Silver Healthcare Limited

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

Summary of findings

Overall summary

This inspection took place on 6 September 2016 and was unannounced. This meant that the provider did not know we would be visiting. The service was last inspected in November 2013, and at that time was meeting the regulations we inspected.

Rosebank Care Home is a 26 bedded home providing residential care to older people with a variety of support needs including those with dementia. It is located in its own grounds in a residential area, close to Sheffield city centre. At the time of our inspection 24 people were using the service, many of whom were living with dementia.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People were safely supported to access their medicines. However medicines were not always securely stored and there was a discrepancy in the count for one person's medicines.

Risks to people arising from their health and support needs or the premises were not always assessed and plans were not always in place to minimise them.

A number of checks were carried out around the service to ensure that the premises and equipment were safe to use.

Staff understood safeguarding issues, and felt confident to raise any concerns they had in order to keep people safe.

The service monitored people's levels of dependency and used this to assess staffing levels. A number of recruitment checks were carried out before staff were employed to ensure they were suitable. The service was in the process of recruiting new staff.

Staff received training to ensure that they could appropriately support people, and the service used the Care Certificate as the framework for its training.

Staff received support through regular supervisions and appraisals. Staff felt confident to raise any issues or support needs they had at these.

Staff had completed a range of training that enabled them to meet people's assessed needs effectively.

The registered manager and staff had received Mental Capacity Act (2005) and the Deprivation of Liberty

Safeguards (DoLS) training. At the time of inspection one person who used the service was subject to a DoLS authorisation. Care plans contained evidence of MCA assessments and consent. We have made a recommendation around MCA and DoLS.

The service worked closely with external professionals to support and maintain people's health. Staff knew how to make referrals to external professionals where additional support was needed. Care plans contained evidence of the involvement of GPs, nurse practitioners, district nurses and other professionals.

The interactions between people and staff were cheerful and supportive. Staff were kind and respectful; we saw that they were aware of how to respect people's privacy and dignity. People and their relatives spoke highly of the care they received.

Procedures were in place to support people to access advocacy services should the need arise.

Care plans were person centred and provided a lot of personal information that was relevant to that person. However care plans did not always capture people's needs. We have made a recommendation regarding care plans.

People were supported to maintain a healthy diet, and people's dietary needs and preferences were catered for. People told us they enjoyed the food although were not offered a choice. The cook did not fully understand how to fortify people's meals and the picture menus did not match what food was on offer that day.

The service was in the process of employing a new activities co-ordinator. At the time of the inspection staff were arranging activities. People were happy with the activities on offer.

The service had a clear complaints policy that was applied when issues arose. People and their relatives knew how to raise any issues they had.

Staff were able to describe the culture and values of the service, and felt supported by the registered manager in delivering them.

The registered manager was a visible presence at the service, and was actively involved in monitoring standards and promoting good practice. Feedback was sought from people and their relatives to assist in this. The service had some good links with the community.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always safely and securely stored. Medicines were administered safely however there were discrepancies in the count of one person's medicine.

Risks to people were not always assessed and plans to minimise the risk were not all in place

Staff understood safeguarding issues and felt confident to raise any concerns they had.

The service monitored staffing levels, and carried out pre-employment checks to minimise the risk of inappropriate staff being employed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training to ensure that they could appropriately support people, and were supported through supervisions and appraisals.

Staff did not always understand the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards to ensure that people's rights were protected. We have made a recommendation regarding MCA and DoLS.

People were supported to maintain a healthy diet, however people were not provided with a choice of main meal.

The service worked closely with external professionals to support and maintain people's health.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity, respect and kindness.

Staff encouraged people to maintain their independence.

People and their relatives spoke highly of the care they received.

The service provided people with information on advocacy services.

Is the service responsive?

Good

The service was responsive.

Care planning and delivery responded to people's needs and preferences. However not all peoples needs were recorded.

People had access to activities.

The service had a clear complaints policy, and people and their relatives knew how to raise issues.

Is the service well-led?

Good

The service was well-led.

Staff were able to describe the culture and values of the service, and felt supported by the registered manager in delivering them.

The registered manager and deputy manager carried out regular checks to monitor and improve the quality of the service. The registered manager was visible and active presence at the service.

The manager understood their responsibilities in making notifications to the Commission.

Rosebank 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 September 2016 and was unannounced. This meant that the provider did not know we would be visiting. The service was last inspected in 2013, and at that time was meeting the regulations we inspected. At the time of our inspection 24 people were using the service.

