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Rosedale Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Rosedale Care Home is a residential care home registered for up to 18 people with a range of physical and mental health needs, including people living with dementia. At the time of our inspection, the home was fully occupied. Accommodation is provided over three floors and two rooms have en-suite facilities. Four rooms are of shared occupancy. Communal areas include a large sitting room, small sitting room, dining room and a small dining area at the end of the kitchen; people have access to gardens at the rear of the home.

At the last inspection the service was rated Good.

Medicines were not always managed safely and we found areas of concern in relation to the handwritten Medication Administration Records (MAR), some medicines which were out of date but not disposed of, the temperature of the room where medicines were stored and the administration of medicines. We discussed these issues with the registered manager. By the second day, the registered manager had begun to take steps to address our concerns.

A system of audits was in place to measure and monitor the service delivered. However, these audits were not effective in identifying the areas of concern we found at inspection. Care records were not kept securely at the time of our inspection. This was raised with the registered manager during the inspection, who arranged for locks to be installed on the drawers before we returned for our second day, thus keeping people's personal information confidentially.

Staff were protected from avoidable harm by staff who had been trained in safeguarding adults at risk. People felt safe living at the home and their risks were identified, assessed and managed in a way to mitigate risks. Staffing levels were sufficient to meet people's needs. Staff had been recruited safely. Premises were cleaned to an acceptable standard.

Staff completed a range of training to enable them to have the skills and knowledge required to care for people in an effective way. Staff received regular supervision with their line managers and attended staff meetings. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were happy with the food on offer at the home and had a choice of what they would like to eat. Healthcare professionals supported people to maintain good health. We identified some issues in relation to the bathing facilities and general upkeep of the home. After the inspection, the registered manager informed us of actions that would be taken to address these.

Staff were warm, kind and caring with people. People spoke highly of the caring nature of the staff. They were involved in decisions relating to their care, as were their relatives. People were treated with dignity and respect. The home had achieved Platinum status for the Gold Standards Framework in relation to their end of life care.

Care plans contained detailed, personalised information about people and how they wished to be supported by staff. People and their relatives were involved in reviewing their care plans. An activities co-ordinator arranged activities for people which were individual and reflected people's preferences. People were happy with the activities on offer. The provider had a complaints policy in place. No formal complaints had been recorded since October 2015.

People and their relatives spoke positively about the care provided at the home and held the registered manager and staff in high regard. Feedback was obtained from people and their relatives about the quality of care provided and the home overall. Staff felt supported by management and enjoyed working at the home. The registered manager worked in partnership with other agencies.

You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were unsafe.

Medicines were not managed safely.

Recruitment systems were in place.

People were protected from the risk of harm by staff who had been trained in safeguarding adults at risk.

People's risks were identified, assessed and managed appropriately.

Staffing levels were sufficient to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff had completed a range of training to support people; they were encouraged to study for additional qualifications. Regular supervision and staff meetings took place.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

Menus provided people with a choice of what they wanted to eat. People were encouraged to life a healthy lifestyle and were supported by a range of healthcare professionals and services.

Some parts of the environment were due to be refurbished. Following the inspection, the registered manager had improved the bathing facilities.

Is the service caring?

Good

The service was caring.

People were looked after by kind and caring staff who knew them well.

As much as they were able, people were involved in decisions relating to their care, as were their relatives.

People were treated with dignity and respect.

The service had achieved platinum status in the Gold Standards Framework for end of life care.

Is the service responsive?

Good

The service was responsive.

People's care plans provided staff with detailed information about people and they support they required.

A range of activities was on offer to people living at the home and an activities co-ordinator facilitated these.

Complaints were managed in line with the provider's complaints policy.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

The audits had failed to identify the areas of concern we found at inspection in relation to the safe management of medicines. People's records were not kept confidentially and some sensitive information was on display in a communal area.

People and their relatives were positive about the quality of care provided and were complimentary about the management and staffing of the home.

