Care Quality Commission

Speciality Care (Rehab) Limited

Rosehill Rehabilitation Unit

Inspection report

Lower Warberry Road, Torquay. TQ1 1QY.
Tel: 01803 291909
Website: www.craegmoor.co.uk

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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?	Good

Overall summary

This inspection took place on the 21 October 2015, and was unannounced.

Rosehill Rehabilitation Unit is a care home without nursing, providing neuro-rehabilitation services for people with an acquired or traumatic brain injury, or long term health conditions such as motor neurone disease. The service provides accommodation for up to 16 people, and has recently undergone a programme of refurbishment and refocus. This has involved changing from a nurse led service with more long term accommodation to a therapy led service to provide more active programmes of rehabilitation for people.

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

Rosehill was a busy and active home, providing care for people with varied needs. The home had a positive atmosphere with people being involved in making decisions about their care and having goals for their progress. We saw many examples of positive and supportive care being delivered, with people having opportunities to develop new skills and positive supportive relationships.

Summary of findings

The thermometer recording the temperature on the medicines refrigerator was found to be faulty on the inspection and was replaced immediately, along with any medicines that might have been affected. Other medicines were stored safely and were given to people in accordance with the prescribing instructions. Some medicine administration had been delegated to staff at the home by district nurses, who maintained an oversight of the administration and had provided specific staff training to enable this to happen safely.

Risks to people were being assessed and actions taken to minimise them where possible. This included through the analysis of falls and accidents. The premises had been subject to a programme of refurbishment, and people were being involved in making decisions about how the accommodation was personalised to meet their needs and wishes. Actions were taken to ensure the safety of the environment and equipment used to support people.

People were protected by the home's systems for the safeguarding of people, and staff understood what they needed to do to keep people safe or report concerns. There were enough staff on duty to support people and the home followed a full recruitment procedure for staff. Systems were in place to ensure staff received the training and support they needed to carry out their role. This included specific and bespoke training courses for staff to help them support people with brain injury.

Care plans were personalised to each individual and contained sufficient detailed information to assist staff to provide care in a manner that was safe and respected people's wishes. The principles and implementation of the Mental Capacity Act 2005 (MCA) were well understood and put into practice, which helped ensure people's rights were protected. There was an active programme of activities for people to follow which were provided one to one or in groups. We joined in an activity group on the day of the inspection which people enjoyed. People enjoyed their meals and people's dietary needs were respected.

Information was available to support people's communication needs which staff understood well. Systems were in place to manage complaints and ensure people with communication difficulties were able to raise concerns. Staff respected people's confidentiality and celebrated successes and special events with people.

The provider and registered manager had ensured that there were effective systems for governance, quality assurance and ensuring safe care for people. They demonstrated good leadership, and there was a clear ethos for the service, which was understood and put into practice by the staff. Changes towards providing a more active programme of rehabilitation for people were being managed well. Systems for quality assurance included seeking the views of people living at the service about what could be improved and what was working well for them. This was done through questionnaires, regular meetings and one to one work with keyworkers.

Records were well maintained, and notifications had been sent to CQC or other agencies as required by law. The home was applying to make changes to their registration to reflect the changes made to the service. This involved the removal of regulated activities that were no longer required.

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?

Good

The home was safe.

Risks to people were being assessed and actions taken to minimise them where possible. This included through the analysis of falls and accidents.

People were protected by the home's systems for the safeguarding of people. Staff understood what they needed to do to keep people safe or report concerns.

There were enough staff on duty to support people and the home followed a full recruitment procedure for staff.

Some medicines had not always being stored at the correct temperature, but were removed immediately from use at the time of the inspection. Other medicines were stored safely and were given to people in accordance with the prescribing instructions.

Is the service effective?

Good

The service was effective.

Systems were in place to ensure staff received the training and support they needed to carry out their role.

The principles and implementation of the Mental Capacity Act 2005 (MCA) were well understood and put into practice. This helped ensure people's rights were protected.

