Rockmount Northwest Limited

Rockmount Northwest

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We previously inspected this service in October 2017. This was because we had received notification of a serious incident which raised concerns regarding the assessment and management of risk in relation to people's mental health needs. At that inspection we looked at two of our questions; 'Is this service safe and is the service well led?' Our findings in October 2017 demonstrated there was a continued breach of the regulation in respect of the systems for monitoring the quality and safety of the service. Following the last inspection we asked the provider to complete an action plan to show what they would do to improve the service to at least good and by when.

The provider wrote to us to say what they would do to meet legal requirements in relation to the breach. During this inspection we found that significant work had been carried out to improve the governance and quality assurance systems in the home.

The service had 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.

Rockmount Northwest is a residential care home for people with a mental health diagnosis. The service provides recovery and rehabilitation support for up to 20 adults with complex mental health needs, who may also have a learning disability. At the time of this inspection, there were 19 people living in the home.

Rockmount Northwest is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The home is situated in Rishton, near the towns of Blackburn and Accrington and is in close proximity to public transport links which gives easy access to either town by bus or train.

During this inspection, we found improvements had been made to quality assurance and auditing processes to help the provider and the registered manager to effectively identify and respond to matters needing attention. The systems to obtain the views of staff had been improved. People felt their views and choices were listened to and they were kept up to date with any changes. However, we noted that further improvements were required to ensure the systems were formalised to enable accountability and to ensure audits included records of care.

We found improvements were required to the knowledge and understanding of the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). People's consent to various aspects of their care was considered and where required DoLS authorisations had been sought from the local authority. The registered manager had made appropriate referral to seek authorisations to restrict

some people for their safety. However, the systems for assessing and recording mental capacity assessments were not in place.
We have made a recommendation about the assessing and recording of mental capacity assessments.

People were happy with the care and support they received and made positive comments about the staff. They told us they felt safe and happy in the home and staff were caring. People were comfortable in the company of staff and it was clear they had developed positive trusting relationships with them. Staff understood how to protect people from abuse.

The information in people's care plans was sufficiently detailed to ensure they were at the centre of their care. People's care and support was kept under review. Risks to people's health and safety had been identified, assessed and managed safely. Relevant health and social care professionals provided advice and support when people's needs changed.

The home was a clean, safe and comfortable for people to live in.

A safe and robust recruitment procedure was followed to ensure new staff were suitable to care for vulnerable people. Arrangements were in place to make sure staff were trained and competent. People considered there were enough suitably skilled staff to support them when they needed any help. Staffing levels were monitored to ensure sufficient staff were available.

People's medicines were managed in a safe manner. People had their medicines when they needed them. Staff administering medicines had received training and supervision to do this safely. We noted that some improvements were required to ensure the medicines administration practices were person centred to promote privacy and dignity.

People were supported to have 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. Staff respected people's diversity and promoted people's right to be free from discrimination.

There was a strong drive to facilitate community and social inclusion. People had access to a range of appropriate activities both inside the house and in the local community.

People's nutritional needs were monitored and reviewed. People were given a choice of meals and staff knew their likes and dislikes. People were promoted to maintain and develop their independence. Staff supported them to undertake some of their daily living activities and to share responsibility for cleaning their own personal bedrooms and communal areas.

People who used the service knew how to raise a concern or to make a complaint. The complaint's procedure was available and people said they were encouraged to raise concerns and were confident they would be listened to.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe in the home and were protected against the risk of abuse.

Safe recruitment practices had been followed. There were sufficient staff available to meet people's needs.

Accident and incident were recorded including the care people received.

The management of people's medicines had improved. They were managed safely and administered by trained and competent staff. However, issues of dignity and privacy regarding the way medicines were administered had still not been addressed.

Is the service effective?

Good

The service was effective.

Staff had received training to improve their understanding of the MCA, 2005 legislation and appropriate authorisations to restrict people had been sought. However, formal assessments of capacity had not been completed.

Staff were provided with training and professional development which enabled them to meet people's needs. People felt that staff were competent and could support them effectively.

The environment was maintained to provide safety and comfort for people. A system of reporting required repairs and maintenance was in place.

