Metropolitan Housing Trust Limited

Rosswood Gardens

Inspection report

4,6 & 8 Rosswood Gardens
Wallington
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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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Rosswood Gardens is a residential care home providing personal care to 10 people. The service can support up to 16 people. People using this service have a learning disability and/or autism. Rosswood Gardens is comprised of three adjoining properties.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support
The service did not provide people with care and support in a safe, clean, well equipped, well-furnished and well-maintained environment that met their sensory and physical needs. People did not benefit from an interactive and stimulating environment.

People were encouraged to be as independent as possible and had choice and control over how they were supported.

The service made reasonable adjustments for people so they could be fully involved in discussions about how they received support, including support in the community.

Staff enabled people to access specialist health and social care support in the community.

Staff supported people to make decisions following best practice in decision-making. Staff communicated with people in ways that met their needs.

Right Care
Staff did not appropriately assess risks people might face, including risks associated with the environment and access to items that may cause harm to people.

People's care and support plans did not always reflect their range of needs and promote their wellbeing and enjoyment of life.

People received kind and compassionate care. Staff protected and respected people's privacy and dignity. They understood and responded to people's individual needs.

Staff understood how to protect people from poor care and abuse. The service worked well with other

agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

People who had individual ways of communicating, using body language, sounds, Makaton (a form of sign language), pictures and symbols could interact comfortably with staff and others involved in their care and support because staff had the necessary skills to understand them.

Right culture
Staff did not effectively evaluate the quality of support provided to people to ensure continuous improvement. The service did not have a culture of improvement and did not make timely improvements to enhance people's quality of life.

People and those important to them were involved in planning their care. Staff asked people, their families and other professionals for their views about the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 20 May 2021) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found that all of the improvements required had not been made and the provider continued to be in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to check whether they were now meeting legal requirements. We also assessed whether the service was applying the principles of Right support, right care, right culture. This report only covers our findings in relation to the Key Questions safe, effective and well-led which contain those requirements.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remains requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rosswood Gardens on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, the premises and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Rosswood Gardens

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors undertook this inspection.

Service and service type
Rosswood Gardens is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Rosswood Gardens does not provide nursing care.

The service did not have a manager registered with the Care Quality Commission. This is a person, who with the provider, are legally responsible for how the service is run and for the quality and safety of the care provided. It is a requirement of their registration with the Care Quality Commission to have a registered manager.

Notice of inspection
We gave a short period notice of the inspection due to the risks associated with the covid-19 pandemic.

What we did before inspection
Prior to the inspection we reviewed the information we held about the service, including statutory notifications received. We used all of this information to plan our inspection.

During the inspection
We communicated with seven people who used the service and one relative about their experience of the care provided. People at the service communicated in a number of ways, including verbal communication, use of Makaton and through people's own signing and body language.

We spoke with seven members of staff including the operations manager, the interim manager, the interim team leader, two support workers and two wellbeing coordinators.

We used the Short Observational Framework for Inspection (SOFI) and spent time observing people. SOFI is a way of observing care to help us understand the experience of people who could not talk with us

We reviewed a range of records. This included five people's care records and three people's medicines records. We looked at staff training and supervision records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found and reviewed additional management records sent. We also spoke with a member of the safeguarding team at the local authority and received feedback from a health professional supporting people at the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to sufficiently assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- People continued to be at risk of receiving support in an unsafe environment.
- Staff had not appropriately assessed and mitigated risks to people's safety. This included the risk of falling from windows because opening them had not been appropriately restricted. People were at risk of injury from access to sharp knives, kettles and irons and were at risk of burns or scalds from free standing heaters. There was also a risk of people not being able to call for assistance, as call bell cords had been tied up, and health hazards associated with mould in a bathroom.
- People's care records did not provide staff with up to date, accurate information about people's individual risks or how they were to be supported.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
At our last inspection the provider had failed to sufficiently protect people from the risk of infection. This was a breach of part of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of regulation 12.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● People were visited by friends and family and this was managed in a safe way. One relative told us , "when things began to open up [the staff] made sure we could visit [the person] with appropriate safety measures in place."

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service had effective measures in place to make sure this requirement was being met.

Systems and processes to safeguard people from the risk of abuse
● People were protected from abuse because staff knew them well and understood how to recognise and report abuse. The service worked well with other agencies to protect people from abuse.
● Staff had training on how to recognise and report abuse.

Using medicines safely
● People were supported by staff who followed systems and processes to administer, record and store medicines safely.
● Staff worked with medical professionals to ensure people had regular reviews of their medicines, and where possible supported people to reduce the amount of medicines they required.

Learning lessons when things go wrong
● Staff raised concerns and recorded incidents and near misses and this helped keep people safe.
● Staff used best practice guidance to record and track incidents, so if people required additional support this could be identified and put in place.
● A relative told us they understood their family member sometimes displayed behaviour that staff found challenging but staff informed them of any incidents and "explain[ed] the strategies they are going to use to address the issue."