The inspection team consisted of one adult social care inspector and one 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 service.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The provider was asked to complete 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. We received the PIR back.

We observed staff interacting with people who used the service and the level of support provided to people throughout the day, including meal times.

During the inspection we spoke with seven people who used the service and four relatives. We looked at three care plans including daily notes, and Medicine Administration Records (MARs). We spoke with three members of staff, including the registered manager, senior carer, care workers and a cook. We also spoke with a visiting healthcare professional. We looked at four staff files, including recruitment records.

We also completed observations around the service, in communal areas and in people's rooms with their

permission.

Requires Improvement

Is the service safe?

Our findings

We asked people and their relatives if they felt safe living at the service. One person we spoke with said, "It is safe here, the doors are always locked." We clarified that although doors were locked people with capacity could easily access outside. A relative we spoke with said, "I feel she is extremely safe here, one hundred percent safe."

On arrival for the inspection day the registered manager checked identification badges and went through the fire procedures. This meant that in the event of an emergency the inspection team were aware of the services processes.

A visiting healthcare professional said, "The safety aspects are good, it seems to be a safe with friendly staff and clients."

We reviewed three care records and found risks to people were not always assessed and plans were not always put in place to minimise them. For example, one person was using a catheter, this was only mentioned in the person's daily notes, and there was no mention of a catheter in the care plan and no risk assessment in place, even though there was a record of the catheter not working properly. We asked the registered manager why there was no care plan for the catheter or risk assessment. The registered manager said the catheter was only being used for a short time, however they realised a short term care plan and risk assessment should be in place and would rectify this immediately. One person was asthmatic and no risk assessment was in place. Another person was an insulin and diet controlled diabetic and although there was some information in the care plan regarding symptoms of diabetic complications there was no risk assessment. This meant that staff were not highlighted to the risk and there was nothing to guide staff on how best to prevent or minimise the risk. The registered manager said they would go through each person's care records and put risk assessments in place where necessary.

People we spoke with said they received their medicines at the correct times. One person said, "I get my medicines at the same time every day."

People were supported to access their medicines when they needed them. We observed a lunch time medicine round and saw the senior carer ask people if they wished to take their medicines and explained what the medicines were for. The staff member showed patience and treated people with respect. Medicines were not always stored securely and safely. On the day of inspection the trolley with the medicines for people downstairs was left in a corridor and not attached to the wall. The registered manager said this trolley was usually in a locked room and attached to the wall in that room. The registered manager secured the trolley. Where it was necessary to store medicines in a refrigerator we could not see evidence of a temperature being taken daily to check the medicines were stored at the correct temperature of between 2 and 8 degrees. the registered manager sent on this information after the inspection day and this showed the medicines were stored at a safe temperature. A secure cupboard was used to store controlled drugs, and stocks were accurately recorded. Controlled drugs are medicines that are liable to misuse.

Medicine administration records (MARs) were used to record the medicines a person had been prescribed and recorded when they had been administered. These had been accurately completed by staff. However there were discrepancies with one person's boxed medicine. The service had received 56 tablets and administered 48 which meant there should have been 12 left, however there were 13 tablets left. This could mean staff had signed to say they had administered a tablet when they had not. The registered manager planned to investigate this after the inspection.

The service used a multi dose system where all the medicines for a time of day were in one pot. We asked the registered manager what happened when a medicine was discontinued. The manager explained that they make a record of this on the MAR chart and at each administration the responsible staff member removed the discontinued tablet. We asked to see the risk assessment to cover this and we were told there was none. This meant there was a potential for a medicine error as the staff member could forget to remove the medicine.

We asked to see the medicine policy. The policy was generic and did not include how staff should work with the system they were using, or incorporate NICE guidelines. The registered manager agreed to update the policy immediately.

These findings evidenced a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014

Checks of the building and equipment were carried out to minimise health and safety risks to people who used the service and staff. We saw documentation and certificates which showed relevant checks had been carried out on the electrical installation, gas services, portable electrical equipment and the lift. We saw a fire risk assessment was in place and regular checks of the fire alarm system, fire extinguishers and emergency lighting were carried out to ensure these were in safe working order. Records showed fire drills were held to ensure staff knew how to respond in the event of an emergency. A full analysis of the fire drill was documented that stated who was involved, how long it took, want went well and where improvements were needed. The registered manager explained that they hide somewhere in the home and staff needed to find them and evacuate them as they would a person who used the service. People who used the service said, "We had a fire drill about six months ago." Another person said, "There was a fire drill in the last few days I think." We saw evidence that a fire drill had taken place the week before the inspection.

