

Achieve Together Limited

Rosebank Lodge

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Rosebank Lodge is a residential 'care home' providing personal care and support to up to 13 people. The service provides support to people with learning disabilities and autistic people. At the time of our inspection there were 9 people living at the care home. The care home accommodates people in 1 adapted building.

A person who lived at the care home in their own self-contained accommodation did not receive any personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

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 Care Quality Commission (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.

The service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right Support

People received a service that was safe for them to live in and for staff to work. The service quality was reviewed regularly, and appropriate changes made to improve people's care and support if required. This was in a way that suited people best. The care home had well-established working partnerships that promoted people's participation and reduced the danger of social isolation.

Right Care

Staff were appropriately recruited and trained and there were enough of them to support people to live in a safe way, whilst enjoying their lives. Risks to people and staff were assessed, monitored, and reviewed. Complaints, concerns, accidents, incidents and safeguarding issues were appropriately reported, investigated, and recorded. Staff were trained staff to safely administer people's medicines.

Right culture

The care home's culture was positive, open, and honest, with leadership and management that was clearly identifiable and transparent. Staff were aware of and followed the provider's vision and values which were clearly defined. Staff knew their responsibilities, accountability and were happy to take responsibility and report any concerns they may have.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The feedback we received from various community health and social care professionals was positive about the standard of care provided at Rosebank Lodge. For example, a community care professional told us, "My clients are very well cared for at Rosebank Lodge and enjoy living there."

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

This service has been in Special Measures since 15 November 2022 when we rated them Inadequate overall. During this inspection, the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected

We conducted an unannounced inspection of this service on 15 November 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to comply with the Warning Notices and outstanding requirements we previously served in relation to Regulations 11 (Need to consent), 13 (Safeguarding service users from abuse) and 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; and, Regulation 18 (Registration) Regulations 2009 - Notifications of other incidents.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions safe and well-led which contain those 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 has changed from inadequate to requires improvement. This is based on the findings at this inspection.

We could not improve the rating from inadequate to good though because to do so requires consistent good practice over time. We will check this during our next planned inspection of the service.

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 COVID19 and other infection outbreaks effectively.

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

Follow up

We will collaborate with the provider to monitor how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Rosebank Lodge

Detailed findings

Background to this inspection

The inspection

We conducted 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 Health and Social Care Act 2008.

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

The inspection was conducted by an 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.

Service and service type

Rosebank Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Rosebank Lodge is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the CQC to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. An acting manager had been in post for 6 months between October 2022 and March 2023, but had now left. A new acting manager had been appointed and would commence working at the care home by May 2023.

Notice of inspection

This inspection was unannounced. Inspection activity started on 5 April 2023 and ended on 12 April 2023. We visited the care home on the first day of the inspection.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We received email feedback from 4 community health and social care professionals, including local authority social workers and an NHS learning disability nurse, who all worked closely with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We met and engaged with 6 people who lived at the care home and spoke in-person with the regional manager, 3 support workers and a registered manager who ran another of the providers care homes.

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

We reviewed a range of records. This included 4 people's care and risk management plans, and 3 staff files in relation to their recruitment. We also checked a variety of records relating to the management of the service, including staff rotas, training, multiple medicines records and provider level audits.

We continued to seek clarification from the provider to validate evidence found. We requested additional evidence to be sent to us after our inspection. This included staff recruitment checks, training and supervision records and quality assurance audits conducted by the provider. We received the information which was used as part of our inspection.

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 inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were still not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

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

Ensuring consent to care and treatment in line with law and guidance

At our last inspection, the provider had failed to ensure people were protected from avoidable harm and deprived people of their liberty unlawfully. This was a breach of regulation 11 (Need to consent) 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 regulation 11.

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.

- People now consented to the care and support they received from staff at the service.
- Staff had now received positive behavioural support training and appropriately dealt with situations where people displayed behaviour that communicated distress. Staff appropriately dealt with situations patiently helping people to calm down when they were getting anxious. A member of staff told us, "I've recently refreshed my training in how to prevent and manage behaviours that challenge in a more positive way and I'm fully aware of the new guidelines that the positive behavioural support team have developed to keep the people who live here and staff safe."
- There were personal behavioural plans in place for people if required. There had been no use of any physical restraint by staff on anyone living at the care home since our last inspection and locks had been removed from all bedrooms where people who occupied these spaces were unable to open their bedroom door.