People enjoyed their meals. Their dietary needs and preferences were met.

People were supported appropriately with their healthcare and were referred appropriately to community healthcare professionals for ongoing support and review.

Is the service caring?

Good

The service was caring.

Staff knew people well and good relationships had developed between people and the staff.

People were encouraged to maintain relationships with family and friends.

Staff respected people's rights to privacy, dignity and independence. Where possible, people were able to make their own choices and were involved in decisions about their day.

Is the service responsive?

Good

The service was responsive.

There was a significant drive to promote social inclusion. People were supported to take part in suitable activities inside and outside the home. Action was being taken to recruit an activities organiser.

Each person had a care plan that was comprehensive and reflected the care they needed and wanted.

People told us they knew who to speak to if they had any concerns or complaints and were confident they would be listened to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The systems to assess monitor and improve the quality and safety of the service needed further improvements. Care plans had not been audited and systems for providing oversight on the registered manager had not been formalised.

There were systems in place to seek feedback from people living in the home, visitors and staff.

People made positive comments about the registered manager and staff. They felt the service was well managed.

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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 19 and 20 April 2018 and the first day was unannounced. The inspection was carried out by an adult social care inspector.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed the information we held about the service such as notifications and safeguarding information. Following the inspection, we asked for feedback about the service from community based mental health professionals. We received positive feedback about the service from three health and social care professionals.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with the registered manager, the administrator, five care staff and a member of the domestic team. We spoke with nine people living in the home.

We looked at a sample of records including six people's care plans and other associated documentation, three staff recruitment and induction records, staff rotas, training and supervision records, minutes from meetings, complaints and compliments records, medicines records, maintenance certificates, policies and procedures and quality assurance audits.

Good

Is the service safe?

Our findings

People who used the service told us they had no concerns about their safety at Rockmount Northwest. All people we spoke with told us they felt safe and secure with the care they received. Comments people made to us included, "I feel safe and comfortable here", "I'm much safer than I was a few years ago, this is the right place for me" and "Of course I feel safe and there are rules to keep us all safe here."

The registered provider had procedures in place to minimise the potential risk of abuse or unsafe care. Staff had received safeguarding training. We saw records of safeguarding enquiries and alerts that had been completed. Evidence we saw demonstrated that care staff were able to report concerns if they suspected people were at risk of exploitation or harm. Safeguarding procedures had been reviewed regularly and information on how to report concerns was readily available in the home. We saw that safeguarding issues and incidents were routinely discussed during staff and residents meetings as well as during staff supervisions. This meant people living and working in the home were familiar with the safeguarding procedures and were able to discuss any action to be taken and lessons learned from incidents. In addition, a member of the staff team was appointed as the safeguarding champion. They attended the local champion's forum. They told us information from this forum was disseminated to both staff and people who used the service. One staff member told us, "We have a duty of care to report any form of abuse and we are encouraged by the manager to whistle-blow or report any concerns externally."

Risks to people were assessed and their safety was monitored and managed so they could stay safe and have their freedom respected. We found accidents and incidents had been recorded and support had been sought from emergency services and health professionals where this was required. Accident and incidents had been analysed to identify patterns and trends. Lessons had been learned from these events. Staff had recorded the support they had provided to people after the incidents. Staff had also reported significant incidents to the local safeguarding authority in line with local and national guidance. While notifications had been submitted to Care Quality Commission, we found two incidents that had not been reported. We discussed the requirements for notifications for such incidents with the registered manager. They assured us that it was an oversight because the people involved had experienced the falls due to medical conditions and were not ordinary falls. They assured us that in the future they would ensure these incidents are notified regardless of the cause of fall.

People were supported to keep their property secure. We noted that all doors had a secure lock and all people had keys to their own rooms which helped people feel secure and assured them that their personal property and valuables were safe.

Staff had completed relevant training and had access to a set of equality and diversity policies and procedures. We also noted people's individual needs were recorded as part of the support planning process. This helped to ensure all people had access to the same opportunities and the same, fair treatment.

