HC-One Limited

Rosebridge Court

Inspection report

191 Darby Lane
Hindley
Wigan
Greater Manchester
WN2 3DU

Tel: 01942526240
Website: www.hc-one.co.uk/homes/rosebridge/

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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

Summary of findings

Overall summary

We carried out an unannounced inspection of Rosebridge Court on 22 and 23 September 2016.

The home was last inspected on 30 July 2014, when we found the service to be compliant with all the regulations we assessed at that time.
Rosebridge Court is a modern purpose built care home which provides support for up to 46 people that require either; residential care, general nursing, dementia nursing or have a mental health diagnosis. At the time of the inspection there were 45 people living at Rosebridge Court.

The home is divided into two separate units, each one catering for a specific client group. Allendale unit on the ground floor largely provides support to people requiring mental health care, whilst the Darby unit on the first floor, caters for people requiring residential or nursing dementia care. Both units have spacious lounge areas, separate dining rooms and an activity room. They have a range of well-equipped bedrooms, including some with assistive technology; all are en-suite with views across the garden.

At the time of the inspection the home had a 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.'

We saw that the home was clean and had appropriate infection control processes in place. Daily, weekly and periodic cleaning schedules were in place and up to date. A 'cleaning specification' document was used to record the task, equipment and cleaning material required, any hazards associated with the task, what PPE was required and the method of cleaning.

All the people we spoke to told us they felt safe. Relatives expressed no concerns about the safety of their family members and were complementary about the level of care provided. The home had appropriate safeguarding policies and procedures in place, with detailed instructions on how to report any safeguarding concerns to the local authority. Staff were all trained in safeguarding vulnerable adults and had a good knowledge of how to identify and report any safeguarding or whistleblowing concerns.

Both the registered manager and staff we spoke to demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. 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. We found that the provider had followed the requirements in the DoLS and related assessments and decisions had been appropriately taken.

We saw medicines were stored, handled and administered safely and effectively. All necessary documentation was in place and was completed consistently. Staff responsible for administering medicines

were trained and had their competency assessed annually.

Staff spoke positively about the training available. We saw all the staff had completed a comprehensive induction programme and on-going training was provided to ensure skills and knowledge were up to date.

Staff confirmed they received regular supervision and annual appraisals, which along with the completion of monthly team meetings, meant they were supported in their roles.

Meal times were observed to be a positive experience, with people being supported to eat where they chose. Staff engaged in conversation with people and encouraged them throughout the meal. We saw drinks were available in all communal areas throughout the home and people were supported and encouraged to drink on a regular basis, with detailed fluid monitoring in place.

Throughout the inspection we observed positive and appropriate interactions between the staff and people who used the service. Staff were seen to be caring and treated people with kindness, dignity and respect. Both people who used the service and their relatives were complimentary about the attitudes of the staff and the standard of care received.

We looked at six care files which contained detailed information about the people who used the service and how they wished to be cared for. Each file contained detailed care plans and risk assessments, which helped ensure their needs were being met and their safety maintained.

The home had two activity rooms and employed two activity co-ordinators. Everyone we spoke to was positive about the variety and frequency of activities available. We saw the activity schedule catered for all interests and abilities and group activities and individual outings were encouraged and supported.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were completed on a daily and monthly basis and covered a wide range of areas including medication, care files, infection control, health needs and the overall provision of care. We saw evidence of action plans being implemented to address any issues found.

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.

Staffing levels were appropriate to meet people's needs.

People we spoke with told us they felt safe living at Rosebridge Court.

Staff were trained in safeguarding procedures and knew how to report concerns.

Medicines were stored, handled and administered safely by trained staff that had their competency assessed regularly.

Is the service effective?

Good

The service was effective.

Staff reported that sufficient and regular training was provided to enable them to carry out their roles successfully.

All staff spoken to had knowledge of the Mental Capacity Act (MCA 2015) and Deprivation of Liberty Safeguards (DoLS) and the application of these was evidenced in the care plans.

The dining experience was positive and we saw that nutritional needs were being assessed with appropriate care plans in place.

Referrals were made to medical and other professionals to ensure individual needs were being met.