A Personal Emergency Evacuation Plan (PEEP) was in place documenting evacuation plans for people who may require support to leave the premises in the event of a fire. This showed that the registered provider had taken appropriate steps to protect people who used the service against risks associated with the home environment.

The registered provider had a business continuity plan, which provided information about how they would continue to meet people's needs in the event of an emergency, such as flooding or a fire and also in the event of having no telephone line or loss of keys. This showed us that contingencies were in place to keep people safe in the event of an emergency.

The service was part of the Sheffield Safe Places scheme. The Sheffield Safe Places scheme is designed to support adults with a learning disability, mental ill health and dementia. If they were to become lost or frightened they could be brought or go to a place that showed the safe places logo. Rosebank was one of these places and staff were trained to offer support and communicate with people who were distressed. They would care for the person until they could return home. The registered manager said, "This is a great initiative with the staff all being fully on board and one resident in particular has become an unofficial

spokesperson." The person who was the unofficial spokesperson proudly showed their badge and safe places ID to us on inspection.

A record was kept of accidents that occurred at the service, which included details of when and where they happened and any injuries sustained. The registered manager said they reviewed this for any trends, and would take any necessary remedial action needed. The registered manager also arranged for an independent falls assessor to review their accidents and incidents. The registered manager said, "This was really helpful as fresh eyes see things differently." One idea that came from this review was to arrange to paint the handrail a different colour. For people living with dementia it can be easier to locate handrails if they are a contrasting colour to the wall.

Staff understood safeguarding issues and knew the procedures to follow if they had any concerns. There were safeguarding policies in place and staff were familiar with them. Staff also received safeguarding training and could easily explain what could constitute as abuse. One member of staff said, "I would report any safeguarding issues to the manager straight away, I did once and this was investigated correctly." And "I know who to report safeguarding issues to, we have all been provided with telephone numbers and I would document everything. " There service had a whistleblowing policy, and staff were familiar with this. Whistleblowing is where an employee reports misconduct by another employee of their employer. One member of staff said, "I have whistleblown in the past at a previous service and I would do it again, anytime without hesitation."

Staffing levels were based upon people's levels of dependency. A monthly assessment of people's needs was carried out, covering areas such as mobility, speech and communication and capacity. The registered manager explained they were in the process of recruiting two new members of staff, one for the day shift and one for the night shift. They were waiting for the return of relevant checks. Staff we spoke to said they thought there was enough staff on duty. One staff member said, "There are usually two staff on each floor, which is fine, the only issue is if someone is off on holiday or sick." The registered manager explained that they were trying to build up a bank of staff they could use in emergencies. Agency staff were used on a nightshift to cover the vacancy as needed, the registered manager stated they always used the same member of staff and all the relevant checks had taken place.

We asked people who used the service and their relatives if they thought there was enough staff. People we spoke with said, "Sometimes they [staff] are a bit rushed, it's certain times of the day." Another person said, "There is easily enough staff, they have a chat with you." And another person said, "On the weekends they are rushing around the week days are usually okay." And another said, "There is enough staff they get round us all, we like them all." Relatives we spoke with said, "Most of the time there are enough staff." Another relative said, "There are enough staff and if they leave they are replaced quickly." And another relative said, "We come at different times without warning and there are always enough staff."

A visiting healthcare professional said, "There are enough staff when things are going well, they probably need more at certain times."

During the inspection we saw staff had time to support people in an unhurried way, and people did not have to wait long for assistance to be given.

The service was clean and tidy, and bathrooms and communal areas were well maintained. Where people were supported to move around the building this was done at a safe and steady pace, and staff knew how to use mobility equipment to assist in this. Throughout the inspection we observed staff washing their hands and using personal protective equipment where necessary, to assist with infection control. People who used

the service said, "It is very nice and clean, kept very clean." Another person said, "It is wonderfully clean." Relatives we spoke with said, "It is always clean and hygienic but not sterile, the clients come first." And another relative said, "It is a very clean place."

A visiting healthcare professional said, "It is probably one of the cleanest homes I have been in, it is bright, clean and uncluttered."

Requires Improvement

Is the service effective?