Risk assessments had been undertaken in keys areas of people's care such as falls, nutrition, choking drug or alcohol misuse and risk of self-harming. The manager had reviewed risk assessments and took

appropriate action when people's needs or risks had increased. For example, we found they had reviewed one person's support needs when their behaviour and mental health presentation changed. There was a review and update in their care plan to demonstrate the change in risk and changes to the measures that were required to minimise the risks to this person's health and wellbeing. In addition, they had requested other health care professionals to undertake reviews where necessary.

We looked at the arrangements in place for managing people's medicines. The service had continued to manage people's medicines safely. Errors had been identified in a timely way through medicines audits and the correct actions had been taken to reduce risks of reoccurrences. People were satisfied with the way medicines were managed. Staff designated to administer medicines had completed safe handling of medicines training.

We observed staff administering medicines during the inspection. They were kind and patient with all of the people they administered medicines to. They administered medicines safely, by checking each person's medicines with their individual records before administering them. This ensured the right person got the right medicine. At our last inspection we noted medicines were administered from a clinic style room which was located near the entrance to the home. We discussed with the registered manager whether consideration could be given to improving these arrangements to better protect the dignity and privacy of people who used the service. During this inspection, we found the same arrangements were in still in place. We discussed with the registered manager and care staff the importance of reviewing their approach to medicines administration. This would reflect a more sensitive, person centred approach. The registered manager informed us that they had discussed with people and people wanted to continue with the practice however they assured us that they would review this.

Protocols were also in place for medicines which were prescribed to be given 'when required'. We noted improvements had been made to handwritten medicines administration records (MAR). At out last inspection we found some handwritten MAR records had not been countersigned to confirm accuracy. At this inspection, all records were countersigned to ensure accuracy of transcribed instructions.

Records were kept for medicines that were awaiting disposal and medicines for disposal were kept securely. Arrangements had been put in place to ensure unwanted medicines were disposed of on a monthly basis. There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They were stored in a controlled drugs cupboard or secure safe, access to them was restricted and the keys held securely. There were daily medicines counts, as well as weekly and monthly audits. Staff had monitored the temperatures in the medicines storage rooms and fridges and kept records of these checks. This ensured that temperatures in medicine storage areas were kept at the recommended levels to prevent medicines from being compromised.

There were policies and procedures which defined and described the service's responsibilities in relation to medicines. People's care records contained comprehensive information about the medicines they took, their benefits and side effects. Arrangements were in place to ensure people could be supported with their medicines should they wish to visit their families for more than 24 hours. This meant that unnecessary restrictions were not placed on people leaving the home.

We looked at the recruitment records of three members of staff and found appropriate employment checks had been completed before they began working for the service. Checks had also been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the

applicant. Recruitment and selection policies and procedures were available.

We looked at the staffing rotas and found a designated shift leader was in charge with five care staff throughout the day and two care staff at night. Domestic staff worked five days each week. The service was in the process of recruiting an activities person. Following our last inspection an administrator had been employed to support with clerical work in the home. The registered manager and deputy manager worked varying hours to provide managerial cover and there was a system to provide out of hours support. Any shortfalls due to leave or sickness were covered by existing staff which ensured people were cared for by staff who knew them.

People made positive comments about the cleanliness of the service. They said, "I clean my own room and decorate it to my own taste, I'm a football fan you see." There were infection control policies and procedures for staff to refer to and staff had been trained in this area. Staff were provided with protective wear such as disposable gloves and aprons and suitable hand washing facilities were available to help prevent the spread of infection. There were contractual arrangements for the safe disposal of waste.

We looked at how the safety of the premises was managed. We found documentation was in place to demonstrate regular health and safety checks had been carried out on all aspects of the environment. We saw equipment was safe and had been serviced at regular intervals.

Training had been provided to support staff with health emergencies, fire safety and the safe movement of people. We observed people being supported safely and appropriately during the inspection; we observed staff offering reassurance when needed. Regular fire alarm checks and regular fire drills had been recorded to ensure staff knew what action to take in the event of a fire. Each person had a personal evacuation plan in place which assisted staff to plan the actions to be taken in an emergency. We noted recommendations made following a recent independent health and safety inspection were being addressed.

A business continuity plan was in place to respond to any emergencies that might arise during the daily operation of the home. The environmental health officer had awarded the service a five star rating for good food safety and hygiene practices. There was key pad entry to enter and exit the home; visitors were asked to sign in and out which would help keep people secure and safe.