People and their relatives were involved in the development of the home through meetings and their feedback was obtained through surveys.

Rosedale Care 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 was an unannounced, comprehensive inspection which took place on 29 August and 1 September 2017. Two inspectors and an expert by experience undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had expertise in dementia care.

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 any improvements they plan to make. We checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people, relatives and staff. We spend time looking at records including six care records, three staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan and other records relating to the management of the service.

On the day of our inspection, we spoke with six people living at the service and four relatives. We chatted with people where they were able to speak with us and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, the deputy manager and two senior care staff.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely in relation to storage, administration or disposal. On the second day of our inspection, we observed care staff administering medicines to people. When medicines needed to be administered during the lunchtime period, they were removed from the medicines trolley and placed into plastic containers. The plastic containers and other medicines were then put onto a wooden tea trolley and wheeled from the kitchen area into the main sitting room. The plastic containers were placed on the coffee table which was centrally positioned in the sitting room. Two staff were involved in the administration of medicines.

We observed staff administering medicines to people and, for the most part, this was done safely. However, we observed one occasion when one of the care staff left the sitting room to administer a medicine to a person in their bedroom and then returned with the empty medicine pot. The staff member who signed the Medication Administration Record (MAR) to confirm the person had taken their medicine, was not the person who administered it. This is not good practice and was not in line with the provider's policy in the administration of medicines, which we later checked. We discussed this issue with the staff member who had signed the MAR and with the registered manager, who both agreed this was an oversight and gave us reassurances it would not happen again. The registered manager said they would be reminding staff that whoever administered the medicine to a person also had to sign the MAR in confirmation. She later confirmed that this had been discussed both formally and informally with both the individual staff concerned and the wider staff group.

Some medicines were stored in a medicines trolley which was secured to the wall in a room next to the kitchen. The temperature of this room was not routinely monitored. We asked the registered manager to check the temperature as it was a warm day and a thermometer was placed on top of the trolley. A reading of up to 26 degrees Celsius was obtained, which is in excess of the recommended maximum temperature of 25 degrees Celsius. We discussed this with the registered manager who agreed to take action to ensure that the room was ventilated sufficiently or a fan was used, to bring the temperature within normal limits. During our inspection, we observed that, at times, the key to the medicines trolley was left in a box on top of the trolley. This meant that anyone had access to the key and that the medicines were not kept securely. We discussed this issue with the registered manager who assured us she would remind staff not to leave the key on top of the trolley. She later informed us that she had implemented the use of a lanyard so senior staff could wear the keys around their neck or lock them away in a key safe.

We checked the MAR for everyone living at the home. We observed that one medicine that had been administered to a person at noon and recorded on the MAR, had also been signed as being given at 17.00hrs at 12.30hrs when we looked at the records. This was inaccurate and we drew this to the attention of the registered manager who told us that the staff member had become flustered because of the inspection and had inadvertently signed the MAR. The registered manager also explained that the member of staff had immediately realised their mistake and had drawn it to the registered manager's attention. The registered manager then made a note on the MAR to alert the member of staff who would be carrying out the next administration of medicines. The first member of staff also alerted the member of staff who would be

carrying out the 5.00pm administration of medicines. That member of staff also saw the registered manager's note. At 5.00pm, the member of staff administered the correct dose appropriately.

We saw that the MAR for two people had been handwritten by one staff member, but had not been checked by another staff member to confirm it had been correctly completed. The National Institute for Health and Care Excellence guidance, ' Managing medicines for adults receiving social care in the community' (NG67), states that, 'Care home providers should ensure that a new, hand-written medicines administration record is produced only in exceptional circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home. The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used'. There was nothing on the handwritten MAR we looked at to confirm that this had been checked by a second member of staff. This meant that medicines were at risk of being recorded inaccurately. In one hand-written MAR, it stated, 'Clonazepam 0.25mg ½ tablet twice a day PRN. Please ask her and record overleaf'. However, nothing had been recorded on the reverse of the MAR, that is, whether this person had been asked if they required this medicine or not. For the same person we saw that two medicines, Aripiprazole and Cyanocobal recorded on the MAR had been crossed out, with no explanation as to why. In another handwritten MAR we read that a person had been prescribed an inhaler for breathlessness, 'Two puffs up to four times a day – record overleaf', but there was no indication as to whether the person required this medicine on a regular basis or 'when required'. On another MAR, we saw that eye drops for one person had been refused by them for a period of eight consecutive days, but no action was taken until we discussed this with the registered manager, who then consulted the person's GP.

