service responsive?

home. Although the complaints were not necessarily upheld there was a clear record that they had been taken seriously, had been promptly investigated, and a response offered to the complainant.

None of the people we spoke with could confirm that they had a care plan and did not recognise the term. Some said they could remember speaking to the senior staff or manager before they entered the home about what they could expect and how their needs would be met, but none had seen or been asked to sign their individual plan.

One person said "I was told what to expect before I came in here, and that has happened, but I can't remember talking about a care plan". Another said "I need help to get up in the morning and the staff help me with other things but I don't know that I have a care plan or key worker. I have an exercise plan from the physio after I broke my wrist, but that's all". A third person told us "I do some things for myself and when I need help I know I can rely on the staff, but I don't know I have a care plan".

We saw that there were two documents which documented care for a person. In the registered manager's office each person had a file which contained detailed information such as about mobility, skin integrity, mental health and medicines. People's weights were recorded monthly. We saw that the weighing equipment had been serviced within the last year.

We saw that on each care file these had been updated in the last month. A more substantive review was held when necessary and this might involve the person using the service and any relatives. We saw that the owner of the home had put audit arrangements in place to make sure that this was the case.

In addition a daily recording sheet was completed for each person living in the home. Only the initials of the person were entered on to the form in order to assist with confidentiality. At the end of each week the sheets for that week were collected together so as to form a weekly record which provided the registered manager with an overview of that person's care. Using the two documents together meant that it was possible to identify short and long-term trends in people's care and take any appropriate action.

However one member of staff told us "I never looked at the care plans. The seniors tell us about each person's needs. But you could go in and take a look at the care plans".

Is the service well-led?

Our findings

The company which owns Rosevilla Residential Home is family-run and during our inspection we saw directors of the company, all of whom are members of this family, working alongside staff and the registered manager in order to provide care to people in the home.

Of particular importance was the relationship between the operations director and the registered manager. Throughout our inspection we saw that they worked closely together. This meant that the registered manager was easily able to refer for advice where required. The family's active association with the home over 25 years provided the registered manager with a ready reference point in understanding how the home had developed and the ethos and values which the registered provider wished to promote.

We saw minutes of meetings which showed that the directors retained a close involvement in the home. Regular meetings had taken place at roughly six monthly intervals with additional meetings as required. Topics discussed included issues causing concern within the home and which required management action, repairs and recruitment. We saw that there were proposals to introduce an element of financial incentive into the pay arrangements for staff in the home which would reward attendance and reliability. This would also reward contribution to activities for people as well as the provision of person-centred care and person-centred record keeping. Person-centred practices are designed to make sure that the person's viewpoint is considered first rather than the needs of the service.

We saw several instances where the registered manager had used an analysis of recent events to influence practice in the home. For example in one instance, the way that a person had been discharged had given rise to a complaint. The home had changed its procedures to ensure that the matters complained about did not happen again. We saw that the manager had responded to medicines errors by making a number of changes to the way that medicines were administered. These included introducing new paperwork around the administration of antibiotics and a colour coded system to reduce these errors. On a third occasion an analysis of a person's falls had led the registered manager to review all aspects of the person's care to find the cause and found that their spectacles needed changing to allow the person to judge distances better.

We saw that there were a number of audits including of care plans, staffing, medicines, and cleaning. An administrator used a computer package which they had tailored to the requirements of the home. This produced a monthly report of items audited and actions required.

Staff told us that they found the management of the home approachable. One member of staff said "If we've got any worries we just go and speak to the manager". Staff told us they liked working at the home and said "I like talking to the people who live here. My favourite bit is knowing they are happy". Staff told us that they were able to negotiate working flexible hours if they needed to because of family or other commitments. We saw two staff surveys from earlier in the year. The most recent of these was dated August 2014 where staff had rated the experience of working at the home as "satisfied" or "very satisfied". Although the return rate to the staff surveys was low we saw evidence that the registered manager had responded to the suggestions made such as by introducing a new format for staff supervision.

Staff confirmed that they received supervision. We saw that there was a supervision policy for the home and that this provided for supervision every six months as well as appraisal once a year. The registered manager told us that she was also planning to introduce spot checks and had taken a turn on the night shift to see how care was delivered at this time. We saw from the diary of hours worked that the registered manager often worked in the home for extended periods of time outside of office hours.

During our inspection we saw that the registered manager had provided staff with copies of the home's safeguarding policy and information about Deprivation of Liberty Safeguards. She expected staff to familiarise themselves with the contents prior to the next supervision session when she would check their knowledge and understanding of these policies with them. We saw from documentation that the approach to supervision was intended to be reflective allowing staff to record their responses to different situations they encountered. The registered manager used supervision to emphasise and reinforce the values she wished to promote including providing care which was centred around each individual person.

Is the service well-led?

However the home did not have a systematic way of collectively engaging the residents in the running of the home. None of the residents said they thought they could influence the way the home was run, except for the sorting out of their own individual concerns and worries.

This was also the case for the two relatives who were interviewed. One had been visiting the home for five years and although they considered themself to be a familiar face in the home, could not recall being invited to comment on the overall running of the home or asked for ideas about how things could be improved in general. The home did not appear to have a residents or relatives committee as a means of exploring these issues

We saw that there had been minutes of family forums for the relatives of people who lived in the home but the last of these was dated February 2014. One relative told us "There was a stage when they had meetings but I don't think many people came". The registered manager told us that she had discontinued holding family forums for relatives since never more than three people had attended. Instead she preferred to try and involve relatives in particular events organised by the home such as a recent charity fund raising event. These events could be used to engage with relatives about issues related to the running of the home.

The registered manager told us that she was introducing quarterly surveys and discharge surveys. Of the three discharge surveys already received all had scored the home at the maximum. We saw that there were a number of audits including of care plans, staffing, medicines, and cleaning. An administrator used a computer package which they had tailored to the requirements of the home. This produced a monthly report of items audited and actions required.

We looked at formal complaints logged in the home over the last three months. We saw that there had been three formal complaints. They had all been dealt with promptly and an explanation of how they had been resolved retained. Compliments were also logged and outweighed the number of complaints.

The home subscribed to an online service which provided sets of policies and procedures which had been tailored so as to be relevant to the home's specific requirements. The home had organised these in files which staff could access alongside the care plans. They were organised in way so as to follow the Care Quality Commission's former method of inspection. We did not think that this made key policies such as safeguarding, whistleblowing and in relation to the Mental Capacity Act 2005 readily available to staff. The registered manager decided to make these key policies available to staff in a box file in the office and to bring their attention to them in staff supervision.

We reviewed our history of notifications from the home to the Care Quality Commission and compared these to concerns the home had registered with the local authority. We were aware that there had been a number of incidents when we might have expected to be informed of incidents in the home but we had not been. We clarified the criteria for such notifications with the manager who undertook to implement this immediately.

We looked at the maintenance records for the home. We were provided with a comprehensive set of certificates showing that the required inspection such as of hoists, fire electrical and gas installations by external agencies had been completed. We also a comprehensive system for making sure that internal checks of the building were undertaken and that repairs were logged and carried out.