Good

Is the service effective?

Our findings

People received effective care because they were supported by a staff team that were skilled and knowledgeable. All people we spoke to gave us positive feedback about the knowledge, expertise, skills and caring approach from the staff. Staff were experienced in supporting people living in the home.

Comments from people included; "The staff here know how to support me. They manage things for me including when I need to see my nurse"; "I'm very happy with the service that staff provide" and, "They support me with everything that I need; I'm much better in here than before; that's what my family think as well."

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 or 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 to see if the provider was working within the principles of MCA. The staff who worked in this service made sure that people had choice and control over their lives and supported them in the least restrictive way possible. We observed staff asking people for their consent before they provided care and treatment such as with administering medicines or with moving from one part of the home to another. Staff told us they understood the importance of gaining consent from people. Where people had some difficult expressing their wishes, they were supported by their relatives or an authorised person. Some consent records had been completed in relation to medicines management and health observations. However, other areas of consent such as photography were not consistently completed throughout the records we looked at.

When we undertook our inspection visit a significant number of people who lived at the home had DoLS authorisation requests submitted to the local authority and some had been authorised. The registered manager was regularly checking progress of the other applications. However, we found mental capacity assessments had not been formally recorded to demonstrate how the registered manager had reached the decision that some people were not able to make their own decision about living at the home, the suggested restrictions and various aspects of their care and treatment. We discussed this with the registered manager and they informed us that they would complete relevant documentation. We also observed that they had involved other professionals to determine people's best interests.

We recommend the registered manager and the provider to seek best practice on the application of MCA/DoLS principles.

The environment had been adapted to meet the needs of people living at Rockmount Northwest. Adequate

living space was provided and furnished to help maintain people's safety, independence and comfort. We noted appropriate signage was in place throughout the home and there were crafts, photographs and creative posters with inspiring words displayed on the corridor walls. Some areas of the home had been redecorated and extended. There was ongoing maintenance work and repairs.

We checked one bedroom and found it had been decorated to a high standard and to the persons' taste. The majority of the bedrooms were decorated to people's tastes and a homely environment had been created with personal items such as such as furniture, photographs, posters and ornaments. This promoted a sense of comfort and familiarity. Some people had their own fridges in their rooms to maintain their independence.

We looked at how the service trained and supported their staff. From our discussions with staff and from looking at records, we found they received a range of appropriate training to give them the skills and knowledge they needed. Staff told us all training was face to face and that they could ask for additional training if they wanted. There were effective systems to ensure training was completed in a timely manner.

All staff spoken with confirmed they received sufficient training that was useful and beneficial to their role. Staff said, "The training is good and you are not limited. I can ask for any additional training. In fact, I have asked for additional training in response to the needs that I identified in some of the people we support", "I completed one week induction and it has been very useful to prepare me for the role", Staff had either completed a nationally recognised qualification in care or were currently working towards one. Training and induction was linked to the Care Certificate which is an identified set of standards that health and social care workers adhere to in their daily working life.

New staff had undertaken induction training which included completion of the provider's mandatory training, working with more experienced staff, competency assessments. The registered manager completed regular reviews with staff during their probationary period to ensure they had the knowledge and skills to carry out their role effectively and competently. There was a programme of follow up and refresher training to ensure staff maintained their knowledge and skills in the mandatory areas.

Staff told us they were provided with support and encouragement from the management team. All staff received formal one to one supervision; this would help identify any shortfalls in staff practice and the need for any additional training and support. Staff told us they were able to express their views and opinions and were updated about any changes at regular staff meetings. However, we noted that improvements were required to the arrangements for monitoring and recording staff supervision. During the inspection, there was no monitoring record to provide an overview of who had received supervision and when their next supervision was due. We could not establish whether staff had received supervision without going through each staff member's record. We shared this with the registered manager who informed us they would review their systems. This would ensure that the provider, the registered manager and visiting professionals could have an effective overview of what supervision staff have been provided.

Staff told us communication was good. Regular handover meetings, handover records and communication diaries kept staff up to date about people's changing needs and the support they needed. Records showed key information was shared between staff and staff spoken with had a very good understanding of people's needs and the management of the home.