We looked at weekly medicines audits, which recorded the date, any concerns and who had checked the medicines, but there was no information or detail on what had been checked to confirm that medicines were managed safely. After the inspection, the registered manager told us they had revamped the medicines audits to include a higher level of detail.

Some medicines which had been stored in the trolley were out of date. For example, some suppositories which showed an expiry date of 05/17, vapour drops which had an expiry date of August 2016 and Lorazepam which showed an expiry date of 04/16. In addition, there was a homely remedy within the trolley for one person who was no longer living at the home. The registered manager disposed of these medicines when asked.

The above evidence shows that medicines were not managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the registered manager told us of the actions they had taken to address the concerns we raised.

Homely remedies were used when required and the provider had a policy in place which provided guidance to staff on the safe use of homely remedies. Homely remedies that might be used included painkillers such as paracetamol, indigestion and constipation remedies and cough linctus. All creams that were for topical use were prescribed for people.

Staff had completed training in the administration of medicines. People had their medicines reviewed at least annually by their GP. Medicines were ordered in a timely fashion. Staff were observed in the administration of medicines by senior staff and their competencies checked.

We asked people whether they received their medicines when they needed them. One person said, "Yes and

I manage them myself. I am offered pain relief; staff look after us very well". Another person told us, "I don't really have any medication; I've never needed it". A third person said, "Yes, staff do it. I always used to do it before I came here".

People were protected from avoidable harm by staff who had been trained to recognise the signs of potential abuse and knew what action to take. We discussed a safeguarding concern with the registered manager which related to a person who had been the subject of an alleged abuse before they moved into Rosedale Care Home. The registered manager assured us she would take action to ensure the relevant safeguarding authority were informed of this incident.

We asked people whether they felt safe at the home. One person described an incident where another person had hit them with a newspaper. Staff had taken immediate action and helped the person. As a result, if the person became worried or concerned, they could ring a portable call bell which staff had given to them; this helped them to feel safe. Another person said, "Yes, I think so. I don't know, I'm just safe. I'm quite safe from other residents". A third person told us, "I've never met anyone bad. I feel quite safe. We are well looked after". A relative said, "It's the best thing for her because I know she's safe". A staff member, when asked about safeguarding explained, "We talk about helping people to feel safe and valued, to end up with person centred care". The deputy manager was also the person-centred safeguarding champion and had completed additional training with a team from the local authority. This training focused on ensuring that the home had a person-centred ethos, which would help provide better care and prevent abuse. They told us about the different types of abuse and signs that might indicate abuse. In addition to mandatory training in relation to safeguarding, staff also engaged more interactively in training at team meeting.'