The premises had been subject to a programme of refurbishment, and people were being involved in making decisions about how the accommodation was used and personalised to meet their needs and wishes.

People enjoyed their meals and people's dietary needs were respected.

Is the service caring?

Good

The home was caring.

We saw many examples of positive and supportive care being delivered. The home had a positive atmosphere with people having opportunities to develop new skills and positive supportive relationships.

Information was available to support people's communication, which was well understood by staff.

Staff respected people's confidentiality and celebrated successes and special events with people.

Is the service responsive?

Good

The home was responsive.

Care plans were personalised to each individual and contained sufficient detailed information to assist staff to provide care in a manner that was safe and respected people's wishes.

The home had a good programme of activities for people to follow which were provided one to one or in groups.

Summary of findings

Systems were in place to manage complaints and ensure people with communication difficulties were able to raise concerns.

Is the service well-led?

Good

The service was well led.

The registered manager had ensured that there were effective systems for governance, quality assurance and ensuring safe care for people.

The registered manager demonstrated good leadership, and there was a clear ethos for the service.

Records were well maintained, and notifications had been sent to CQC or other agencies as required by law. The home was applying to make changes to their registration to reflect the changes made to the service. This involved the removal of regulated activities that were no longer needed.

Rosehill Rehabilitation Unit

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 was 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 21 October 2015, and was unannounced. It was carried out by one adult social care inspector. We looked at the information we held about the home before the inspection visit. Following the inspection we contacted four professionals who have placed people at the service and the local Care Trust quality monitoring team to gather their views about the service.

We spent time observing the care and support people received, including staff supporting people with their moving and transferring and being given medicines. We spent time with people living at the service over a mealtime and joined in an activity group. On the inspection we also spoke to or spent time with five of the ten people who lived at the home, one visitor, a visiting district nurse, the registered manager and regional manager for the home, and six members of staff. We spoke with the staff about their role and the people they were supporting.

We looked at the care plans, records and daily notes for five people with a range of needs, and looked at other policies and procedures in relation to the operation of the home, such as the safeguarding and complaints policies. We looked at five staff files to check that the home was operating a full recruitment procedure, and also looked at their training and supervision records. We looked at the accommodation provided for people and risk assessments for the premises, as well as for individuals receiving care and staff providing it.

Good

Is the service safe?

Our findings

The service was safe.

People told us they felt safe at the home. One person told us "I like it here and I am happy to stay." We saw people approaching staff for re-assurance and support during the inspection.

Medicines were being administered safely. We found the thermometer for the medicines refrigerator was faulty. This was replaced immediately, and any medicines that might have been affected were removed from use.The controlled drugs book contained a record of some medicines that had been prescribed for a person at the end of their life but had not been used. These had been returned to the pharmacy for destruction but had not been properly recorded in the medicines book.

A medicines audit had been partially completed in the week of the inspection, and staff had received training in how to safely administer medicines, where people could not take medicines by mouth. We observed people being given their medicines. We saw this was done well with people being given time and an explanation of what they were taking. Protocols and administration guidelines were in place for emergency medicines for example to support people with epilepsy. Some medicines were given under the delegated authority of the district nursing or hospital teams. We saw named staff had been trained individually to administer medicines to a named person. One person was at Rosehill receiving respite care. District nurses attended to give the person their medicines, as the home's staff had not been trained to administer medicines to that individual. This told us that protocols were being followed.

Systems were in place to identify and report concerns about abuse or poor practice. Staff had received training in how to protect people, and policies, procedures and information was available on how to raise concerns. Staff understood what to do to raise a concern and told us they would do so if they were worried. The service had acted promptly to support and protect people where there had been any concerns. Safe audited systems were in place to manage any money held for people by the service.

There were effective systems in place to manage risks to people. People's files contained individual risk assessments, including for the management of behaviours and long term health conditions/mobility issues. Risk assessments had been undertaken of the environment and were available for safe working practices. Equipment was serviced and maintained in accordance with the manufacturer's instructions and emergency plans were available for staff, for example in the case of fire or facilities failure. Fire evacuation plans contained photographs and clear instructions on people's mobility needs. Maintenance issues were identified and signed off when completed.