Is the service caring?

Good

The service was caring.

Both people living at the home and their relatives were positive about the care and support provided.

Throughout the inspection we observed positive interactions between staff and people. Staff members were friendly, kind and respectful and took their time to listen to what people had to say.

People were able to make choices about their day such as when to get up and how to spend their time. Staff understood the importance of promoting people's independence.

Is the service responsive?

Good

The service was responsive.

Assessments of people's needs were completed and care plans provided staff with the necessary information to help them support people in a person centred way.

Care plans and other records were regularly reviewed and signed off, with involvement from the person themselves, their family or other representative.

The home had a comprehensive activities programme in place, supported by the two co-ordinators they employed. Everyone we spoke with was positive about what activities and outings were available.

Is the service well-led?

Good

The service was well-led.

Audits and monitoring tools were in place and used regularly to assess the quality of the service, with action points generated and details of progress clearly documented.

Both the people living at the home and staff working there said the home was well-led and managed and that they felt supported by management.

Team meetings were held regularly to ensure that all the staff had input into the running of the home and were made aware of all necessary information.

Rosebridge Court

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 22 and 23 September 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors from the Care Quality Commission (CQC).

Before commencing the inspection we looked at any information we held about the service. This included any notifications that had been received, any complaints, whistleblowing or safeguarding information sent to CQC and the local authority. We also spoke to the quality assurance and teams at Wigan Council.

Before the inspection, the provider completed a Provider Information Return (PIR). 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.

During the course of the inspection we spoke to the registered manager, assistant operations director, five staff members and a trainee nurse. We also spoke to four people who lived at the home and three visiting relatives.

We looked around the home and viewed a variety of documentation and records. This included six staff files, six care plans, eight Medication Administration Record (MAR) charts, policies and procedures and audit documentation.

Good

Is the service safe?

Our findings

We asked people who used the service if they felt safe living at Rosebridge Court. The four people we spoke with told us they did, and one person said, "Yes, I have been here many years, I do feel safe." Another said, "Yes, I do." We asked relatives visiting the home for their opinion, one told us, "It's got better, it didn't always have a gate across the doorway. I asked for one to stop other people who live here from being able to wander in and out and this was put in place." Another said, "Yes [my relative] is safe, the staff are very good."

We looked at the home's safeguarding systems and procedures. The home had a dedicated safeguarding file which contained detailed reporting criteria along with copies of all necessary documentation. This ensured that anyone needing to report a safeguarding concern could do so successfully. We noted that a log of any referrals made had been kept, along with a list of action points, explanations and dates of when these had been completed.

We spoke to five staff about safeguarding adults. Each member of staff confirmed they had received training in this area and that this was refreshed every six months. The staff all demonstrated a good knowledge of what to look out for and how they would report concerns. One staff member told us, "Yes, I have done training in this; it is refreshed every six months." Another said, "I would go to [registered manager] or [deputy operations director] if I had any concerns." Staff also confirmed they had received training in whistleblowing and knew how to report any concerns. One told us, "I've done whistleblowing training and know the procedure. I would report to my line manager or go higher if needed."

We looked at six staff files to check if safe recruitment procedures were in place and saw evidence that Disclosure and Baring Service (DBS) check information had been sought for all staff, although this was kept in a separate file. We noted that staff also had at least two references on file as well as a full work or educational history.

Upon arrival at the home, we completed a walk round of the building to look at the systems in place to ensure safe infection control practices were maintained. The premises were clean throughout and free from any offensive odours. We saw bathrooms and toilets had been fitted with aids and adaptations to assist people with limited mobility and liquid soap and paper towels were available. The bathrooms were well kept and surfaces were clean and clutter free. Cleaning products were stored safely and Control of Substances Hazardous to Health (COSHH) forms were in place for all the cleaning products in use.

The home completed dependency assessments for all the people who used the service, but did not incorporate this information into a dependency screening tool to determine the number of staff needed to meet people's needs. We asked the registered manager about staffing levels and were told that between 8am and 8pm the ground floor ran with five staff, consisting of two nurses and three carers on weekdays and one nurse and four carers at weekends, when less appointments and more social activities occurred. The first floor ran with six staff, consisting of one nurse and five carers. On nights the home ran with six staff in total with one nurse and two carers on each floor and there was an additional staff member for each floor that worked 8pm – 11pm, to assist with evening routines.