Risks to people were managed so that people were protected. We asked people whether they were involved in making decisions about any risks they might want to take. One person said, "I do things for myself you know. They do their best to make sure the place is safe and the security is good. I am very careful. I can access where I want to go. I'm not taking any chances and doing anything stupid". A second person told us, "If I need help I ask. I'm quite happy indoors". We looked at a range of risk assessments contained within people's care plans. These included people's risk of malnutrition, pressure areas, moving and handling, medicines, falls and health issues. Plans had been drawn up to provide information to staff on what action to take should people need to be evacuated in the event of an emergency. The registered manager told us they had an agreement with the care home next door should people require a safe place to be evacuated to. In the event of an electricity failure, a generator could be used as back-up. Risk assessments in relation to premises and safety of equipment had all been completed appropriately.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. The registered manager told us they never needed to use agency staff as permanent staff could work flexibly when required. People felt there were enough staff to meet their needs overall. One person said, "The staff are busy so naturally you have to wait sometimes; they are dedicated. I do think sometimes at night they need a third person. I don't know if they have agency staff". A second person told us, "Normally they are quite good. If I want the toilet in the night I just ring and they are there". Staff too felt staffing levels were sufficient. The deputy manager explained, "[Named registered manager] is really responsive when it comes to staffing levels. We try and offer a home for life and people's conditions change. Staff can go to the manager if they feel more staff are needed. At busy times of day there are always staff around". We looked at staffing rotas over a four week period. These confirmed that there were four staff on duty during the morning and three care staff in the afternoons. At night, two care staff were on duty, one awake and one sleeping. The registered manager said, "I don't believe in very long shifts, so my staff tend to do between three and five hour shifts. Staff are flexible, so they can come in early or leave late".

We looked at staff files and at the recruitment processes that were followed when new staff came to work at the home. The registered manager said, "I recruit depending on when I have a vacancy, but we don't often have vacancies". Staff were checked on their suitability to work in care through checks with the Disclosure and Barring Service and references obtained. The registered manager had satisfied herself that employees were fit and proper persons for the jobs they were employed to undertake.

We looked around the home and generally the premises were clean and odour free.

Good

Is the service effective?

Our findings

People we spoke with felt that staff had the knowledge and skills they needed to carry out their roles and responsibilities. Staff completed a range of mandatory training including moving and handling, safeguarding, infection control, mental capacity and deprivation of liberty, dementia, including Dementia Friends and training in relation to end of life. We checked the staff training plan which showed that staff had completed their training as required. One staff member said, "Every month we have an update to training, like recently we had safeguarding training". Another staff member told us, "They make the training really fun, especially first aid. It makes it simple. You can always ask if you're not sure. [Named registered manager] encourages staff to do learning". Staff were also encouraged to study for additional qualifications such as diplomas in health and social care. On the first day of our inspection, we met with an assessor from a local college who told us that staff were, 'good' and that four staff had just completed their diplomas. Some staff had also completed additional training and were 'champions' of particular areas such as, end of life, infection control, moving and handling, safeguarding and dementia. Champions used their training and knowledge in their specialist areas to advise and guide other staff where needed.

Staff received regular supervision from their line managers and these were completed every six months. Staff supervision records we looked at showed that various topics were discussed including, a review of the staff member's work performance, training, support and development, work targets and standards required, personal needs and matters arising and any other issues relating to work performance. The deputy manager said, "We also use staff meetings as group supervisions. We do informal supervisions all the time and are constantly observing. Staff always have someone to talk to". Staff meetings were generally held on every 2nd Tuesday of the month and the agenda was compiled by staff. The deputy manager said, "We go over the minutes of the last meeting and check that actions have been taken". We looked at a staff meeting record for 11 July 2017 at which the minutes of the previous meeting were discussed, inspection and residents. The registered manager told us, "Staff meeting minutes go out with staff payslips, so no-one can say they're not aware of what's going on". One staff member told us, "I love my job. I get up in the morning and look forward to coming. It's like a big family. If I can make one person smile and laugh, I can go home happy".

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We looked at capacity assessments for a range of people. These were not detailed, but provided enough basic information for the local authority to make a decision in relation to whether they should be subject to a DoLS. We looked at records for one person whose DoLS had been authorised. However, there was backlog of assessments which had been submitted to the local authority and were awaiting authorisation/refusal. Where people's relatives had been granted power of attorney over their affairs, paperwork was copied and placed within people's care plans to show relatives could make decisions on their family member's behalf in relation to finances and/or health and welfare. One relative who had power of attorney said, "My mother hasn't got the capacity to make her own decisions; she will agree to suggestions".