We looked at how people were protected from poor nutrition and supported with eating and drinking. There was a variety of choice for people. We observed there was a buffet style arrangement for breakfast in the morning. People could help themselves to cereals of their choice. In addition there was a hot drinks

machine for people to help themselves. People told us, "The meals are alright. We choose our own cereal in the morning and help ourselves", "I enjoy the meals and we all have a choice of two main meals." There were initiatives for promoting healthy life styles such as the benefits of healthy eating. People confirmed they were offered meals of their choice, including meals that met people's religious requirements. People had been involved in the weekly menu planning and told us they received plenty to eat and drink.

During our visit, we observed lunch being served in the main dining room. We observed people enjoyed their meals. The meals looked appetising and the portions varied in amount for each person; some were provided with extra helpings on request.

Information about people's dietary preferences and any risks associated with their nutritional needs was shared and maintained on people's care plans. Staff were aware of people who had special dietary needs such as a soft diet. People's weight was checked at regular intervals and appropriate professional advice and support had been sought when needed.

We looked at how people were supported with their healthcare needs. People's care records included detailed information about their medical history and any needs or risks related to their health. Appropriate referrals were made to a variety of healthcare agencies. The community psychiatric nurses and care co-ordinators regularly visited people to review their medicines, treatment plans and community treatment orders. People considered their health care was managed well.

Appropriate information was shared when people moved between services such as transfer to other services, admission to hospital or attendance to mental health tribunals. A member of staff accompanied people with a summary of their essential details, information about their medicines. In this way people's needs were known by staff and taken into account and care was provided consistently when moving between services.

We looked at how technology and equipment was used to enhance the delivery of effective care and support. We noted the service had internet access to enhance communication and provide access to relevant information. This also enabled people to have on-line contact with families and friends. There was also an up to date website where information was shared about the service, activities and any updates on progress and planned developments. Since our last inspection the provider had introduced an electronic care records system. Staff had been provided with hand held devices to for inputting details of the care they provided. CCTV was available covering the perimeter of the building to ensure people's safety.

Good

Is the service caring?

Our findings

People told us they were treated with care, respect and kindness and they were complimentary of the support they received. They said, "Staff are brilliant and kind", "Staff are very caring." One person said, "The staff are good to me. We all look out for each other." One health care professional said, "Rockmount Northwest is always a pleasure to ring and visit. Staff really seem to know and care about the residents and often go over and above the roles."

Another health care professional shared some extremely positive comments. They said, "I was very impressed by the genuine thoughtfulness, care and support that was given to the person during their transition to Rockmount. Staff at Rockmount continued to encourage them to visit regularly, to involve them in getting their room just as they wanted when discharged from hospital."

The overall atmosphere in the home appeared happy, calm and peaceful. We observed good relationships between staff and people living in the home and overheard banter, laughing and encouragement during our visit. We observed staff interacted in a caring, friendly and respectful manner with people living in the home. There was a key worker system in place which provided people with a familiar point of contact in the home to support good communication. People confirmed there were no restrictions placed on visiting and we saw relatives visiting as they wished.

We observed people were treated with dignity and respect at all times and without discrimination. People told us they could spend time alone if they wished. We observed staff knocking on doors and waiting to enter during the inspection. We observed a workman seeking permission from people before they entered their bedroom to undertake repairs. There were policies and procedures for staff about caring for people in a dignified way. This helped to make sure staff understood how they should respect people's privacy, dignity and confidentiality in a care setting. People were encouraged to maintain their independence and to develop new skills. They said, "Staff help me when I need help" and "I can go out when I like." Each person was responsible for their own laundry, however support was available from staff if needed.

From our discussions and observations it was clear staff understood the importance of acknowledging people's diversity, treating people equally and ensuring that they promoted people's right to be free from discrimination. People's preferences with regard to being cared for by male or female staff were recorded. People's ethnicity and sexual orientation was recorded in their care documentation, this meant people's needs would be fully met in line with their ethnicity or sexuality. Information about people's spiritual or religious needs had been recorded in their care plans and staff had been specifically employed to support people support people with their beliefs. For example, a staff member supported people every week to ensure they could attend the Mosque. In addition there were specific care plans on how to support people during specific religious periods such as Christmas and Ramadan. A quiet room was available for people to use for their prayers. This meant the provider had considered how to support people to meet their religious and faith needs.