Staff were competent and confident in managing situations where people's behaviours might present challenge or risks to others. We saw one person became frustrated and angry while carrying out a task. Staff supported the person to manage their anger safely in another area of the room. This was in accordance with the person's care plan. The person returned to the group successfully following the episode. This showed us that staff understood people's needs and how to manage risks to them and others.

People were protected because the service had followed a full recruitment procedure when appointing new staff. Staff files showed that references and employment histories had been obtained, and disclosure and barring service checks had been carried out. The process maximised and respected equality and diversity in the staff group. The service had access to recruitment support and advice from the company's Human Resources services. Staff had copies of the organisations grievance and disciplinary policies and contracts.

There were enough staff on duty to support people's needs. People at Rosehill had individual packages of care and support which for some people included allocated 1:1 time, up to 24 hours a day. The service employed an occupational therapist, physiotherapist and had just recruited a psychologist, as well as care and support staff. Rotas indicated team leaders, as well as other specific roles such as Fire Marshals. Where some people presented challenges staff supporting them were regularly changed to ensure they did not become over tired and were still able to support the person effectively.

The service learned from incidents or accidents. Incident reports including body maps were clearly completed and fully audited, with an analysis undertaken to identify any trends or patterns. Forms were sent to an external manager for review and oversight, and actions were taken where

Good

Is the service safe?

indicated. For example we saw that one person had been assessed for a new shower seat following two falls. The seat had been provided and there had been no further incidents.

Good

Is the service effective?

Our findings

The service was effective.

The registered manager had ensured that staff had received or were to receive the training they needed to carry out their role. The home's training matrix demonstrated that staff received core training and specific training to meet the identified needs of individuals. For example most staff had received training in infection control, crisis management and introductions to autism and Asperger's syndrome. Staff had also received introductory training in brain injury and an intensive bespoke course was to be provided over the next six months to increase staff skills and understanding in this area. The course was planned to cover cognitive rehabilitation therapy principles, to help support people learn skills that have been lost as a result of brain injury or learn new ones to compensate for those that have been lost. The registered manager was addressing individual skills audits with staff through the appraisal process which was ensuring staff all had the support they needed to receive the training they needed to carry out their role. Where there were gaps training plans were in place to address this.

The home employed specialist professional staff such as an occupational therapist and physiotherapist. They told us they were supported to maintain their professional development and registration, and had been creative in setting up professional support networks and development days to share good practice and maintain skills.

The registered manager had re-commenced the systems for staff support which had lapsed prior to her appointment. All staff were booked onto a series of supervision and appraisal meetings, which included feedback from people living at the home about the staff member and their performance. Appraisals included objectives and goal setting for staff personal and professional development. The registered manager had also recommenced staff meetings. Staff we spoke with told us they had the training and support they needed to do their job. One told us "Absolutely I get the support and training I need."

People had access to the healthcare they needed, both inside and outside of the home. We saw evidence in people's files of both services visiting the home and of people being supported to attend medical reviews.

We observed staff working with people. We saw they were able to understand how people's care was to be delivered. For example we asked a staff member about one person's communication needs and how they would communicate if they did not want to do something. The staff member showed us the person's communication system and how they understood and respected the person's wishes in relation to their care.

We spent time at lunchtime with people over a mealtime. This was not a very communal activity, as people sat at individual tables, or in different rooms, and were served from a trolley. This was due in part to people's individual wishes and needs. The manager confirmed she was making attempts to make this a more sociable and informal time for people. Since the last inspection the home had provided a training kitchen which had allowed people greater freedom in helping to make their own meals. We saw this being used on the day of the inspection with people being involved in making their own breakfast with staff support. This had increased people's sense of independence and opportunity to develop skills in self-care.

