

Mrs Beverley M Winchester

# Roseleigh

## 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** 

### Overall summary

Roseleigh is a residential home which provides care and accommodation for up to six adults with learning difficulties including autism. The home is a detached house located in Horley. On the day of our inspection six people were living in the home. People had varied communication needs and abilities. Some people were able to express themselves verbally; others used body language to communicate their needs. Some of the people's behaviour presented challenges and was responded to with one to one support from staff.

This inspection took place on 9 September 2015 and was unannounced.

The home did not have 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 and associated Regulations about how the service is run. The manager of the home is in the process of registering to

# Summary of findings

become manager of this location. They were not present on the day of inspection and we were supported during our inspection by another registered manager and the area manager.

Staff had written information about risks to people and how to manage these. We found the registered manager considered additional risks to people in relation to community activities and changes had been reflected in people's support plans.

Staff had received training in safeguarding adults and were able to evidence to us they knew the procedures to follow should they have any concerns. One staff member said they would report any concerns to the registered manager. They knew of types of abuse and where to find contact numbers for the local safeguarding team if they needed to raise concerns.

Care was provided to people by a sufficient number of staff who were appropriately trained. Staff were seen to support people to keep them safe. People did not have to wait to be assisted.

People who displayed behaviour that challenged others had shown a reduction of incidents since being at the home and the number of staff on duty were adequate for their individual needs.

Processes were in place in relation to the correct storage of medicine. All of the medicines were administered and disposed of in a safe way. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

The Care Quality commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager and staff explained their understanding of their responsibilities of the Mental Capacity Act (MCA) 2005 and DoLS and what they needed to do should someone lack capacity or need to be restricted.

People were provided with homemade, freshly cooked meals each day and facilities were available for staff to make or offer people snacks at any time during the day or night. We were told by the registered manager that people could go out for lunch if they wished.

People were treated with kindness, compassion and respect. Staff took time to speak with the people who they supported. We observed positive interactions and it

was evident people enjoyed talking to staff. People were able to see their friends and families as they wanted and there were no restrictions on when people could visit the home.

People were at the heart of the service; and took part in a wide range of community activities on a daily basis; for example trips to the shops, and attending college. The choice of activities was specific and innovative to each person and had been identified through the assessment process and the regular house meetings held.

People had an individual support plans, detailing the support they needed and how they wanted this to be provided. We read in the support plans that staff ensured people had access to healthcare professionals when they needed. For example, the doctor, learning disablement team or the optician. People's care had been planned and this was regularly reviewed with their or their relative's involvement.

It was clear from our observations that the supporting manager and area manager knew the people very well and that people looked at them as a person to trust. Staff felt valued and inspired under the leadership of the management.

The manager had a robust system of auditing processes in place to regularly assess and monitor the quality of the service or manage risks to people in carrying out the regulated activity. The manager had assessed incidents and accidents, staff recruitment practices, care and support documentation, medicines and decided if any actions were required to make sure improvements to practice were being made.

The manager kept up to date with any changes in legislation that may affect the service, and participated in monthly forums with other managers from other services where good practice was discussed.

The service notified the Care Quality Commission of any significant events that affected people or the service and promoted a good relationship with stakeholders.

Complaint procedures were up to date and people and relatives told us they would know how to make a complaint. Confidential and procedural documents were stored safely and updated in a timely manner.

# Summary of findings

Staff were aware of the home's contingency plan, if events occurred that stopped the service running. They explained actions that they would take in any event to keep people safe.

People's views were obtained by holding residents meetings and sending out an annual satisfaction survey which staff supported people to complete using different methods of communication.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was safe.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of the safeguarding adult's procedures.

Medicines were managed safely, and people were supported to take their medicines themselves.

The provider ensured there were enough staff on duty to meet the needs of people individually.

Staff were recruited safely, the appropriate checks were undertaken to help ensure suitably skilled staff worked at the service.

Written plans were in place to manage risks to people. There were processes for recording accidents and incidents.

Good



### Is the service effective?

The service was effective.

Staff had the skills and knowledge to meet people's needs.

Staff received regular training to ensure they had up to date information to undertake their roles and responsibilities. They were aware of, and followed the requirements of the Mental Capacity Act 2005. Best interest decision had been documented accurately.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were offered a choice of food that met their likes and preferences.