Staff we spoke with had a good understanding of the MCA. One staff member said, "Everyone has mental capacity unless proved otherwise and may need support to make decisions". They talked about best interest decisions and the importance of documentation to support any decisions taken on a person's behalf. When asked about DoLS, this staff member said, "If they don't have capacity and want to go out on their own we need to put a DoLS in place". We asked staff about whether they ever restrained people. The provider had a policy in place in relation to the use of restraint. The deputy manager told us, "We don't physically intervene" and described the use of distractions and acceptable interventions that might be used with people who displayed behaviour perceived as challenging.

We asked people whether they were happy with the food at Rosedale Care Home. One person said, "I am happy with the food and we get a choice; we get more than enough, no problem there. I don't have a special diet, but I have coffee whenever I want it. I drank tea all my life and then I couldn't take it any more – most strange! On Sunday lunch, I have a small sherry, but I've never been a drinker". A second person told us, "There's plenty of it and I eat most things". A third person said, "The food is all right, but I'm not a big eater. Cups of tea are regular and I like fresh juice. It's there if I want it". We looked at the menus which provided choice for people. The registered manager said, "People have choices. We know people's likes and dislikes". For people at risk of malnourishment or who were underweight, food was fortified with butter and cream. Staff who cooked meals had also been on training in relation to the management of people's nutritional needs. A relative said, "Mum is diabetic and needs staff to make sure she eats properly". Another relative told us, "She's eating and drinking, which she wasn't before she came to live here. Now she eats everything they put in front of her". Special diets were catered for as required, for example, for people living with diabetes, gluten or lactose intolerance. Nutrition care plans had been drawn up for people and their food preferences recorded.

People had regular access to healthcare professionals and services. We asked people whether they saw a GP at the home. One person said, "Yes, there's no problem there and they come round once a week anyway. I don't need a dentist". A second person told us, "I've never seen a doctor since I've been here, but if I needed one, I would ask". A third person said, "The doctor in the home spoke to the home staff not me". We could not establish whether this person had been seen by the GP or whether they had thought the GP was visiting them when in fact they were seeing another resident. We met with the GP who was visiting the home on their regular weekly visit. They told us, "I've been coming here since October last year, once a week. It's the very best residential care home I've ever stepped in. [Named registered manager] is very interactive with her staff. They are very good at self-managing and only ring when they need to". A healthcare assistant was also visiting on the day of our inspection and told us, "It's always very friendly and everyone is very well cared for. They will ask our advice and take on board anything we advise". The deputy manager told us that people had access to the GP, district nurses, optician, dentists and chiropodists and care records recorded these health visits and outcomes. Where required, referrals were made to other healthcare professionals, such as speech and language therapists or tissue viability nurses.

We asked people whether they were involved in decisions relating to the environment. One person said, "Well we have meetings from time to time and have chance to put forward any complaints". A second person told us, "I'm sure they would ask us if they needed to". We observed that the carpet in the large sitting room was worn and in need of replacement. The registered manager told us that a new carpet was on order and would be fitted soon. A staff member, when asked about the environment, said, "It's a home. It might not be colour co-ordinated and things may be a bit shabby, but it's homely". We looked at the bathing facilities available to people. Two people had en-suite rooms and the other 16 residents had access to one bathroom and one shower room. People we spoke with were not concerned about the bathing facilities and felt they were adequate. We saw that a bathroom adjacent to one of the ground floor rooms was not in use and was cluttered with old equipment and furniture. Another bathroom located on the first

floor contained unwanted items of furniture such as an old TV, armchair, foam mattress and overlap table. This bathroom was not in use. A second bathroom on the first floor, containing a bath and shower, was used. However, only the bath was working as a pair of stepladders placed in the shower cubicle prevented it from being used as it needed repairing. There was a walk-in shower room on the ground floor. We asked relatives for their comments on the availability of baths and showers to people. One relative said, "[Named person] has a shower or bath every Monday, that's her slot. It is only once a week usually, but that is what she wanted". A second relative told us, "She prefers a bath, but she told me last week she had a shower". One person said, "You have to share with other people. There is only one shower". The deputy manager said, "We talk to the residents. People choose bath or showers in the morning or evening, we all work together. It's always people's choice". We discussed the access to bathing facilities that were available to people and of the bathrooms that were not in use. After the inspection, the registered manager informed us they were clearing out one of the bathrooms so it would be functional, together with a second shower.