- Staff had also received up to date MCA and DoLS training and were aware of their duties and responsibilities in relation to the MCA and DOLs.
- Care plans had all been reviewed and clearly described what decisions people could make for themselves. The assessment process addressed any specific issues around capacity.
- There were now processes in place where, if people lacked capacity to make specific decisions, the service would involve people's relatives and professional representatives, to ensure decisions would be made in their best interests. We found a clear record of the DoLS restrictions that had been authorised by the supervising body (the local authority) in people's best interests.

Assessing risk, safety monitoring and management

At our last inspection, the provider had failed to ensure people received a safe service. This was a breach of regulation 13 (Safeguarding service users from abuse) 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 regulation 13.

- People were now supported to stay safe while their rights were respected.
- Peoples care needs were risk assessed and were actively supported to take acceptable risks and enjoy their lives safely.
- People now had up to date care plans that contained detailed person-centred risk assessments and management plans to help staff keep people safe. For example, detailed behavioural support, communication passports, moving and handling, and falls prevention plans were now in place for people who required them. This meant staff now had access to detailed guidance about the actions they needed to take to keep people safe.
- The risk assessments and management plans were regularly reviewed and updated as people's needs changed. For example, the providers own positive behavioural support managers had spent 6 months at the care home helping staff review and update behavioural support plans for everyone who lived at Rosebank Lodge.
- The staff team were familiar with people's daily routines, preferences, the risks they might face and the action they needed to take to prevent or appropriately manage those risks. For example, staff were aware of the action to take to minimise risks associated with people choking whilst eating and drinking. A community care professional told us, "The staff who work at Rosebank Lodge are all very caring and dedicated. They know my clients and how to appropriately support them in order to meet their care needs." Another community care professional added, "I do believe the staff working at the care home now know what risks people living there might face and how to manage them safely."
- Staff received training in the areas required to conduct their role and responsibilities safely. Training provided included safeguarding, moving and handling and safe management of medicines.
- Regular checks were completed to help ensure the safety of the home's physical environment and their fire safety equipment. There was clear guidance available for staff to follow to help them deal with emergencies. For example, in relation to fire safety we saw personal emergency evacuation plans were in place to help staff evacuate people in an emergency.
- General risk assessments were regularly reviewed and updated including reference to equipment used to support people, such as mobile hoists. This equipment was regularly serviced and maintained.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse. People's use of verbal language was limited to

communicate their views about living in the care home so they did not comment on the service. Their body language during our visit was relaxed and positive indicating that they felt safe.

- The provider had clear safeguarding and staff whistle-blowing policies and procedures in place. Whistleblowing is the term used when a worker passes on information concerning perceived wrongdoing, typically witnessed at work.
- Staff were trained how to identify signs of abuse and the appropriate action needed, if required. They knew how to raise a safeguarding alert. Staff had to confirm that the provider had made their safeguarding procedure available to them and they had read it. A member of staff told us, "I have received up to date safeguarding training and know I must always tell the person in charge of each straight away if I suspect or see pole who live here are being abused or neglected." A community care professional added, "I believe now [name of regional manager] has taken up the role of managing the service they would deal appropriately with any allegations of abuse or neglect.
- Staff demonstrated a thorough knowledge of what people's gestures, and sounds they made meant including different pitches indicating their moods and if they were happy or not and things they wished to do.
- Areas of individual concern about people, were recorded in their care plans. For example, this included where people had been assessed as being of risk of financial abuse and what action staff had to take to prevent this happening.

Staffing and recruitment

- We were assured the provider's staffing and recruitment systems were safe.
- Staffing levels were flexible. The provider used a dependency tool to calculate the number of staff that needed to be on duty at any one time in order to meet people's needs. For example, since our last inspection 1 to 1 support had been introduced for a person living at the care home whose needs had changed. There were now enough staff to safely meet people's care and support needs. Manager's and staff were visibly present throughout this inspection and matched the duty rota for the day. We observed staff were always quick to respond to people's requests for assistance or to answer their queries.
- The care home had very few staff vacancies and were not reliant on temporary agency staff. A community care professional commented, "Staff retention has remained stable at the care home in the last 6 months."
- The provider's staff recruitment process was thorough, and records demonstrated they were followed. The provider conducted thorough pre-employment checks to ensure the suitability of staff for their role. These included checks on prospective new staffs identify, previous employment, their character, their right to work in the UK and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- The staff recruitment process also included interview questions that were scenario-based to identify prospective staffs' skills and knowledge of learning disabilities.