Staff supported people to attend healthcare appointments and liaised with other healthcare professionals as required if they had concerns about their care.

Good



### Is the service caring?

The service was caring.

People told us they were well cared for. We observed caring staff that treated people kindly and with compassion. Staff were friendly, patient and discreet when providing support to people.

Staff took time to speak with people and to engage positively with them.

People were treated with respect and their independence, privacy and dignity were promoted. People and their families were included in making decisions about their care.

Good



# Summary of findings

## Is the service responsive?

The service was responsive.

People's care was personalised to reflect their wishes and what was important to them. Support plans and risk assessments were reviewed and updated when needs changed.

Staff were knowledgeable about people's needs, their interests and preferences in order to provide a personalised service.

Staff supported people to access the community which reduced the risk of people being socially isolated.

People felt there were regular opportunities to give feedback about the service.

**Good**



## Is the service well-led?

The service was well led.

There was not a registered manager in place.

There was an open and positive culture which focussed on people. The management welcomed and acted on people's and staff's suggestions for improvement.

The manager had a robust system in place to monitor the quality of the service provided and as a result continual improvements had been made.

Staff were supported by the management team. There was open communication within the staff team and staff felt comfortable discussing any concerns.

**Requires improvement**



# Roseleigh

## 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 09 September 2015 and was unannounced. The inspection team consisted of one inspector and an 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 care service.

Before the inspection, we reviewed all the information we held about the provider. We contacted the local authority commissioning and safeguarding team to ask them for their views on the service and if they had any concerns. We also reviewed information sent to us by the provider in the form of notifications and safeguarding adult referrals made to the local authority. A notification is information about

important events which the provider is required to tell us about by law. The provider had not been sent a Provider Information Return (PIR) before the inspection, the PIR is a form that asks the provider to give some information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who used the service. We observed care and support in communal areas and looked around the home, which included people's bedrooms, the main lounge and dining area. We spoke with three people, three members of staff, the supporting manager, the behaviour therapist and the area manager.

We reviewed a variety of documents which included four people's support plans, medicine records, four weeks of duty rotas, maintenance records, all health and safety records, menus and quality assurance records. We also looked at a range of the provider's policy documents. We asked the registered manager to send us some additional information following our visit, which they did.

Roseleigh had been inspected in February 2015 where no areas of concern had been identified.

# Is the service safe?

## Our findings

People told us they felt safe and did not have any concerns. One person said “It’s my home, I am safe here.”

Staff had a good understanding of what constituted abuse and the correct procedures to follow should abuse be identified. For example, one member of staff explained the different types of abuse and what the local authority safeguard protocols were. They said, “I would report anything to the manager.” The manager showed us the safeguarding policy which was in place and staff had signed to show they had read and understood their responsibilities. The home reported incidents to the local safeguarding team appropriately.

Staff had individualised and personalised guidance so they could provide support to people when they needed it to reduce the risk of harm to themselves or others. Behaviour management plans had been developed with input from specialist professionals, such as behaviour therapists. We observed staff interactions with people during the day. Staff followed guidance as described in the people’s support plans. We spoke with the visiting behaviour therapist who told us that people and the staff are supported individually to promote positive behaviours within the home.

There was a transparent and open culture that encouraged creative thinking in relation to people’s safety. People’s choices on how they lived their lives was the first priority and the manager and staff would ensure that people were able to achieve this. Assessments of the risks to people’s safety in relation to life choices they had made had been developed while ensuring that people remained as independent as possible and had a meaningful and fulfilling life. For example people were supported to undertake work placements such as with national rail. The behaviour therapist told us the provider was working with local businesses to develop other work placements for people.

Support plans contained risk assessments in relation to people who required one to one supervision, as well as individual risks such as walking to the shops, accessing community transport and nutrition. Staff told us they had signed the risk assessments and confirmed they had read

and understood the risks to each person. They were able to describe individual risks to people, their behaviours and how to address these. People who were able to had signed their risk assessments and understood what they were for.

There were safe procedures in place for the administration and storage of prescribed medicines. The supporting manager said that they encouraged people to be as independent as possible with their medicines. We looked at medication administration records (MAR) and confirmed this had happened. People who were on as required medicines had protocols in place which we saw staff had followed. Staff and people administered the medicine collaboratively as directed and this showed us that people had received their medicines as prescribed and that staff managed medicines safely and appropriately. We observed staff administering medicines safely and in a dignified manner. Staff had training in the safe administration of medicines and their competencies were assessed. The home was supported by the local pharmacy in providing their training programme.