We asked staff for their views on staffing levels at the home and their ability to meet people's needs timely. One told us, "Yes, there's enough staff to meet people's needs, there's always five on this floor if not more." Another said, "Staffing levels are alright. We can meet people's needs." Whilst a third said, "We've more than enough, staffing levels are very good here."

We were unable to check alarm call system data, as the current system in place did not produce this information. However we asked staff how long people had to wait for assistance. One told us, "A couple of minutes at most, but pretty much straight away." Another said, "A minute or two if not straight away." From observations over both days, we noted that staff's response to call bells was prompt.

We looked at how accidents and incidents were managed at the home. Accidents and incidents were recorded correctly and historical records were held in an accidents/incidents file, which included guidance on incidents that need to be reported under the Duty of Candour. Audits were completed each month and each incident had an 'investigation outcome' template which identified the details of the incident, if it constituted a Safeguarding concern, how and why the incident happened, and what action had been taken to prevent re-occurrence. For example one person had fallen unwitnessed in their bedroom and the service had placed the person on regular checks throughout the day and night, introduced a profiling bed, an alarmed pressure mat and made a referral to the falls team.

We looked at medicines management within the home. Each person had a Medicine Administration Record (MAR) chart in place, which included their date of birth, date of admission, room number, GP details, detailed allergies and potential difficulties in taking their medicines. The chart also detailed how and where people would like to take their medicines for instance; in their room with a glass of water.

We viewed eight M.A.R charts during the inspection and saw that all prescribed medication had been administered and signed off correctly, with a running balance documented for each medicine. We saw a specimen signature chart was in place and this tallied with the staff signatures on the MAR charts. We completed stock checks of ten people's medicines including two people who were prescribed a controlled drug. All medicines we checked had the correct amount remaining, indicating that all medicines had been administered correctly.

The home had when required medicines (PRN) protocols in place. These explained what the medicine was, the required dose and how often this could be administered, time needed between doses, when the medicine was needed, what it was needed for, if the person was able to tell staff they needed it and if not what signs staff needed to look for along with any potential side effects. This ensured 'as required' medicines were being administered safely and appropriately.

We checked the controlled drug (CD) cupboard and saw this was locked with the key stored separately. We checked the stock levels of two people's medicines in the CD cupboard and saw that these tallied with the CD register. We also noted that all entries were supported by two staff signatures as is required.

Records indicated that one person was sometimes given their medicine covertly. We saw that guidelines were in place of when to do this, these indicated that if the person was asked and refused twice, medicines should be given covertly. Before commencing the covert medicines programme, a best interest meeting had been held involving the person's GP, their relative and nursing staff to discuss this. We saw the best interest assessment continued to be reviewed monthly.

The home had detailed, current medicines policies and procedures in place. We saw that all the staff authorised to give medicines had completed training in this area and had their competency assessed, every

12 months.

Good

Is the service effective?

Our findings

We asked people living at the home for their views on the food. One person told us, "It's very nice." Another said, "The food is good here." We asked relatives for their opinions, one told us, "The food is very good, they have a good selection each day." Another stated, "My [relative] has a pureed diet, they always make it look like what it should be, for example when having a roast dinner you can tell it's meat, potatoes and vegetables, with them all being displayed separately."

We were told that the home used the 'dignity in dining' model and the meal time experience was monitored to ensure tables had been set properly, people were greeted appropriately and supported to sit at the table of their choice, people were offered a cold and/or hot drink. The process also looked at presentation of food, support requested and provided and the promotion of conversation. We saw staff were mindful of each of these areas during meal times and were clearly aware of their roles, ensuring that everyone was served in a timely manner and dishes were emptied and removed promptly. We also noted that people were able to attend breakfast at a time of their choosing, some were seated and eating at 8.40am, whilst others arrived at 9.30am.