Good

Is the service caring?

Our findings

People were looked after by kind and caring staff. We asked people for their comments about the staff at Rosedale Care Home. One person said, "Oh yes, they're dedicated to the job, I think so. I believe in God and someone would take me to church if I wished it". A second person told us that staff were very caring and, "I couldn't be in a better place". A third person agreed that staff were warm and friendly. A relative said they were always made to feel welcome and offered a cup of tea, adding, "It's home from home". Another relative told us, "Mum's keyworker is lovely. Some carers are better than others". A third relative said, "I have nothing but admiration for staff".

We observed staff spending time with people. For example, a member of staff was sitting next to one person in their room, assisting them to eat their lunch. We spoke to the staff member, who then introduced us to the person they were assisting. We observed the staff member was attentive and caring towards the person. It was clear that they knew each other very well and were enjoying each other's company. The deputy manager gave their feedback about the home and said, "It's the atmosphere and the culture. It's hard to write down on a piece of paper. When you walk through the door you can sense the atmosphere and staff are friendly". On the second day of our inspection we observed one member of care staff asking people if they would like a hug; lots of people did. People also cared about each other and during the lunch period, we observed one person encouraging another to eat their lunch in a very friendly and warm manner.

We asked people whether they were involved in decisions relating to their care. One person said, "I think so. They already know about me, it's all in my notes". A second person told us, "They would if I had a complaint, but I've got nothing to complain about. I'm not fussy". A third person said, "I think my likes and dislikes are considered a little. Sometimes I just feel I'm another client". Relatives told us they were kept fully informed about their family member's care. One relative explained, "They always inform me of anything, like shopping I need to get. They phoned me the other day about the 'flu jab". They added that their family member always contributed to any decisions relating to their care.

People were treated with dignity by staff who understood how to respect people. Referring to dignity, the deputy manager said, "Staff are really aware. When we say 'dignity', it's about covering people up, encouraging people to do things for themselves, the environment, making sure people have their hearing aids, for example. Some people need support from staff to be themselves". The deputy manager said that the topic of treating people with dignity and respect was often discussed at staff meetings. A member of care staff said, "We give people a choice, listen to what they want and encourage independence' it's a person-centred approach". A third staff member told us, "We always say what we're doing, keep people covered and clothed. Doors are closed and staff knock. We never leave people sitting on a commode. You treat people how you would want your mum to be treated".

Some people were accommodated in shared rooms; four rooms at the home were of double occupancy. To some extent, people could maintain their privacy as there were curtains which could be drawn round the bed. However, these did not extend sufficiently to provide privacy for people when they wanted to use the washbasin in their room, for example, if they wanted to wash or clean their teeth.

The home had been recognised in their end of life care and had recently achieved Platinum status for the Gold Standards Framework (GSF), an accreditation which recognised the high standards of care in relation to caring for people at the end of their lives. Where possible, people had contributed to making advanced care plans which included their last wishes. In the Provider Information Return (PIR), the registered manager stated, 'Rosedale's advanced care planning process is approved and carried out in collaboration with our site GP and all staff are trained in or have a good awareness of advanced care planning by the registered manager who has formal training and assessing qualifications'. The registered manager felt that ensuring people had a comfortable, pain-free and dignified death was important and said, "We're very keen, not only as being a specialist area for us, but as career progression for staff". A relative told us their family member had visited their GP to discuss their 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) form. DNACPR forms are completed when it is felt that, to resuscitate a person in the event of heart failure, would be futile and likely to be unsuccessful. DNACPRs that we looked at had been completed with the involvement of people where possible, and their relatives. Staff told us that, if it was their wish, people would spend their last days at Rosedale Care Home, rather than be admitted to hospital or into a nursing home. One person, when asked what they wanted in relation to end of life care said, "I would just go along with it. Staff would do what they could for me". Another person told us, "You spend your life saying goodbye to people; I'm the only one left now". A relative commented that staff knew people very well and cared about them, even travelling to Essex for one person's funeral.