We observed enough staff during the day that people did not have to wait. Staff supported people on a one to one basis. The supporting manager told us that staffing levels were determined based on people’s needs. Their dependency levels were assessed and staffing allocated according to their individual needs; for example, one person received one to one support and supervision. The manager told us staffing levels were constantly reviewed to meet the changing needs of people, we were told that extra staff employed by the provider would be used if necessary. Staff told us they felt there were enough staff to meet people’s needs.

Staff recruitment records contained information to show us the provider took the necessary steps to ensure they employed people who were suitable to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring Service (DBS) check. The DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

The management had systems in place for continually reviewing incidents and accidents that happened within the home and had identified any necessary action that needed to be taken. We were told that any incidents of behaviour that challenge others were referred to the Behaviour Specialist employed by the provider for

## Is the service safe?

support in managing behaviours and identifying triggers that may have caused the incidents. The behaviour specialist said that if triggers were identified and actions implemented it would reduce the risk to people of incidents happening again.

The supporting manager told us the home had an emergency plan in place should events stop the running of the service. They explained that the provider owned the property directly behind and that should the need arise people would be taken there. Staff confirmed to us what they were to do in an emergency.

# Is the service effective?

## Our findings

Staff ensured people's needs and preferences regarding their care and support were met. Staff were knowledgeable about the people they supported and understood their life choices. One staff member told us about how people preferred to be supported with personal care at different times of the day. They describe to us people abilities and strengths.

People were encouraged and supported to be involved in the planning and preparation of their meals. We saw that food choices were displayed in the kitchen. People were asked each weekend their choices for the following week and this was recorded in a book. Lunch was cooked by the staff as people were out of the house taking part in activities, everyone got involved in preparing the evening meal. People who were unable to communicate verbally were supported to make their choice by using picture cards.

People had a choice about what and where they wanted to eat. People were able to choose to eat their lunch where they wanted and lunch was served in separate bowls so people could help themselves. People's weight was monitored on a monthly basis and each person had a nutritional profile which included the person's food allergies, likes, dislikes and particular dietary needs. There was no one at Roseleigh who had specialist dietary requirements.

In the kitchen one of the staff members demonstrated how they supported people appropriately. They explained that it was called, "hand on hand" where a person put their hand over the support worker's hand so that they could take part in activities but also stay safe. They explained that the person had a verbal vocabulary of about 12 words but that they responded well to basic Makaton (a form of sign language) and adapted questions in different ways to assist people with understanding so they could make a decision. We saw staff communicate with various people using Makaton, to ask them if they were happy, what they wanted for lunch, and to explain the programme for the afternoon. This ensured that the person was involved in their choices about food and ensured they were able to communicate effectively with staff in relation to their nutritional needs.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act (MCA) 2005. They aim to make sure people in care homes are looked after in a way that does not inappropriately restrict their freedom. The provider said people could go out on their own if they wished, but they chose not to. If they were to do so, staff would explain the risks to them and sought their consent that they supported them.

Mental capacity assessments had been undertaken for everyone and included assessments for the decision on people's annual flu jab and consent to care. We saw in people's support plans clear evidence of how choices were made; for example for dental surgery that required a general anaesthetic. The documents contained records of the best interest meeting held and those people that were involved such as the person, the family and the social worker. The best interest checklist described how one person was unable to read and write and stated that 'they are to be supported to understand the decision that needs to be made through using photos and visual prompts.' This meant that the manager had obtained or acted in accordance with the consent of people, and had completed documentation for establishing and acting in accordance with the best interests of people. We saw staff through the day offer people choices of what to eat, and if they would like to go out and where they would like to go.

Staff received training which included how to support people in a safe and dignified manner that may be at risk of causing harm themselves or others. Staff had access to a range of other training which included positive behaviour support, MCA, DoLS and manual handling. Staff were up to date with their training and were assessed for competency by the manager in certain topics such as administration of medicines. They were observed undertaking care practices to ensure that the dignity and respect of people was upheld. This meant staff developed essential skills to provide the appropriate support in a positive and constructive way.

