

Stilecroft (MPS) Limited

Rosecroft Residential Home

Inspection report

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Workington
Cumbria
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26 November 2015

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 21 and 23 April. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rosecroft Residential Home on our website at www.cqc.org.uk

This focused inspection took place on the 25 November 2015 and was unannounced. When we previously inspected this service on the 21 and 23 of April we found that the service was in breach of regulations relating to medicines and record keeping. During this inspection we found that the service had carried out the necessary improvements and were no longer in breach of the Health and Social Care Act Regulations.

Rosecroft Residential Home provides care and accommodation for up to 51 older people. Situated in Workington it is a large detached property set in its own grounds. The accommodation is over two levels, on the ground floor is a small unit for people who live with dementia.

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

We found that the service had made sufficient improvements to the way it managed medicines.

The service had improved the way it planned people's care and the written records of care reflected this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Is the service safe?

We found that action had been taken to improve safety.

There were new arrangements in place for the ordering, storage and disposal of medicines.

The staff were aware of people who required special dietary arrangements that related to the type of medicines they were prescribed.

Documentation relating to medicines was being completed correctly.

We could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Requires Improvement ●

Is the service responsive?

Is the service responsive?

We found that action had been taken to improve responsiveness.

Care plans were of a consistently good standard.

There was a new electronic care planning system in place.

We could not improve the rating for responsive from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Requires Improvement ●

Rosecroft Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

We undertook an unannounced focused inspection of Rosecroft Residential Home on 26 November 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 21 and 23 April 2015 inspection had been made. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service responsive? This is because the service was not meeting some legal requirements.

The inspection was carried out by one adult social care inspector.

During the inspection we spoke with two people who lived in the home, three care staff, a member of kitchen staff, the administrator and the registered manager.

As part of the inspection we looked at four care records and care plans relating to the use and storage of medicines. We looked at people's individual care records and risk assessments to help us see how their care was being planned with them and delivered by the staff.

Before our inspection we reviewed the information we held about the service. We looked at the information we held about notifications sent to us about accidents and incidents affecting the service and the people living there. We looked at the information we held on safeguarding referrals, concerns raised with us and applications the manager had made under Deprivation of Liberty Safeguards (DoLS).

Is the service safe?

Our findings

When we previously inspected Rosecroft Residential Home we reviewed how people's medicines were managed and if they received them safely.

At that time we found medicines were not safely administered. We saw a medicine being given inappropriately, medicines that had not been stored correctly and poor arrangements around the ordering of medicines. We judged that this had a major impact on people who used the service.

On this inspection we found the provider had new arrangements in place for the ordering, storage and safe disposal of medicines.

The staff members we spoke with demonstrated their knowledge of medicines and their administration. For example we noted that some people had medicines prescribed that required special dietary arrangements. We found that the person administering the medicine, the care staff and the kitchen staff were all aware of these arrangements and carried them out correctly.

We performed a spot check of medicines and found that amounts of medication in stock were correctly documented. We also looked at the medication administration charts (MAR charts). We saw that the member of staff administering medicines had correctly completed the MAR charts to say who had had their medicines and who had not. We saw that some people's medicines had been omitted on the morning of our inspection but staff had correctly filled in the MAR chart and given reasons as to why. For example if someone was asleep.

We judged that the service was no longer in breach of the Health and Social Care Act.

Is the service responsive?

Our findings

On our previous inspection we noted that some of care plans in the home were basic and non specific, particularly those relating to people who lived with dementia. We judged that this had a moderate impact on people who used the service.

During this inspection we found the service had improved on its care plans. The staff had started to use an electronic care plan system that helped to prompt them to write detailed care plans that were person centred in order to meet people's needs.

The care plans we looked at for people who lived with dementia contained sufficient detail. They outlined people's needs, the support they required and examined risks to people's health and wellbeing.

When we spoke with staff they told us that they thought that care planning had improved. People who used the service appeared more involved in the care planning process and told us that they were satisfied with the care they received.

We judged that the service was no longer in breach of the Health and Social Care Act.