Staffing and recruitment
● The service had enough staff to support people, including for one-to-one support. However, this was being covered by the provider's bank staff team and staff picking up additional shifts. The provider was currently having difficulties recruiting additional staff.
● There had not been any new staff recruited since our last inspection and therefore we did not review this area of service delivery.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs
- The environment was not homely and stimulating.
- The design, layout and furnishings in people's homes did not reflect their individual needs and preferences.
- At our previous inspection the provider told us a full refurbishment of the service was being undertaken, however, this had not occurred, and the environment still required refurbishment.

A safe and suitable environment was not provided. The provider was in breach of regulation 15 (premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support
At our last inspection the provider had failed to adequately assess people's needs and follow appropriate healthcare support and guidance. This was a breach of part of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of regulation 9.

- Staff worked with health and social care professionals to assess people's needs in line with best practice guidance.
- People had health actions plans and health passports which were used by health and social care professionals to support them in the way they needed.
- People were supported to attend annual health checks. A relative told us their family member was supported with their health needs, they said, "[The staff] are supporting [their family member] through an ongoing dental problem."
- Advice from multi-disciplinary team professionals about how to improve a person's health, independence and wellbeing was included in people's support plans.. We overheard staff talking about the achievements a person had made recently. They were full of praise for the person who had been able to achieve a task which had exceeded expectations.

Supporting people to eat and drink enough to maintain a balanced diet
At our last inspection the provider had failed to adequately support people to maintain a healthy, balanced

diet. This was a breach of part of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of regulation 9.

● People received support to eat and drink enough to maintain a balanced diet. We observed people sitting and chatting together to eat lunch. It was a friendly atmosphere and people talked with affection with each other and about each other.
● People were involved in choosing their food, shopping, and planning their meals. We observed that pictures were used to help people make meal choices.
● Staff encouraged people to eat a healthy and varied diet to help them to stay at a healthy weight. A health professional told us, "The quality and variety of the food provision does appear to have improved." A relative said, "With our blessing [their family member] has been on a diet and it is definitely working"

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

At our last inspection the provider had failed to support people in line with the Mental Capacity Act (MCA) 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of regulation 11.

● Staff worked with health and social care professionals to ensure people's needs were assessed and they were supported in line with the MCA.
● For people the service assessed as lacking mental capacity for certain decisions, staff clearly recorded assessments and any best interest decisions.
● Where appropriate, people had been assessed under the DoLS procedures. However, staff remained confused about some of the DoLS conditions. We advised them to liaise with social care professionals to seek clarification to ensure people were supported in the least restricted way.

Staff support: induction, training, skills and experience
At our last inspection the provider had failed to ensure staff received appropriate training and support to enable them to carry out their duties. This was a breach of part of regulation 18 of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of regulation 18.

● People were supported by staff who had received good quality training in evidence-based practice. This included training in communication, equality and diversity, health and safety, manual handling, MCA and DoLS, safeguarding, first aid, autism awareness and epilepsy awareness.
● Updated training and refresher courses helped staff continuously apply best practice.
● Staff received regular supervision and felt supported in their roles.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
At our last inspection the provider had failed to ensure there were appropriate systems in place to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider had not undertaken the actions required to meet all of the breaches of regulation identified at our last inspection, putting people at continuous risk of receiving unsafe care.
● The provider's quality reviews and audits were not effective in identifying and improving the quality of care delivery.
● Timely action was not taken to address improvements required, particularly in relation to the environment, risk management and the quality of care records.

The systems in place to assess, monitor and improve the quality and safety of the service were ineffective and placed people at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
At our last inspection the provider had failed to adequately engage and involve people at the service. This was a breach of part of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of regulation 17.

● People, and those important to them, worked with managers and staff to develop and improve the service. One relative said, "We are kept abreast of issues and most importantly [their family member]

appears happy and content - which is our biggest concern."

● People told us about what they did during the day and how they were supported to choose what activities they did and how they spent their time. People were supported to be involved in service delivery to help with building life skills and developing their independence. For example, one person helped staff to undertake fire safety checks and the fire alarm tests. Another person supported staff with the night-time security checks. This helped build people's skills and also supported them to reduce their anxieties around these tasks.

● The provider sought feedback from people and those important to them and used the feedback to develop the service. Feedback surveys had been undertaken and a regular meeting was held with people to obtain their views. Staff used a variety of communication methods to ensure everyone's views were heard.

● Since our last inspection staff had familiarised themselves with the Right Support, Right Care, Right Culture good practice guidance and were supporting people in line with principles of this guidance to enable people to have greater choice, control and independence.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The service apologised to people, and those important to them, when things went wrong.

● Staff gave honest information and suitable support, and applied duty of candour where appropriate.

Working in partnership with others

● The provider worked with health and social care professionals to improve practice and the support to people. Since our last inspection staff had been working closely with a range of health and social care professionals to improve overall service delivery and specific support to ensure people received person-centred care.

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 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured a safe, suitable, properly maintained environment was provided. Regulation 15 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people received safe care and treatment. Risks to people's health and safety had not been adequately assessed or mitigated. Regulation 12 (1)

The enforcement action we took:

A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there were appropriate systems in place to assess, monitor and improve the quality and safety of the service. Regulation 17 (1)

The enforcement action we took:

A warning notice was issued.