Using medicines safely

- Medicines systems were well-organised, and people received their medicines safely.
- Medicines were safely administered, appropriately stored, disposed of, and regularly audited by managers and senior staff. People kept their medicines safely secured in individual medicines cabinets located in their bedrooms. We found no recording errors or omissions on any medicines records we looked at. A community care professional told us, "My clients do receive their prescribed medicines as the should and this was evident to me when I carried out my unannounced check."
- People's care plans included detailed guidance for staff about their prescribed medicines and how they needed and preferred them to be administered. This included detailed guidance about when and how to safely administer any 'as required' medicines people might be prescribed.

- Staff authorised to manage medicines in the care home were clear about their responsibilities in relation to the safe management of medicines. These staff received safe management of medicines training and their competency to continue doing so safely was routinely assessed by managers.

Preventing and controlling infection

- The provider followed current best practice guidelines regarding the prevention and control of infection including, those associated with COVID-19.
- The providers policy in relation to all visitors to the care home testing for COVID-19 has recently changed to reflect the governments risk-based approach. The provider continued to access COVID-19 testing for people living, visiting, or working at the care home if they showed signs or symptoms of COVID-19.
- Similarly, the providers personal protective equipment (PPE) policy had also been amended to reflect the governments risk-based approach to the wearing of PPE in care homes. This meant it was no longer mandatory for all visitors and staff working at the care home to have to wear personal protective equipment (PPE).
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. The care home looked and smelt hygienically clean.
- Staff had received up to date infection control and food hygiene training that people said was reflected in their work practices.

Visiting in care homes

- The care home's approach to visiting followed government guidance and the impact on people in relation to this was that they could receive visitors safely. People could visit the care home whenever they wished providing they followed the services infection prevention and control policy and procedures.

Learning lessons when things go wrong

- The provider learnt lessons when things went wrong. The home had regularly reviewed accident and incident records to reduce the possibility of reoccurrence.
- Any safeguarding concerns and complaints were reviewed, analysed, and responded to with emerging themes identified, necessary action taken and ways of avoiding them from happening again looked at. This was shared and discussed with staff during team meetings and handovers.
- The provider had systems in place to record and investigate any accidents and incidents as they occurred. This included a process where any learning from these would be identified and used to improve the safety and quality of the service they provided. For example, all the care homes communal areas had been redecorated and furnished in the last 6 months.

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 inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was still inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

Managers and staff being clear about their roles, and understanding quality performance, risks, and regulatory requirements; and Continuous learning and improving care

At our last inspection the provider had failed to ensure systems in place monitored the service to drive improvements. This was a breach of regulation 17 (Good governance) 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 regulation 17.

- The service has improved and was moving in the right direction through continuous learning.
- The provider had completed a time specific action plan and had made all the improvements they said they would to address all the outstanding issues we identified at their last inspection.
- The regional manager recognised the importance of learning lessons and continuous improvement to ensure they maintained high-quality, person-centred, and safe care for people. For example, they had recently introduced an electronic governance and record keeping system that automatically flagged up when records were not appropriately maintained by staff or when things had gone wrong.
- managers routinely monitored the quality and safety of the service, at both a provider and service level. For example, visiting managers routinely toured the care home in-person to observe staffs working practises, check the safety of the building and obtain feedback from people living there. A quality assurance compliance manager also regularly visited the care home to conduct their own internal audit. These quality assurance checks and stakeholder feedback were routinely analysed to identify issues, learn lessons, and develop action plans to improve the service they provided people.
- The outcome of these audits and checks were routinely analysed to identify issues, learn lessons, and develop action plans to improve the service they provided people. For example, the providers quality assurance systems had indicators that identified how the service was performing, areas requiring improvement and areas where the service was achieving or exceeding targets.
- Community care professionals spoke positively about how the provider was now continuously learning and improving the service. A community care professional told us, "I have no immediate concerns about the care home having recently visited. The regional manager continues to have oversight of Rosebank Lodge

regularly visiting and conducting spot checks and internal audits there. [Name of regional manager] is clearly committed to continuously improving the service people who live there receive." Another community care professional added, "I was reassured by the regional manager that they were making the improvements they needed to do to rectify all the issues the CQC found at their last inspection and ensure they now provided people who lived there with good, safe care."