Our findings

We asked the people who used the service if they thought the staff had enough training to undertake their role. One person said, "The staff are well trained." Another person said, "They [staff] are very well trained, I am satisfied." And another person said, "They [staff] are not especially trained, they need more training on moving and changing." Relatives we spoke with said, "They [staff] seem to be well trained they deal with the difficult one's well." Another relative said, "For definite, they understand what she [relative] needs well."

A visiting healthcare professional said, "The staff seem to be doing their jobs properly when I have observed them, they know what the service users' needs and wants are and they are always passing information on."

We confirmed from our review of staff records and discussions that staff were suitably qualified and experienced to fulfil the requirements of their posts. Staff we spoke with told us they received training that was relevant to their role. We confirmed from our review of records that staff had completed training which included safeguarding vulnerable adults, the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), dementia, dignity and respect, equality and diversity, fire safety, food safety, moving and handling, medication and infection prevention and control. Refresher training for moving and handling was booked in for October 2016.

Staff spoke positively about the training they received, and said they would be confident to request any additional training they wanted. One staff member said, "We have had training in safeguarding and equality and diversity." Another staff member said, "I have had medication training and training in infection control."

The registered manager was utilising applications on smart phones such as the Domiciliary Care Toolkit to support staff. This was a free resource which aimed to support required workplace training and was divided into four key content areas which were values and behaviours, safeguarding, administration of medications and service user health and wellbeing.

New staff undertook an eight week induction programme, covering the service's policy and procedures and using Care Certificate materials to provide basic training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that will be expected. The registered manager said, "The induction process also takes into account past experience and questions asked on the interview also gauge understanding. Also we have a sign off sheet other than the care certificates where upon staff are observed carrying out specific tasks by an experienced senior or manager once observed they will be signed off." New staff were supervised during induction to discuss depth of knowledge and the understanding they have. Feedback was sought from the inductee and other staff from regular meetings.

Recruitment procedures were in place to ensure suitable staff were employed. Applicants completed an application form in which they set out their experience, skills and employment history. Two references were sought and a Disclosure and Barring Service (DBS) check was carried out before staff were employed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and

vulnerable adults. This helps employers make safer recruiting decisions and also to minimise unsuitable people from working with vulnerable adults.

Staff were supported through supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. A staff supervision plan showed all staff received six supervisions annually one of which was an appraisal. During supervision staff discussed future work targets, training support and development needs and any matters arising that may impact on their work performance. Staff were asked to prepare for their annual appraisal by describing how well they have performed in the last 12 months, what part of their job did they feel they did well or could do better, if the staff member was having any difficulties and if any further training was required. Staff we spoke with found the supervision and appraisal process very useful. One staff member said, "They [supervision and appraisals] are very good, I always have an agenda, such as once it was about becoming senior, I had full discussions about that with the manager and they were good discussions, about how I felt. The manger always asks how we are feeling."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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. On arrival to the inspection we were told that 24 people had a DoLS authorisation in place. On further investigation we found this not to be correct. We saw evidence that one person had a DoLS in place. We asked the registered manager and staff how many people had been granted an authorisation and they could not tell us. The registered manager did not maintain a matrix of people's DoLS status, which would allow them to monitor the status of authorisations and progress of applications. The registered manager said, "We were acting on advice received from the Local Authority which stated that everyone entering a care home needed a DoLS." The registered manager had only been in post since December 2015 and the authorisations for many people using the service had been submitted to the local authority prior to their start. We recommend the registered manager rechecks all the authorisations and their progress and to keep a record of who has a DoLS in place and when it is due for a resubmission. The registered manager followed this up after inspection and confirmed that at present only the one person had been granted an authorisation and they now had a matrix in place. The registered manager contacted CQC to say that staff had received further training on this subject which would support their understanding.

We saw evidence that consent had been sought and signed as agreed for having photos taken, the care plan and information sharing.

The registered manager had started to implement the MCA pocket guide for staff to support them with their learning.

People we spoke with said, "I can do what I want." Another person said, "There are no restrictions."

Where appropriate, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) were recorded in people's files and contained evidence of authorisation by their GP.

People were supported to maintain a healthy diet. People were regularly weighed and food and fluid charts were used to monitor their nutritional health. Where weight loss had occurred, appropriate referrals were made to dieticians and the speech and language therapy (SALT) team.