A GP told us that when people were coming to the end of their lives, their needs would be discussed and anticipatory medicines procured as needed.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. We looked at care plans which were detailed and contained personal information about people. For example, a document entitled, 'This Is Me' provided information about people before they came into the home, what their lives were like, their likes, dislikes and preferences, including their spiritual needs. Care plans provided guidance to staff on people's care and support needs including their personal care needs, mobility, nutrition, skin integrity, day and night-time routines. The deputy manager told us, "Staff do read care plans. They look at them if they have concerns about something or need guidance – it's all there". The deputy manager added, "We have an annual review with people about their care plan. Keyworkers see people every morning and they understand people. Sometimes it can be the most intimate 1:1 time during the day. Any problems can be addressed". A relative said, "I think I have seen my mum's care plan and it's due for review. We had a meeting about dementia once". Another relative told us they met to review their family member's care plan twice a year to discuss this. They added that they had been involved in preparing a personal profile or life history of their family member and that this was kept in their room. They added, "Mum wanted her own bedding and the staff keep to that".

We asked people whether they were involved in reviewing their care plans. One person said, "Yes, they go through my care plan, but I have no family. I have good friends who are my next of kin". Another person was not sure whether they had seen their care plan and told us, "I don't think so. If need be I think my family would be involved". People and their relatives all spoke highly of the care provided at Rosedale Care Home and of the responsive nature of staff to meet their needs. Staff at the home did not wear uniforms; as one staff member said, "We don't wear uniforms because this is people's home". This helped to prevent any barriers occurring between people and staff and promoted equality in the relationships that had been developed.

An activities co-ordinator helped to plan and engage with people in a range of activities. The registered manager had arranged for them to undertake training specifically designed in how to provide meaningful activities for older people, including people living with dementia. The registered manager told us that there was, "Something happening every day of the week". An activities calendar we saw showed that people could join in with board games, arts and crafts, 'active games', exercises, pampering and reminiscence. A hairdresser visited the home regularly and was present on the day of our inspection. We observed that people enjoyed having their hair washed and styled and felt better for the experience. The registered manager said, "Staff take people out, for example, to go shopping. A lot of people have very supportive families who also take them out, but I would like to do more outings". We observed the activities co-ordinator spent time sitting with people and that activities were organised in line with people's preferences. A relative, referring to their family member, said, "She's got company all the time; there's always someone around. She does quizzes, but doesn't like arts and crafts. She likes music and sings". We observed people in the large sitting room, relaxed and happy, enjoying activities such as jigsaws, dominos, crosswords or reading the newspaper.

We asked people if they knew how to make a complaint if they had any concerns. One person said, "I would

go to [named the providers]. I do feel they would take it seriously and the staff as well. We're well looked after". Another person told us, "I would ask the head person. I don't know her name. If I didn't do that, I would tell my daughter and she would sort it out". A third person said, "I would go to head office. I don't see why they should not take me seriously". A relative said, "I would be able to say if I wasn't happy about something". A staff member added, "[Named registered manager] has her office, so people can talk to her anytime". The provider had a complaints policy, but no formal complaints had been received since October 2015.

Requires Improvement

Is the service well-led?