At our last inspection, the provider had failed to notify the Commission of reportable incidents. This was a breach of regulation 18 of the Care Quality (Registration) Regulations 2009 - Notification of other Incidents.

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

- The management team understood their responsibilities in relation to their CQC regulatory requirements around notifiable incidents. For example, in the last 6 months managers had submitted notifications to us without delay in relation to allegations of abuse and neglect, serious injuries and Deprivation of Liberty Safeguard applications.
- The service remains without a registered manager which the provider is required to have in post to oversee the delivery of regulated activities at this location. This registration issue notwithstanding, an acting manager was in day-to-day charge of the care home for 6 months between October 2022 and March 2023 and they had been continuously supported by a regional manager and various registered managers from the providers other care homes. In addition, the provider has recently appointed a new acting manager who will commence working at the care home by May 2023. A community care professional told us, "I have done an unannounced visit to the care home and from what I saw things seem to be running well. I believe since [name of regional manager] has taken over the running of the service the changes she has made has benefited all the people who live and work there."
- The service's previous CQC inspection report was clearly displayed in the care home and was easy to access on the provider's website. The display of the ratings is a legal requirement, to inform people, those seeking information about the service and visitors of our judgments.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- The care home's culture achieved good outcomes for people and was now more positive, open, inclusive, empowering, and person-centred. People who lived in the care home were treated with dignity and appropriately cared for on an individual level. For example, people kept their prescribed medicines in individual locked cabinets located in their bedroom's so they could be managed in a person centred way that respected their privacy and dignity.
- People's care plans had been reviewed and updated since our last inspection and were now person-centred and contained detailed information about individual's unique strengths, likes and dislikes, and how they preferred staff to meet their care needs and wishes.
- The regional manager had a clear vision for the care home. They told us they routinely used individual supervision and group team meetings to remind staff about the provider's underlying core values and principles.
- The regional manager understood the need to be open and honest when things went wrong. They reported all concerns to the relevant people and organisations and shared outcomes with people, their relatives, and the staff team. When things had gone wrong with people's care and support they received an apology, including relatives, where appropriate.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics

- The provider promoted an open and inclusive culture which sought the views of people living in the care home, their relatives, and staff.
- The provider used a range of methods to gather people's views about what the care home did well or might do better. For example, this included regular one-to-one meetings with their designated keyworker, group meetings with the people they lived with and multi-professional care planning reviews.
- Managers and staff ensured they engaged and involved people living in the care home in its day-to-day running. They did use various methods to communicate with people and share essential information with them in ways they could easily understand and preferred. For example, staff used easy to read pictorial cards to help people who could not communicate verbally with them make informed choices about what they wanted to eat at mealtimes. A community care professional told us, "There is now better more regular communication with resident's families, which includes quicker responses to emails and the introduction of a monthly Newsletters for families. Family members have responded positively to these improvements."
- The provider valued and listened to the views of staff. Staff were encouraged to contribute their ideas about what the service did well and what they could do better during regular individual meetings with their line manager and group team meetings with their fellow co-workers. Staff told us they received all the support they needed from the management team. A community care professional told us, "The morale of staff appeared good and had definitely improved in recent months." This was confirmed by staff, 1 of whom said, "Staff morale has definitely improved since last year now the new managers are here every day helping us to meet the needs of everyone who lives at Rosebank Lodge. I feel supported and very much part of a team now. We all work so much better together."

Working in partnership with others

- The provider worked in close partnership with various community health and social care professionals and external agencies. This included the local authority, GPs, learning disability nurses, hospital discharge teams, the positive behavioural support team, social workers, speech and language therapists, and the CQC. A community care professional told us, "I do feel the provider listens and acts upon any advice I have given them regarding meeting my client's needs. I did notice at my last visit [name of regional manager] they were following through with the actions I said would benefit my clients." Another community care professional added, "I know the service now works very closely with the London Borough of Merton's safeguarding department regarding any allegations of abuse that might be raised."
- The regional manager and staff told us they regularly consulted with these external bodies and professionals, welcomed their views and advice, and shared best practice ideas with the whole staff team.