We asked people who used the service and their relatives what they thought of the food. One person said, "It is like hotel food." Another person said, "It is well cooked and piping hot." And another person said, "I don't think we get a choice but I always like the food." Relatives we spoke with said, "The food looks perfectly alright." And another relative said, "The food is good and you always get the opportunity to eat with mum and dad if you want."

A visiting healthcare professional said, "The food looks lovely."

We asked the cook if anyone had any special dietary requirements. We were told there was one person who needed their food cut up small. We asked the cook how they fortified people's diets and they said they added milk. A fortified diet describes meals, snacks and drinks to which additional nutrients have been added through foods such as cream, butter, milk and milk powder. The aim is to provide a diet which has a higher nutrient density without increasing portion size. As the cook said they only added milk it could be a training need. There was no clear record in the kitchen of people's likes, dislikes and dietary needs. The cook said the information was passed on from the care staff and wrote on a piece of paper. There were two cooks employed by the service working on different days. The cooks had no kitchen assistants and worked alone preparing breakfast, lunch and tea for 24 people. The cook also washed up afterwards and placed crockery into a steriliser. We discussed the workload with the registered manager who said they would look into this. The registered manager also said they were confident in both cooks ability re fortified food etc. but would look into available training as part of their commitment to training.

Picture menus were in a perspex wall container in both dining rooms. On the day of inspection the main meal was chicken pie. The menu downstairs was mince and dumplings and the menu upstairs was sausage casserole. This could lead to confusion of what was on the menu that day.

People were not provided with choice of a main meal. However, when the meal was being served they if they did not like it the cook would make them a sandwich or jacket potato. One person who used the service said, "They will get something else if I don't like the meal." We questioned why people were not provided with a choice before entering the dining room. We were told they know people well and their likes and dislikes.

We observed at lunchtime, and saw most people chose to eat in either the dining room, sit in a lounge chair with a table in front of them or have their meals in their room. The overall ambiance was homely. People were served drinks whilst they were waiting for food to be served. There were good conversations taking place between people who used the service and staff. The cook served the meals and knew people's likes and dislikes and provided different portions and different amounts of gravy to people. We observed staff moving about the room asking if the meal was nice and giving encouragement to eat without enforcing or rushing people. People were provided with as much time as they wanted to enjoy their meal. Where people needed support with eating, this was done discretely and patiently. Staff encouraged people to do as much for themselves as they could before offering to help. Once everyone had been served their meal, staff sat with people and chatted.

People were supported to access external professionals to maintain and promote their health. Care plans contained evidence of referrals to professionals such as GPs, the district nurse, dieticians, speech and language therapist and nurse practitioner.

We spoke a visiting healthcare professional who was visiting the service during our inspection. They said, "We come and do a round once a week, they fax a list over of people who they want us to see. Any advice we provide is followed, nothing is overlooked." This helped to ensure people continually received the most effective care to meet their needs.

We found the environment was suitable for people's physical needs and attention had been paid to supporting people with dementia. For example, there was pictorial signage as prompts to locate bedrooms, toilets, shower rooms and communal rooms and block coloured bedroom doors in different colours.

Good

Is the service caring?

Our findings

We asked people who used the service if they were happy living at the service and if they were well cared for. People we spoke with said, "I like living here." Another person said, "The care is good." A relative we spoke with said, "It has a good atmosphere, it is like sitting in your own front room." Another relative said, "While I have been here I have not had problems with her care."

People and their relatives spoke positively about the care and support they received from staff. One person said, "They are very nice girls." Another person said, "There is always someone there if you need them." And another person said, "Staff are very kind and considerate." Relatives we spoke with said, "The staff get to know their needs and likes very quickly." Another relative said, "The staff are friendly and kind. They have a little joke with them." And another relative said, "They [staff] work hard but are caring enough, you have to be a special person."

One staff member we spoke with said, "I enjoy working here as it is a friendly environment." Another staff member said, "I like to care and help knowing that I make people safe and happy."

We saw staff were courteous towards people who lived at the service, knocking on bedroom doors prior to entering and dealing with any personal care needs sensitively and discreetly in a way that respected the person's privacy and dignity.

We asked staff how they maintained people's privacy and dignity. One staff member said, "If something happened in a public area I would always take them back to their own room to help." Another staff member said, "When delivering personal care I always make sure doors are closed and the person is covered as much as possible."

People said care was delivered with dignity and respect. One said, "[Staff] maintain my privacy and dignity." Another said, "They [staff] treat me with respect and look after my dignity." A relative we spoke with said, "The staff are very good, they treat people with respect and empathy."