Management supported staff to review the appropriate induction and training in their personal and professional development needs. The induction consisted of the recommended Skills for Care induction (Skills for Care is the employer-led workforce development body for adult social care in England. By working with employers and

## Is the service effective?

sharing best practice, they help raise quality and standards across the whole sector and ensure dignity and respect are at the heart of service delivery). The management held regular supervision sessions and annual appraisals with staff which looked at their individual training and development needs. One staff member told us about their induction training. They said they had received a good induction when they first started working at the home and that training had been on-going. They said, "The training really supported me do my job."

Support plans contained up to date guidance from visiting professionals and evidence that people had access to other health care professionals such as GP's, psychiatrist, specialist support and development teams and chiropodists. This showed us that the staff had up to date information of the specific conditions people experienced and were always seeking to improve the person's care, treatment and support they provided by implementing best practice.

# Is the service caring?

## Our findings

One person told us, “I really like the staff, they help me.” People looked relaxed and comfortable with the care provided and the support received from staff. One person was heard talking to staff throughout lunch, seeking advice and support. We heard staff reply cheerfully and with kindness to their requests

We spent time in communal areas and observed staff interaction with people. We saw companionable, relaxed relationships were evident during the day. Staff were attentive, caring and supportive towards people. Staff were able to describe to us each person’s needs. The supporting manager said people were encouraged to be independent. For example, clean their room, do their own washing, help prepare meals and attend college. Each person did their own personal shopping with staff.

Staff knew people’s individual communication skills, abilities and preferences. There were a range of ways used to make sure people are able to say how they felt about the caring approach of the staff and whether they had a sense that they mattered and belonged. Staff knew they needed to spend time with people to be caring and have concern for their wellbeing. The conversations between staff and people were spontaneous and relaxed. Staff understood the different ways in which people communicated and responded using their preferred communication method for example Makaton.

People who had been assessed as requiring one to one support had this provided with consistency and the same member of staff was assigned to the person throughout the day which gave the person reassurance that their care would be delivered consistently. Staff were knowledgeable about people and gave us examples of people’s likes, dislikes and preferences. We heard the supporting manager and staff regularly ask people how they were.

Staff told us they reviewed peoples’ support plans regularly. They said they would involve the person in reviewing their care and ask for input from relatives. Support plans had been signed by either people who used the service or their relative. One relative we spoke to said that they were regularly contacted by the home and invited to care review meetings which they attended.

Staff gave good examples of how they would provide dignity and privacy by closing bathroom doors and other examples. We observed staff calling people by their preferred names and knocking on bedroom doors before entering. People were well dressed and clean. For example, with appropriate clothes that fitted and tidy hair which demonstrated staff had taken time to assist people with their personal care needs. One person told us, “I didn’t like having my hair washed so the staff give me incentives to do it.”

# Is the service responsive?

## Our findings

One person said they had been supported to undertake activities that they were interested in. One person told us they had wanted to go aboard with staff and this had been arranged with them by staff. They told us, “Two more sleeps to go. I’m going for three days to Paris.”

Records we viewed and discussions with the staff demonstrated a full assessment of people’s needs had been carried out before people had moved into the service. Some people had lived with the provider for many years. As a result the staff and other people knew each other extremely well and were able to provide care that was person centred, and support friendships that had developed between people.

People’s care and support was planned proactively and in partnership with them. Staff used innovative and individual ways of involving people so that they felt consulted, empowered, listened to and valued. The home had a Makaton word of the week which both staff and people learnt to support their communication. Support plans comprised of various sections which recorded people’s choices, needs and preferences in areas such as nutrition, healthcare and social activities. We saw each area had been reviewed at regular intervals. Staff said they used various different communication methods for this such as photos and PECS (picture exchange communication). People who were able to, told us they had been involved in reviewing their plan of care.

Each person had a keyworker who sought the person’s views and supported them when planning activities, holidays and opportunities to access the community. One person said, “I am going on a bus to town for food shopping. And, “My girlfriend is coming on Saturday. We’re going to have a takeaway and go out for a walk.” Staff explained that they liaise with them so that both people can be supported to maintain their life relationship.