Where people needed support to eat this was given sensitively and in ways that supported people's dignity. Meals were presented well. The cook was able to tell us about people's preferences and choices, including textures that people needed to help with swallowing difficulties.

For example one person needed their meal presented in a 'fork mashable' texture. People were supported to suggest meal options and the cook told us that she received feedback from people and tailored the menus accordingly. Malnutrition assessment tools were used to identify people at risk of poor nutrition, and dietary advice was sought. The home had access to Speech and Language therapy staff to help assess people's communication or swallowing difficulties.

Since the last inspection the home had undergone a programme of renovation and upgrading. People told us they had been involved in making decisions about their rooms, for example one person told us that they had chosen a new bed for themselves and were waiting for new

Good

Is the service effective?

pictures to arrive that reflected their interests. Corridors were wide enough for wheelchair access and moving and handling equipment to be moved successfully and there was a passenger lift to access the first floor. Attached to the home was a separate unit, which could be used to support individuals who wished to live in a quieter low stimulus environment or people progressing further into their rehabilitation with greater independence. The rooms we saw were bright and well decorated. Communal areas were clean and attractive, and outside areas were accessible and well maintained. The home had a hydrotherapy bath and therapy gym which was well used. Development was under way for a sensory room in the annexe and there was some accessible signage to support people to remember how to mobilise independently around the building.

Although not all staff had completed their training in Mental Capacity Act (2005) and Deprivation of Liberty safeguards we saw that they had an understanding of the need to gain people's consent to care. We saw staff asking people for their permission before carrying out support tasks with them, and continued to check this throughout the support they were giving.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The registered manager was familiar with the Deprivation of Liberty Safeguards and applications to deprive people of their liberty on the grounds of their safety and welfare had been authorised for some people living at the home under this legislation.

Good

Is the service caring?

Our findings

The home was caring.

We saw staff supported people's dignity and treated them with respect. In the interactions we saw people were supported by staff that understood people's needs and respected their wishes. People at the service were encouraged to set personal goals for achievement, and we saw staff working with one person to develop their independence, and another with communication.

Staff told us that they enjoyed working with people at the home. One staff member told us "We become part of their family. It's a really caring place to work and we really do care about people here". Another staff member told us about a person they had been supporting that day. They described the person as "Incredible", and described to us in detail the person's strengths, personality and achievements before mentioning the disabilities that they had, which were significant. They told us about the person's response when their room had recently been redecorated and showed us collages of photographs they had compiled for the person. They introduced us to this person and we saw there was an affectionate and humorous relationship between both parties. This told us staff valued people as individuals.

People's files contained information about their wishes and preferences in relation to their care. Staff understood and followed these. We saw staff celebrating successes with people, such as with improved mobilising or when independently planting onion and garlic sets in the gardening group. People were involved in making decisions at the home through the "Your Voice groups, and regular contacts with their keyworkers.

There was a lot of laughter and cheerful banter at the home, with people being relaxed in each other's company. A relative we spoke with told us that the home was "phenomenal" and said "I can't praise them highly enough. It feels like home, and we are made very welcome when we visit".

Information on advocacy services was on display and people were supported with communication systems that met their needs. For example one person used an alphabet spelling chart to communicate their needs and wishes. However a staff member showing us this told us "I know what he wants sometimes without (Name of person) even having to say – we know just by a look" and they both laughed. People's rooms had communication tools and white boards so that people could orientate themselves to the day's activities and date.

People's privacy was respected. Care was delivered in private areas of the home such as bedrooms, and all rooms were for single person occupation. Staff spoke about people respectfully, and daily notes were written to reflect positive outcomes for people as well as challenges they had faced that day.

Good

Is the service responsive?

Our findings

The home was responsive.

Each person living at the home had a plan of care based on an up to date assessment of their needs. A relative we spoke with told us they had been involved in drawing up the care plan to support their relation in making their needs known. Staff understood and followed the plans and we saw them referring to them and writing up notes throughout the day of the inspection.