People were dressed appropriately in suitable clothing of their choice. People also confirmed there were no

rigid routines imposed on them that they were expected to follow. We observed staff supporting people in a manner that encouraged them to maintain and build their independence skills. For example, people were supported to maintain their relationships and visit their local community on their own where possible. One person told us, "I'm very independent I can go out and about on my own and manage my own time."

People were encouraged to express their views by means of daily conversations, completing satisfaction surveys and at residents' meetings. The residents' meetings helped keep people informed of proposed events, enabled them to have a say about their food and gave people the opportunity to be consulted and make shared decisions.

One person told us they had their room decorated according to their personal preferences. Bedrooms were fitted with appropriate locks and people told us they could spend time alone if they wished.
Useful information was displayed on the notice boards and along the hall ways. This informed people about how to raise their concerns, any planned activities, the regulations under which the home operated, events in the local community and any changes in the home. Information about advocacy services was displayed. The advocacy service could be used when people wanted support and advice from someone other than staff, friends or family members.

Good

Is the service responsive?

Our findings

People who lived at Rockmount Northwest gave us positive comments about the staff team and the care and support they received at the service. All responses regarding life in the home were positive and people shared with us details of the various activities and ventures they undertook. Comments from people included, "I do all sorts of things, I play football every week and watch my local football team playing, I'm never bored", "I go to the gym on my own I have my own routine", "I have been studying at college and have just finished" and "I work at a local farm helping out."

There was a strong emphasis on providing and supporting people with a variety of activities of their choice. We saw people had season tickets for their local footballs teams. They told us staff supported them to attend the matches. In addition, two people played football for a local social football team. During the inspection, we observed people leaving the house independently attending their gym sessions, golf sessions and some were looking forward to their art classes. On the day of our visit we observed a pool competition was on. People were excited and looking forward to the competition. One person told us, "I like the art classes, we do some work and we can have a brew." We saw examples of art and crafts that people had completed to thank their staff.

People were supported to maintain local connections and important relationships and to have an active social and economic role in their local community. Some people were accompanied by staff to visit the local shops and enjoy meals out whilst another person attended the local gym. We observed other people relaxing and chatting to staff, visitors to the home or each other. We were told social evenings were held in and out of the home to support people with making personal relationships. One person told us, "You can choose what you want to do. I have a bus pass and will go to town when I want, its free here." This meant that people were supported to live as they wished, helped to reduce social isolation, stigma and enhanced people's well-being and feeling of self-worthiness.

The registered manager told us, "We place a lot of importance on activities both in the community and also in house, having recruited an activity coordinator for four days per week to organise group and one to one sessions for people." They also said, "We strive to reduce stigma and barriers by accessing non segregated activities when available including having our Christmas party in the local cricket club where families and friends come along." This meant people were able to engage in meaningful and enjoyable activities both inside and outside the home.

There were examples of people being supported to develop independent living skills. For example, people were responsible for cleaning their own bedrooms. They were also responsible for their laundry. One person told us, "We each have our own allocated laundry day when we can bring our clothes to the laundry, load the machine and dry our clothes." Key workers supported people to ensure that they were managing these tasks safely. In addition people were responsible for their own medicines when they visited their relatives for more than one day.

A health care professional told us, "Overall I have been extremely impressed with this service (and it is the

first time I have placed anyone at Rockmount) and there is a real warmth about the relationship and approach that staff have towards services users. I have recognised this with all staff, for example, the manager, deputy manager and support workers."