The daily menu was displayed outside the dining room. Breakfast was cereals, porridge, yoghurt, toast and preserves. A hot breakfast was also available on request. We saw two main choices were available along with a dessert and 'cake of the day' at lunch and dinner. An allergen awareness chart was also displayed.

We looked at how the home managed people's nutrition and hydration needs. Special diets were catered for, food allergies were documented and people's nutritional needs were assessed with nutrition and hydration care plans in place. Throughout the day water and ready mixed cordial was made available in the dining rooms, lounges and activity rooms and regularly refreshed. We saw that 'dignity teacups' were used in people's rooms as a prompt to staff that the person's fluids were to be monitored. We checked four people's fluid charts over four days in the last month and saw that daily recommended intakes had been documented along with each type of drink they had consumed, the volume of fluid consumed and any elimination information. Whilst not everyone had reached their recommended daily intake, we saw evidence they had been frequently offered a drink and had consumed between six and eight drinks per day.

We looked at the homes staff training documentation which was stored electronically. Each staff member had an individual record detailing what training sessions had been completed, the date of completion and expiry. The computer system also identified which staff were due to attend training sessions and these were then scheduled. We saw each staff member had completed a comprehensive induction programme, which included sessions on moving and handling, safeguarding, dementia care, infection control, nutrition and hydration and equality and diversity. The home also provided what they termed 'MAPA' training, which dealt with the presentation and management of challenging behaviours. Records indicated that so far this year, 89% of staff had successfully completed their required refresher training sessions, with the remaining11% booked on upcoming sessions.

We asked staff for their opinions on the training provided. One told us, "We do loads of training on 'touch',

and we get our competency assessed every year." Another said, "We do different training on 'touch', if you want to do anything training wise, you just need to ask and they will put you on it." We saw that seven people who worked on the Darby unit, had been put forward and completed additional dementia training, which included a two day course entitled 'dementia capable care'. One staff told us, "I have done loads of dementia training, such as 'yesterday, today, tomorrow'."

We also saw evidence that the Care Certificate was in place at the home. The Care Certificate was officially launched in March 2015 and employers are expected to implement the Care Certificate for all applicable new starters from April 2015. We noted that the care certificate had been incorporated into the home's induction training programme and all staff that had commenced employment after April 2015 had completed this.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of providing this. We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff confirmed they had received training and had an understanding of both. One told us, "Yes, I know all about capacity." Another said, "Most people downstairs are under DoLS, all information about this is in the care files." A third told us, "If someone hasn't got capacity, it's about making choices for them in their best interest."

At the time of the inspection, 17 people had a DoLS in place with a further 26 people awaiting assessment following submission of the necessary documentation. We saw that the registered manager completed a tracking document, which detailed when each application had been submitted, if and when it had been granted, date for review and date for renewal. We saw evidence that action had been taken to chase up outstanding applications, and that all renewal times had been met.

Within people's care files we saw that any potential restrictions had been dealt with as per the MCA, with best interest meetings held and the least restrictive intervention being utilised. All best interest decisions were reviewed regularly. An example of this was that several people had wooden gates across their door way. This allowed their bedroom door to be left open, as per their wishes but restricted access to other people who used the service.

The staff we spoke with said they received regular supervision from their line manager. One told us, "We have supervision regularly." Whilst another said, "We have supervision every three months." Two staff members also told us that appraisals were "done yearly". We viewed staff supervision and appraisal documentation. We saw that the home had a supervision log in place which was monitored electronically and alerted management of any staff that were overdue. We saw that all but five staff had completed a supervision within the last three months. Those staff that had yet to complete a supervision this period had done so between April and June 2016. We saw that appraisals were carried out every 12 months, with the process being staggered to ensure this could be facilitated.

We looked at how the home sought consent from people. Each care plan contained consent forms, which had been signed by either the person themselves or their representative. During the course of the inspection we observed staff knocking on people's doors and waiting for a response before entering, staff asked people if they wished to take their medication and would they like to participate in the activities on offer. Three of the people we spoke with all told us that staff reliably sought their consent before providing any care.

We saw the service worked closely with other professionals and agencies to meet people's health needs.