A visiting healthcare professional said, "People are treated respectfully, this is one of the nice homes."

Staff encouraged people to maintain their independence. Staff we spoke with said, "I let them do as much as they can for themselves and encourage them, such as washing themselves or combing their hair." Another staff member said, "We encourage independence and only provide help if it is wanted."

People who used the service said, "They [staff] will help if you ask." Another person said, "They [staff] ask what we want and what we need, there is always someone there if you need them." Relatives we spoke with said, "They let [relative] wander around and go out when they want to, they are independent." Another relative said, "[Relatives name] is supported to be independent, they can do what they want when they want."

Relatives told us they were free to visit whenever they wanted to, and always felt welcome and involved when they did. A relative told us, "It's lovely here, we come at all different times and are made very welcome." Another relative said, "I can come and go as I please I am always asked if I want something to eat or drink as well."

Information was available to people throughout the service. For example, there were notice boards informing them of planned activities, up and coming events and other relevant information. Each person had a notice in their bedroom which included the name of their specific key worker and the person's likes and dislikes.

Nobody at the service was using an advocate. Advocates help to ensure that people's views and preferences are heard.

Plans were starting to be in place to begin End of Life care for one person at the service. Their care records contained very basic details of discussions that had taken place regarding this, though care plans had not yet been produced and further information was needed. We asked the registered manager about this and they said, "This is sometimes a difficult topic for people to discuss we try to get all relevant information and this would be used to produce End of Life care plans."

Good

Is the service responsive?

Our findings

We asked people and their relatives if they were involved in their plan of care. People we spoke with said, "I am involved in looking at my care plant." Another person said, "I talk to staff about what is important to me." Relatives we spoke with said, "I am involved in the care plan and have reviewed it." Another relative said, "They [staff] involve the family on any decision. "And another relative said, "I am involved in [person's name] care, you are welcomed to say things."

A visiting healthcare professional said, "The staff respond to wishes, I believe that relatives are involved in reviewing care plans and always invited in for the reviews."

Before people were offered a place within the service a pre-admission assessment was completed. The assessment was used to capture people's needs, abilities and levels of independence as well as information about their life history.

We looked at three people's care plans; each plan contained guidance for staff to ensure people received the support they required consistently and in line with their preferences.

People's care records contained information about the person's life history and things that were important to them, such as particular events or family information. At the beginning of each care plan was a one page profile which was completed with the person and recorded what people appreciated about them such as 'I am very polite' and 'I have a good knowledge of cars.' It stated what was important to the person such as 'I have exceptional hearing and like things to be quiet.' How to support me for example, 'I am blind so ensure I know what I am wearing, explain things around me such as what food is on the plate. This allowed staff who had not supported the person before to familiarise themselves with that person's personal preferences and wishes.

People's care plans had been written in a person centred way and re-enforced the need to involve people in decisions about their care and to promote their independence and ensuring dignity and self-esteem were maintained for example don't shout or get too close to me respect my personal space. The care plans we saw covered all aspects of people's care and support needs including personal hygiene, physical well-being, diet, weight, sight, hearing, communication falls and medicines. Care plans also had information on any relevant medical issues such as diabetes.

Care planning and delivery responded to people's needs and preferences. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. For example one person sometimes liked to sleep on a couch; this was fully detailed with information for what staff were to do such as keep the person comfortable and warm. People's sleeping care plans were very detailed with information stating what the person preferred to wear to bed, their sleeping position, how many pillow's they liked and how they liked their room such as dark with the door slightly open.

The registered manager had introduced a file called the 'lifelong learning journal, this was being used to

record insights that were learnt daily about people who used the service. For example, one person who used the service loved Weetabix but since being placed on end of life did not enjoy them as much. One staff member found that mixing the Weetabix with Fortisip's (a high protein supplement) the person loved the taste and resumed eating. Another person could become upset if they were asked about their family but if staff started the sentence in a certain way they were less upset. These daily learning's would then be added to the care plans.

We saw staff provided people with person-centred care. For example, staff knew which people required specific equipment to meet their needs. This included moving and handling aids, pressure relieving cushions and mattresses. One staff member said, "I understand the value of caring for each person on an individual basis."