Our findings

A range of systems was in place to measure and monitor the quality of the service overall. However, the audits in place had not identified the issues we found in relation to the safe management of medicines. People's care records were not always held confidentially or securely. Daily logs relating to people's care were stored in unlocked drawers in a communal area. This room was not locked and was accessed by staff and people living at the home. We saw that some notices attached to a wall in this room contained sensitive information about people's individual needs. Improvements were only made by the registered manager after the areas of concern had been discussed with them.

The above evidence shows that systems or process were not operated effectively to assess and monitor the service. Care records were not kept securely. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the issues relating to confidentiality with the registered manager. By the second day of our inspection, improvements had been made and personal information relating to people was stored in a locked facility. Sensitive information was no longer on display.

The registered manager had introduced some initiatives into the home which had a positive impact on the care and support people received. For example, staff had completed a project to encourage people to drink in sufficient quantities to promote good hydration, a project to reduce the risk of people being admitted to hospital and a system to promote good communication about people's care needs between staff who looked after them.

People and their relatives spoke positively about the service provided at Rosedale Care Home. Residents' meetings took place and we looked at the minutes for a meeting held in July 2017 which showed items discussed: residents, menus, laundry, entertainment and activities, environment, staffing and arrangements for a garden party which was planned in August. The next residents' meeting was scheduled for October 2017. People were aware of meetings that took place. One person said, "We have meetings once a month" and another person told us, "They have meetings, but I choose not to go to them". One staff member said that relatives were invited to residents' meetings, but, "Relatives don't always want to engage with these. The manager lives locally and is always on the end of a phone". In addition to residents' meetings, a newsletter was produced to update people and relatives on what was happening at the home. We were shown a copy of the newsletter which was circulated in June 2017. People were asked for their feedback about the home through residents' surveys and comments were positive. A friend of one person at the home told us, "I helped to choose the home for [named person]. I was overwhelmed, her room is great. I walked in and there were all these smiling faces. It felt really comfortable. There's something unassuming about this place. The manager was brilliant. [Named person] was very unsure and very nervous initially. The manager went to collect her and staff have been very patient. Now she feels safe and she's happy".

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered

persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We asked people for their views on the way the home was managed. One person said, "I think they carry out things very well. I am extremely lucky. I don't think people realise how much I appreciate it". Another person told us, "Everything is very well organised – the staff – different people have different abilities and some do it better than others". Staff felt supported by the registered manager. One staff member said, "If anything was not right, you could go to the manager; she is more of a friend". Another staff member said, "The manager genuinely cares. If I have any problems, she will talk things through and is very supportive. It's a happy staff team and she is the leading light who shines through. It is like a family. It's like I leave one family and go to another". A third staff member told us, "I think this is the best care home and it's really homely and comfortable. The manager is really good and cares about everyone. I like feeling appreciated and valued".

People and their relatives felt that the care on offer at Rosedale Care Home was of a high standard. A relative said, "I can't fault it. It's a great place with brilliant staff. They just get on and do it. I have no concerns at all". Another relative told us, "The staff are wonderful and so is the home".

Where people had sustained falls, these were analysed and any emerging trends identified. Daily, weekly and monthly checks we looked at related to the health and safety of the home, including infection audits. Call bells were tested regularly and on the first day of our inspection. Checks in relation to fire safety and maintenance were all satisfactory. Staff training was reviewed and cleaning schedules were in place. A staff member talked about the 'family atmosphere' of the home and said, "People always seem happy and it's clean. If people want something, they have it".

The registered manager worked in partnership with other agencies, including the local safeguarding authority. The registered manager was the chair of the Local Care Association and worked with the Skills for Care Sussex Networking Group, Dementia Care Pathway (Horsham Dementia Care Alliance) and the Local Workforce Action Alliance and Mental Capacity Networking Group. This enabled the registered provider to network with others and share information to inform good practice.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way for service users in relation to the proper and safe management of medicines. Regulation 12(1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation as not being met: Systems and processes were not in place to ensure the effective assessment and monitoring of the service. Confidential records were not kept securely. Regulation 17(1)(2)(a)(c)