Following a recent refurbishment, Rosehill is refocusing the service as a specialist rehabilitation resource for people with brain injury or long term conditions that affect people's brain function. Assessment tools used in the service were appropriate to acquired or traumatic brain injury such as tools for measuring brain injury and people's ability to function, or for the development of depression in people with brain injury. The assessments used were able to support comparison over time to assess the progress people had made. We looked at the assessments for one person which clearly showed areas where they had made significant progress, and other areas for future development and support.

Plans contained clear information about people's personal profiles, key skills and past history. Plans to support people's individual daily care needs were clearly broken down into detailed stages so that staff could follow them consistently. They were being reviewed regularly and contained individual risk management plans where needed, for example with managing long term health conditions. "Hospital passports" were available for each person in case of a sudden admission to hospital. These contained information on how the person liked and needed to be supported and how they communicated to inform hospital staff of how to support them well.

Files also contained individual activity plans. These covered areas that people wanted to develop skills in or enjoyed as well as therapeutic activities for people We joined in a gardening group that people were participating in during the inspection. This was supported by the home's gardener and involved planting and preparation of vegetables. We saw people enjoyed the activity and participated well. Other plans included a mixture of therapeutic and social activity for people.

Systems were in place to manage concerns and complaints about the service, although no formal complaints had been received. This included systems for auditing and analysing any concerns to identify and learn lessons from the outcome of investigations.

Information was available to people in appropriate formats to support their communication on how to report concerns. Discussions had been held at the home's "Your Voice" meetings on how people could raise a concern if they were worried about something, or felt they were not being treated respectfully. Where people had significant difficulties communicating issues verbally, discussions had been held at key worker meetings to identify how staff might pick up issues through people's behaviours, and this was recorded in people's care plans. For example we heard that one person had been identified by staff as being tearful, and this had coincided with a new duvet cover being provided. This was replaced and the person's behaviours changed. This showed us that the home's staff took time to try to identify and respond to people's concerns and wishes.

The company also operated a telephone hotline for complaints from members of the public.

Good

Is the service well-led?

Our findings

The service was well led.

The registered manager had only recently been appointed to the home, but was very experienced in managing similar services. They demonstrated a commitment to high standards of care and promoting people's rights, and a clear vision for the future development of the service. Changes in legislation and CQC requirements had been shared amongst the staff team at staff meetings, and staff told us they were positive about the service and the changes being made. One person told us the registered manager was "Brilliant. I like her".

People benefitted from good standards of care because the service monitored the quality of the care delivered through quality assurance and quality management systems. A programme of audits and checks were in place on an 'e-compliance system', to monitor safety, medicines, risks and quality of care issues throughout the year. These were monitored by the organisation and regional manager, and triggers within the computerised system indicated where audits or training updates were due. The home had audited themselves against inspection standards and good practice guidance, and action plans were in place to address any areas needing development, such as training and supervision. Audits of practice had also been carried out by a person who was a user of services in another location operated by the same provider. This showed us that the provider valued the input of people using similar services. Regular compliance visits were undertaken by the regional manager, which were thorough and included areas for development and assessments against legislation.

Questionnaires were sent to relatives, visiting professionals and people who lived at the home to gather their views about the home and any improvements people felt would be of benefit. The service user satisfaction survey last carried out in July 2015 was analysed and an action plan had been drawn up. We saw that actions had been taken and feedback given to people about changes being made as a result of the consultation. As an example people had been involved in making more menu choices including "Fry up Friday" where people had said they wanted a leisurely brunch cooked breakfast.

The registered manager told us that the service was looking at best practice and accreditation schemes that would offer development opportunities and accreditation of the work being carried out that would be understood by commissioners of services. The service was considering applying for Headway accreditation during the coming year.

Records that we saw were well maintained and up to date. Policies and procedures were up to date, well maintained and accessible. Administration and business support was available to the management team through the home's administrator.

The service was registered to provide regulated activities which were no longer relevant to the services being provided. We saw evidence that the service had made approaches to the CQC to have these conditions changed to better reflect the service being provided.