Care plans were reviewed on a monthly basis to ensure they reflected people's current needs and preferences. Daily notes were used to assist staff coming onto shift to familiarise themselves with any developments that had occurred that day. These contained detailed and comprehensive updates on people. The daily notes contained detailed information if a referral to an external professional had been made or if a visit had taken place from any external professionals. However we found some details in the daily notes were not reflected in the care plans. For example one person's daily notes stated that their catheter was not working properly. The care plan did not mention that this person had a catheter in place. We discussed this with the registered manager who said that this catheter was for short term use, but understood a care plan should be in place and would rectify this immediately. We recommend the manager makes sure all care plans reflect people's current needs.

The service was in the process of looking for a new activities coordinator. We asked people and their relatives if they thought there were enough activities taking place. People we spoke with said, "We don't have activities every day." Another person said, "There is not much to do, but they [staff] have said they will try to help me with my hobby." Another person said, "They [staff] help us with our hobbies and seeing our friends." And another person said, "[Registered manager's name] has taken me to see football matches when I want and they don't work weekends but they come in their own time to take me."

Relatives we spoke with said, "There always seems to be something going on, like sitting outside in the sun and staff sit with them." Another relative said, "There is a reasonable amount of activity for what they [people who used the service] can do." And another relative said, "There is not much on at the moment, the carer's try to do things."

People were encouraged to join in activities but their decisions were respected when they chose not to. We observed people walking about the service freely. Staff knew people's needs well and provided them with choices. People were able to spend time in their preferred places such as their bedroom or communal rooms. One person we spoke with said, "They [staff] asked me if I wanted to go and sit in the lounge but I feel too weak today." One staff member said, "We try to prevent social isolation by encouraging people to leave their rooms."

On the day of inspection the activity was a musical, we observed people were not fully engaged with this. One staff member said, "I brought the musical in as they all love DVD's I usually sit with them but I have been too busy today."

Staff we spoke with felt that all staff were trying to offer as many activities as they could whilst there was no activity coordinator. One staff member said, "We try to go on lots of outings, we usually take one or two residents to the town or the peace gardens, or even to Tesco shopping then for a Costa coffee afterwards."

And "I took one gentleman to the pictures, we get a taxi and then have drinks and popcorn, as long as we plan it in advance to get staff in to cover we get lots of outings booked in." Staff explained how they tried to do 20 minute activities here and there such as making decorations. People from the local community also visited the service and we were told that the church had been in the day before and people also visited a lunch club at the church every Thursday, where they had lunch and singing.

One staff member explained how they organised fundraising to buy things for the service. The staff member said, "We raised money and bought garden furniture, everyone enjoys sitting in the garden when it is sunny we often have tea outside. We are also doing a McMillan coffee morning on the 30 September which will be fun."

The service had a complaints policy and procedure which detailed timescales for acknowledgement and investigation. It also provided information of who to escalate complaints to should the person remain unsatisfied following an internal investigation. The procedure was on display in the service and was also included in the service user guide. The service did not receive many complaints but when people raised issues we saw these were dealt with according to the registered provider's policy. People who used the service and their relatives said they did not know the complaints procedure and had not needed to know. One person who used the service said, "I have never wanted to complain." A relative we spoke with said, "I have never complained I have never worried about the care."

Good

Is the service well-led?

Our findings

The service had a registered manager who had been registered with the Care Quality Commission since July 2016.

We asked staff to describe the culture, visions and values of the service. One said, "The culture of this home is valuing openness and honesty and involving residents and relatives in the running of the home through listening and responding to them." Another staff member said, "Residents value the truth even in situations they don't understand." And another staff member said, "Our visions and values are to make this as homely and friendly as possible."

The registered manager and the deputy manager carried out a number of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The registered manager carried out daily, weekly and monthly checks of areas including medication, health and safety, staffing levels, infection control and falls analyses. The registered manager and the deputy manager also carried out night time and weekend audits. The last one was done at 3:30am to check on staff, people who used the service and the appearance of the home.

No meetings for people who used the service and their relatives took place. We asked the registered manager how they involved people in the running of the service and kept people up to date. The registered manager explained they send out questionnaires, carry out market research, talked to people individually and put notices on the notice board. The registered manager said they would look into setting up meetings for people and their relatives. One relative we spoke with said, "I don't know about meetings, we raise issues at the time and they get sorted immediately."