Involvement with these services was recorded in people's files and included podiatrists, opticians, general practitioners (GP) and speech and language therapists (SALT).

Good

Is the service caring?

Our findings

The people we spoke with told us they liked the staff and found them to be caring. One told us, "Yes, they are caring." Another said, "Yes, they are all very nice." We asked relatives for their opinions. One told us, "The staff are so friendly and caring." Another said, "Staff are always very nice to me and [relative], never met any as friendly or caring and I have worked in care." A third said, "If I ask them anything, they fall over themselves to help out or find the answer if they don't know."

We asked people who lived at the home if staff treated them with dignity and respect. All confirmed that staff did so, with one telling us, "Yes, all the time". Another told us, "Yes, they do and they will chat to me about things that I like." Relatives we spoke with were also positive in their feedback, one said, "Yes, they definitely treat [relative] with dignity, if they are unsure of anything they always ask me." A third said, "Yes, no problems at all with this. [Relative] always liked to wear tights; the staff respect this and ensure that they do when possible."

The home had a dignity champion. A dignity champion is a designated person who is passionate about maintaining people's human rights; person centred care and provides support to the team to achieve this. The homes champion had their name and picture, along with information about the different ways to maintain dignity, displayed prominently in the home.

We asked staff how well they knew the people they cared for and how they knew what they wanted. One told us, "Talk to them, ask them what they would like." Another said, "They tell you during their one to one time, plus through general conversation with people." A third told us, "We have a card communication system, which consists of words and pictures; this allows people who can't speak to show us their needs and what they would like."

Over the course of the inspection we spent time observing the care provided in all areas of the home. We saw staff interaction with people was warm and friendly. For example one staff member was observed to kneel down so that they were at eye level with one person and said, "Hello my lovely, you're looking beautiful today" to which the person responded positively.

Upon entering a person's bedroom a staff member said, "Morning, have you had a nice sleep? What do you want to wear today [person's name]? Do you want a jumper on or a t-shirt or what about a shirt and a jumper?"

We saw evidence of appropriate physical contact used as a means of reassurance. On one occasion we saw a person sat in the dining room who was distressed. A staff member squatted down at the side of them, took the person's hand and discreetly asked them what they could do to help. The person noticeably calmed as a result of the staff's intervention.

During the inspection one person who used a wheelchair told us they were bored. We spoke with staff about this and as a result a nurse approached the person and engaged in a extended and quiet conversation

about what they wanted to do and where they wanted to go. When this was established the nurse said, "Okay [name] you put your feet on here (guiding their feet to the wheelchair footplates) and took the person to their place of choice.

The staff we spoke with displayed an awareness and understanding of how to promote people's independence. One said, "Give people the choice, let them do what they can." Another told us, "Ask, offer choice such as physically show people two meals plated up or lift out two or more items of clothing and encourage them to decide." On one occasion we witnessed a person mobilising with the use of a rollator. A staff member walked alongside the person providing encouragement and validation throughout. Even when the person became unsteady, the staff member did not offer undue assistance, they asked if the person wanted to stop for a moment, ensured the person was safe and asked them to say when they were ready to continue.

At the time of the inspection no person using the service was in receipt of end of life care, however the staff members we spoke with told us they had all received training in this area. We saw that where they had been open to discussing this, people's care files contained end of life care plans, which documented people's wishes when they were at this stage of their life. Where people had made an advanced decision regarding end of life care this was recorded correctly, dated and signed appropriately. Staff told us they involved families and other necessary parties when developing end of life care plans or carrying out assessments.

Good

Is the service responsive?

Our findings

We saw that people received care that was personalised and responsive to their individual needs and preferences. Prior to any new admission a pre-assessment was carried out with the person and their relative(s). People's support needs and wishes were described on their care plans so that staff knew exactly what tasks to undertake and how to go about doing so.

Each care file we viewed contained a detailed individual profile. This had been written by or in collaboration with the person themselves and/or a family member. The profile contained information relating to what other people liked and admired about the person, important things in their life, what they liked to do during the day and what their personal care needs and wishes were. Each care file also contained a social and psychological care assessment. This was a comprehensive document which covered a number of areas including the person's family history, any religious or cultural considerations, special details such as important dates, birthdays and memories, their likes and dislikes, fears or apprehensions along with their social interests. This meant staff had information to ensure people's care was personalised.