We checked how the provider ensured that people received personalised care that was responsive to their needs. The care plans were well written, comprehensive and person centred. Each care record contained a detailed personal and medical history. There were details of each individual's likes and dislikes as well as signs and symptoms for staff to look out for as an indication of when a person's mental health started to deteriorate. Best approaches to support people in the event of a relapse and details of their community mental health workers was also at hand in the event staff needed to use them. The care records had been developed, where possible, with contributions from each person, their family and their care co-ordinator. They identified what support each individual required. People told us they had been consulted about support that was provided before using the service. People's needs were carefully assessed before they moved into the service. This was to ensure that the home and staff were able to meet people's needs before they decided to admit them into the home. The transition process was comprehensive and holistic. A health care professional told us, "I have experienced an extremely smooth transition of a patient moving from long-term secure hospital to Rockmount."

Staff completed a range of assessments to check people's abilities and review their support levels. They checked individual's needs in relation to safety, mental and physical health and medicines. Specific requirements for each individual had been identified. For example, people who required assistance with accessing the community, soft diet, people who were at risk of mental health relapse and people who were at risk due to their vulnerability. Assessments and all associated documentation were personalised to each individual who stayed at the home.

There were systems in place to ensure staff could respond quickly to people's changing needs. This included a handover meeting at the start and end of each shift and the use of communication diaries, notice boards and handover sheets. In addition, staff had involved people's care co-ordinators, community psychiatric nurses and their GPs when they felt the need to do so. Details of the review and any changes to treatment of care plan were included in the care files. This showed a multi-disciplinary approach to mental health care.

Since our last inspection, the provider had introduced computerised care records. These were still being phased in at the time of our inspection. We saw staff using handheld devices to update people's daily records and the registered manager had a system to identify any alerts or actions that they needed to review using the computerised system. This meant the provider had responded to the need to modernise their practices in line with technological advances.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We looked at how the service shared information with people to support their rights and help them with decisions and choices. The registered manager confirmed the safeguarding procedure and service user guide could be available in different font sizes to help people with visual impairments. We found there was information in people's care plans about their communication skills to ensure staff were aware of any specific needs. Some posters in the home were written in an easy read format. We would now expect the provider to incorporate the practices into their policies to ensure consistency.

We looked at how the service managed complaints. The service had a policy and procedure for dealing with

any complaints or concerns, which included the relevant time scales and the contact details for Care Quality Commission (CQC) and external organisations. We noted there was a complaints procedure displayed in the entrance of the home and included in the welcome pack. There had been three complaints made about this service since the last inspection visit. People told us they were able to discuss any concerns during resident meetings; they told us they were resolved at that time. We also saw examples of responses that had been prepared by the registered manager following people's complaints. We received compliments from a professional who told us, "It is a pleasure to be able to talk so positively about this placement but this is a true account of how I have found my experience."

Where possible, people's choices and wishes for end of life care were being recorded, kept under review and communicated to staff. Where people advance care preferences were known, they were clearly recorded in their care records. Although the home did not admit people who were terminally ill, we saw there were times when people's physical health had deteriorated and they chose to remain at the home towards the end of their life. We noted that not all staff had received up to date end of life training. However, staff we spoke with told us they had requested this in light of people's changing needs. The registered manager assured us that this training would be arranged. This would demonstrate that staff were supported to develop their knowledge, skills and confidence to deliver end of life care.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection of October 2017, we found the provider had failed to operate effective systems to monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time we found the quality monitoring systems were not fully effective. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

During this inspection we found improvements had been made to the governance systems. Since the last inspection the provider had recruited an administrator to support the registered manager with clerical work related to care delivery. We saw that the management team and staff had worked hard to introduce much needed changes and improvements in areas such as the management of people's medicines and the quality assurance systems. However, we have made a recommendation in relation to the assessment of people's mental capacity to consent to their care arrangements. We found there were no formal care file audits which could have identified the shortfall before our inspection.

We found there was a governance framework in place to ensure that quality monitoring was reviewed and regulatory requirements were managed correctly. The registered manager monitored the quality of service by using a wide range of regular audits. These included audits of the medicines systems, staff training, health and safety, infection control and fire systems. We saw action plans were drawn up to address any shortfalls. The plans were reviewed to ensure appropriate action had been taken and the necessary improvements had been made. However, we noted that care files were not routinely audited to ensure the information they contained was accurate and up to date. This meant that the quality assurance processes in the home needed further improvements to ensure the provider and the registered manager can effectively identify areas of non-compliance.