Staff supported people to access the community which reduced the risk of people being socially isolated. Daily records recorded the care and support people had received and described how people spent their days. This included activities they had been involved in and any visitors they

had received. People said about activities they had taken part in such as going to the day centre, bowling, on holiday and other activities. One person told us that they have a job, “Watering flowers on the railway station

People were at the heart of the service. Staff spent time chatting with each person and responding to their need for companionship. People and their relatives had been asked about their personal histories and any interests or hobbies and efforts were made to support people to continue with these. For example, one person was passionate about trains and buses and staff had supported them to get a travel pass and regularly go on trips.

Staff ensured that people’s preferences about their care were met. One staff member told us there was always a handover and the first thing they did was to read the communications book. We did not observe handover as staff were on duty for a long day. They had written daily notes about people and would highlight any changes to the needs of the person to the manager so that the care plan could be reviewed for accuracy. People’s health passports were regularly updated. A health passport is a useful way of documenting essential information about an individual’s communication and support needs should they need to go into hospital.

People were actively encouraged to give their views and raise concerns or complaints. The service saw concerns and complaints as part of driving improvement. People’s feedback was valued and people felt that the responses to the matters they raised were dealt with in an open, transparent and honest way. The provider held a client voice group in which a representative person from each of the provider’s service’s attended. They would discuss all types of things from activities, accommodation to food and feed back to head office. They would also make suggestions for improvements. People had asked if they could look at the possibility of work placements and the provider had approached some local companies about this.

People new how to complain if they needed to. There was an easy read complaints procedure for people to use. There had been no formal complaints received in the last 12 months. The supporting manager showed us the complaints policy and explained how they would deal with a complaint if one arose. They told us they would ensure the outcome of the complaint was fed back to the person concerned and actions implemented if necessary.

## Is the service responsive?

The supporting manager showed us satisfaction questionnaires that people had completed all of which showed positive comments. They explained to us that the

care staff had supported peoples' individually to fill them in. Relatives and external professionals were also being sent questionnaires for their views on how the service runs and any improvements that might be needed.

# Is the service well-led?

## Our findings

Staff said management were approachable. People said that they liked the manager, although the manager was not present on the day of inspection people spoke fondly of them. We observed people approach the supporting manager with openness and in a friendly manner.

The home did not have a registered manager. The day to day manager of the home had transferred from another of the provider's homes. They were registered with CQC for the other home, however needed to submit the appropriate applications to become registered for Roseleigh.

There was an open and positive culture within the service which focussed on people. Staff expressed their confidence in being able to approach the management; even if this was to challenge or report poor practice. They felt they would be taken seriously by the new manager. Staff told us they had been supported through their employment and were guided and enabled to fulfil their roles and responsibilities in a safe and effective manner.

Staff told us they had staff meetings regularly and supervisions and could always request extra meetings if they wanted to talk about anything. The staff showed us the communication books that were used regularly as a daily method of sustaining continuity of care. For example noting how people were feeling, following up on doctors appointments etc.

The provider had arranged an employee's voice group which allowed 360 degrees feedback which enabled staff to discuss and ensure they followed best practice. One of the issues discussed was to join the Social Care Commitment. The **Social Care Commitment is the adult social care sector's promise to provide people who need care and**

**support with high quality services.** It is made up of seven 'I will' statements, with associated tasks. Each commitment will focus on the minimum standards required when working in care. The commitment aims to increase public confidence in the care sector and raise workforce quality in adult social care.

The manager carried out a robust audit process to ensure the quality of the service and drive improvements in best practice. These included checks of support plans, all aspects of the environment, fire safety and the minibuses. To enhance and update their knowledge and service delivery, the management researched and reviewed varied publications and websites that specialised in providing guidance and advice to improve health and social care. Guidance and advice were followed in practice when they were appropriate to people's needs.

The manager has developed and sustained a positive culture in the service encouraging staff and people to raise issues of concern with them, which they have always acted upon. The manager gained daily feedback from people about their choice and preference. People had been supported to complete satisfaction surveys. The manager had sent surveys to family members and professional's and was waiting for the responses to be returned.

All the policies that we saw were appropriate for the type of service, reviewed annually, were up to date with legislation and fully accessible to staff. The staff knew where they could seek further guidance and how to put the procedures into practice when they provided care.

The manager had ensured consistently that the appropriate and timely notifications had been submitted to CQC when required and that all care records were kept securely throughout the home.