People we spoke with could not remember whether they had been involved in planning their care. However one relative told us, "I have seen it [care plan], though not for a while but as either me or my sister visit daily, they tend to discuss things with us on an on-going basis." Another said, "We have regular meetings and go through the care plan, I have been involved from the start."

We saw records of family and advocate involvement in both initial care planning and reviews of care plans, with reviews taking place every six months or sooner if any issues of note or major changes had arisen. Additionally staff members reviewed each person's care plan on a monthly basis, documenting if any changes or amendments had occurred.

We asked staff how they knew what was important to the people they cared for. One told us, "It is documented in the care plans, plus we talk to people and ask them." Another said, "This information is in the care files, but I will also ask the person themselves or their family." Staff also confirmed that they had regular access to care files, to ensure they knew each person's needs and kept updated on any changes. One said, "I have access to these, I read them whenever possible at night during my shift." Another told us, "We are encouraged to read a file and keep up to date, whenever we are just sat in the lounge observing."

We observed daily care charts being completed. These covered a range of areas including showering or bathing, body washes, oral hygiene, pressure care, fluids and nutrition. We looked at records for the last seven days and noted that they had been completed consistently. We compared three people's bathing preferences, as detailed in their care files, and saw that their wishes had been adhered to.

Whilst reading the six care files we came across a number of occasions when the service had been responsive to people's needs. In one instance, after noticing that a person had lost two kilogrammes over a six week period, the home arranged a SALT assessment, completed a review of the person's medication with the GP and upon advice made a referral for a gastroscopy. In another instance where a person had lost three

kilogrammes, the home sought involvement from their GP, reviewed medication and requested that the kitchen develop higher calorie snacks and smoothies, which were being offered to this person.

During the inspection we observed staff members being responsive to people's needs. On one occasion a person approached a staff member, who was encouraging people to take part in the morning activity, and said that they fancied having a shower, rather than taking part. The nurse in charge immediately made some changes to the rota in order to facilitate this. On another occasion, a person approached a staff member and said they fancied a walk to the shop and would they support them to do so. Within two minutes, arrangements had been made and the person left for the shop.

During the course of the inspection we observed a range of different activities being carried out. These included scarecrow making for the upcoming Autumn festival, an outing to the local café and a game of bingo. People we spoke with were positive about the activities on offer. One told us, "I do bingo, go on outings, go to the pub for lunch, loads of stuff." Another said, "There is plenty to do here." Relatives were equally complimentary, one told us, "I think it's very good. They have outings all over the place, aquariums, SeaWorld, Rivington. They do lots in here as well." Another said, "There's always something going on, they always try and involve [person]."

The home had an activity room on each floor containing art and craft materials, music, games and puzzles. The upstairs activity room was called the 'memory lane café' and contained a piano and a number of remembrance items as well as being decorated in a 'seaside' theme.

The activities available were displayed throughout the home on notice boards and included knitting, active games, tea and chat, sing-along, group and individual outings, board games, music, worship and holistic therapies. Group activities for the week included gardening club, mystery tour, name that tune, arts and crafts and a coffee morning. The home also had a number of leaflets and other information on display relating to potential outings or artists who could visit the home, with a request for people to record their suggestions.

We looked at how complaints were handled. The home had a complaints file, which included the policy and procedure for dealing with these, however no written complaints had been received. We were told that as well as operating an open door policy, the registered manager held formal 'managers surgeries' each week, with minutes taken of any issues raised. We saw that at a meeting on 16 August 2016 a family had raised a concern about their relatives bedding being placed on someone else's bed. This had resulted in a discussion about the introduction of an alternative labelling system that was due to be discussed at the next relatives meeting.

Dates for relatives meeting had been identified for the year ahead and the next meeting was scheduled for 22 September. Minutes of meetings were made available to people and their families and a list of attendees at each meeting was kept. Due to recent attendance issues, the registered manager had recently introduced a confirmation slip on the invite, which they hoped would help increase numbers.