Feedback was sought from people, their relatives and external professionals through questionnaires. These were sent out every three to four months or as needed. The most recent ones were done in March 2016 and June 2016. The majority of feedback received was either good or excellent. Comments included, 'fantastic care and support,' 'exceptional team to speak to,' 'staff are friendly,' and 'everything is fantastic, the food is yummy.' The registered manager said if there were any issues raised; an action plan would be put in place to address it. For example, one person had raised the need for an area of the home to be painted. The registered manager said this had been added onto the refurbishment schedule.

The registered manager was a visible presence around the service. The registered manager covered care shifts as and when needed during the week.

We asked people and their relatives what they thought of the registered manager, if they were involved with how the service was run and if the service was well run. Everyone we spoke with felt they could talk to the staff to raise issues, be listened to and they could influence how the service was run. People we spoke with said, "They would change things if you made a good point." Another person said, "They ask about things and

if you like it or not." And another person said, "Nothing needs changing." One person said, "The manager is alright but they could exert their authority more often." And another said, "I see the manager, I don't tell them things but I could if something was wrong."

Relatives we spoke to said, "They [staff and registered manager] listen and do take notice." Another relative said, "He is a good manager, helpful and approachable." And another relative said, "He is very friendly, he has been alright with the residents." Another relative said, "It seems well run." And "He is good and manages well."

A visiting healthcare professional felt that the service was well led and had a good atmosphere saying "The manager is good; the staff are good with communication and are friendly and welcoming. In my experience the home is well run and managed. I have not had any concerns or worries."

At the time of inspection no meetings were taking place for people who used the service; the registered manager stated they do plan to re-introduce these meetings in October 2016

We asked staff what they thought of the registered manager. One staff member said, "The manager is actively involved and gives good honest feedback along with praise for good work and that things run smoothly." Another staff member said, "The manager is really good, and approachable, they are there for you if you have questions." And another staff member said, "[Registered manager's name] is inspirational, firm but fair."

Staff meetings took place every other month at which staff could raise any general issues or concerns they had. Where suggestions were made they were acted on. For example, at one staff meeting a carer suggested getting the key worker role up and running better. We could see that a key worker system was now in place. At the recent staff meeting topics included health and safety, training, infection control, lesbian, gay, bisexual and transgender (LGBT), radicalisation, safe places and activities.

The registered manager had introduced a chalk board to highlight important and interesting information to staff. For example there was a reminder for the staff to access the Domiciliary Took Kit App, the board documented how well the last fire drill had been and recruitment news.

The registered manager was planning on putting systems in place to encourage and promote good practice. For example they were going to appoint staff to become champions in areas such as dignity and dementia. The registered manager said, "I am really proud of my staff."

The registered manager explained how they try to embed the Equality Act and human rights for people using the service. The registered manager was able to demonstrate how they had and will continue to build upon this to promote best practice. For example the registered manager provided information on a recent meeting the service had held with certain people who used the service, their families and staff to work out how they could maintain these people's human rights and ensure their personal choice and dignity was respected.

We asked for a variety of records and documents during our inspection. We found these were very well maintained, organised, easily accessible and stored securely. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

We asked the registered manager what links they had with the community. The registered manager said, "We have already a strong relationship with the local church and this has also been enhanced with joint projects such as collecting glasses for Africa and in the coming months work towards the McMillan coffee morning. The local church also has access to Rosebank once a month for activity's and sing alongs."

The registered manager also said, "I have drafted a proposal to the government to join the Dementia Action Alliance (D.A.A) part of this application suggested Rosebank could be used as a drop in point for family and community members to drop in on a pre-determined day to discuss Dementia or Alzheimer's."

We asked the registered manager how they kept up to date with changes in legislation and guidance on best practice. They told us they accessed the CQC website and attended quarterly meetings with the local authority. They also told us the service had four staff who were nominated 'champions' in infection control, dementia, dignity and end of life care (EOL) and through these roles staff had made links with the Alzheimer's society, local authority safeguarding teams and district and Macmillan nurses.

The registered manager also attended best practice meetings, manager's forums and the council's provider reference groups. The registered manager explained that these meetings look at the leadership qualities framework and promote good practice not only the service but also how to improve community links, for example religious groups, fundraising, coffee mornings, community meetings and forums.

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 Risks to people were not always assessed and plans were not always put in place to minimise them. There were discrepancies in one person's boxed medicines, the medicine fridge temperature was not recorded, no risk assessment was in place for staff to remove discontinued medicines from a multi dose system. the services medicine policy was too generic and did not reflect the system they were using.