At our last inspection, we found there was no documented evidence to demonstrate how the registered provider had provided oversight on the registered manager and the service. During this inspection in April 2018 we found they had introduced a sign in record to show when the nominated individual and their representatives had visited and who they had spoken to. However, this was not robust enough to demonstrate how they had checked that the registered manager was complying with regulations. We shared our findings with the registered manager and the nominated individual and they informed us that formal compliance visit records would be implemented immediately. They also informed us they had regular supervisions with the registered manager. A record of provider compliance checks would demonstrate that the provider is exercising their responsibility in providing oversight on regulatory compliance and holding the registered manager accountable.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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 felt their views and choices were listened to and they were kept up to date. They told us, "The manager's door is always open we can walk in anytime" and "I feel like can have a say on my care, but you know there are rules everywhere you go, so I respect that." People were encouraged to share their views and opinions about the service by talking with management and staff, attending regular meetings and by taking part in the annual satisfaction survey. Records showed people had been kept up to date about and their opinions had been sought and acted on.

At our last inspection, we found staff surveys had not been analysed or outcomes of the survey shared with staff. The registered manager informed us this would be implemented. During this inspection we found the views of people living in the home, staff and visiting health and social care professionals had been obtained during a recent customer satisfaction survey. The results for the survey completed by people who lived in the home had been analysed and shared with them. Action had been taken to address some of the suggestions in the survey. However, the staff survey had not been analysed. The registered manager informed us that they had discussed the survey with staff in the staff meeting. We saw minutes of the meeting which showed some of the issues raised in the survey had been discussed.

Comments from professional visitors included, "I have continued to be contacted regularly by staff and any issues have been dealt with promptly and appropriately. The Service user who is normally quite isolative and withdrawn, yet challenging, has engaged well with staff and other residents and has flourished whilst being at Rockmount.", "They contact me for advice on good practice regularly, as they constantly look for ideas of where they can improve even further", "The home's management team have worked so hard" and, "There is real warmth and passion with all staff, for example, the manager, deputy manager and support workers."

The registered manager had responsibility for the day to day operation of the service and was visible and active within the service. They were regularly seen around the home, and were observed to interact warmly and professionally with people and staff. All staff spoken with made positive comments about the registered manager and the way the home was managed. The registered manager was described as 'approachable', 'fair' and 'effective'.

The registered manager told us they were committed to the continuous improvement of the service. They were able to describe their achievements over the last 12 months and planned improvements for the year ahead. For example they told us, "We work closely with local services in terms of health promotion initiatives. In the last 12 months we have held charity fundraising events for Rethink, East Lancashire hospice raffle, Macmillan coffee mornings and Marie Curie cake sale. The registered manager had also set out planned improvements for the service in the Provider Information Return. This demonstrated the registered manager had a good understanding of the service and how it could be developed and improved.

Staff felt valued and were confident they worked well together as a team. Staff said, "The manager appreciates us; it makes a difference as it's not just a job", "It's good to get a thank you", "We get thanked for what we do. We are told if we are doing things wrong but we get praise for doing it right" They said communication with the registered manager and deputy manager was good and they felt supported to carry out their roles in caring for people. Staff said they felt they could raise any concerns or discuss people's care. There was a clear management structure. Staff were aware of the lines of accountability and who to contact in the event of any emergency or concerns; there was always a shift leader on duty with designated responsibilities.

Regular staff meetings had taken place and records showed they had been kept up to date and were listened to. Staff were provided with job descriptions, staff handbook, contracts of employment and had

access to policies and procedures which would make sure they were aware of their role and responsibilities.

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as the local authority safeguarding and deprivation of liberty teams. While the registered manager had reported a number of incidents to CQC. We found three incidents that had not been reported. We spoke to the registered manager who informed us that they had looked at the incidents which related to falls and considered that they were not reportable as they were caused by medical conditions. The registered manager assured us that all incidents would be reported in the future with details of the causes of the incident and what the service had done to support people involved.

We noted the service's CQC rating and a copy of the previous inspection report was on display in the home and on the home's website. This was to inform people of the outcome of the last inspection

The registered manager had forged good links with the local community and with other registered managers and providers in the local area, which helped to make sure people received care that was reflective of best practice.