The home displayed thank you cards and letters as well as logging compliments received electronically. We saw that positive feedback received included: 'I am very pleased with the cleanliness, food, activities, but most of all the carers; nothing is too much trouble for them. The managers are respectful and answer all my questions.' 'This is a very welcome and friendly home that you feel part of'. 'When I visit [person] all the staff are very friendly... all of the family can see how well she is being looked after and would recommend here to anyone'. 'We are so pleased we found Rosebridge Court for her. Always a good atmosphere and smiling faces.'

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, they are Registered Persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home had a clear management structure in place, with each floor being overseen by the nurse in charge and the registered manager having overall responsibility for the home. The registered manager told us that an assistant manager had been employed earlier in the year, however this person had not successfully completed their probationary period and the home had yet to recruit anyone else. The assistant operations director was present in the home during both days of the inspection; staff we spoke with told us that they were a regular presence in the home, offering support to the registered manager and other staff.

The staff we spoke with felt that the home was well-led and managed and they felt supported. One told us, "They have really supported me with family issues, been flexible with my shifts so that I could continue working here." Another said, "[Registered Manager] is very good, she is really supportive." A third added, "[Nurse] upstairs is very supportive, everyone here is to be honest."
Relatives spoken to also provided positive feedback, one told us, "I know [registered manager], she is very approachable. Always has an open door and happy to speak to you whenever."

Staff told us they enjoyed their jobs and there was a positive culture within the home. Comments included, "I love my job…the atmosphere here is very good." "Love working here…we all get along and are good workers." "There's a good atmosphere throughout the home."

We saw that team meetings were completed on a regular basis. Minutes were taken and action plans generated. Staff told us theywere able to contribute to the meetings and discuss things pertinent to them. One said, "Staff meetings are every month or so, we can bring things up if we want to." Another said, "Meetings on this floor are every month, although we sometimes meet in between if there are any issues we need to discuss." We looked at a selection of meeting minutes and saw that topics raised included provision of care, training, the inspection process and infection control.

The home's policies and procedures were stored electronically and included key policies on medicines, safeguarding, MCA, DoLS, moving and handling and dementia care. Policies were updated at provider level; this meant that the most up to date copy were always available. Staff were made aware of key policies through induction training and the staff handbook.

We saw systems in place to monitor the quality of the service. The registered manager completed daily 'walk rounds' which allowed them to observe the provision of care. Each 'walk round' was documented and looked at a number of areas including infection control, environmental health and safety, dining experience and overall care practices. Action points were generated then signed and dated upon completion. The registered manager also completed monthly out of hours and weekend checks, to ensure they monitored all

aspects of the service.

Home visits were completed each month by either the assistant operations director or a registered manager from another HC-One home. During the visits a full audit of the home and the care provided was completed. This included reviewing a random selection of care files, people's MAR charts and medication, management of people's health needs and the environment, including infection control and health and safety. Areas which needed to be addressed were highlighted and an action plan generated, with the registered manager providing feedback on progress. We looked at the reports from June and July this year and saw that all issues identified had been actioned, signed and dated as completed.

The home also completed a self-assessment tool, which was based around the CQC's five 'key questions'. This allowed the home to monitor whether it was meeting the required standards and document how this could be evidenced.

We saw that the home completed a number of other monthly audits in areas such as catering and kitchen management and care planning. Again action points and a section for reporting on progress were included on the documentation. Through comparing action points from the care plan audit in August to two people's care files, we were able to evidence that these had been followed through.

We found accidents; incidents and safeguarding had been appropriately reported as required. We saw the registered manager ensured statutory notifications had been completed and sent to CQC in accordance with legal requirements and copies of all notifications submitted were kept on file.

We saw community links had been made with a local nursing college. A student nurse was on placement at the home during the inspection. They told us that they had thoroughly enjoyed the experience and had received lots of support, so much so that they had applied for a bank position, so that they could remain involved with the home whilst they continued their studies. We also saw that a friends and family network meeting had been held earlier in the year, which was attended by the local authority and CQC.