Disabilities Trust

Rosewood

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 21 October 2014 and was an unannounced inspection.

Rosewood is a a home that supports up to four adults with learning disabilities and complex needs. There were four people living at the service when we inspected.

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

People were safe and were supported by staff who understood how to keep them safe and what action they should take if they suspected abuse was taking place. Staff had been trained in safeguarding. Staffing levels were assessed and implemented to meet the complex needs of people and one relative said there were, "Always quite a few staff around". Staff were recruited using safe recruitment practices and checks were undertaken, including criminal records checks. People had their risks assessed to ensure their freedom was supported with the minimum of restriction. Behaviour support plans were in place which gave detailed information to staff about how to support people who had behaviours that challenged. Accidents and incidents were recorded and patterns of

Summary of findings

accidents and incidents were identified so that lessons could be learned. Medicines were administered, stored, ordered and disposed of safely. Staff were trained in administering medicines and records were completed showing when medicines had been administered.

Staff received a range of comprehensive training, although not all training that needed to be updated annually had been completed by all staff. There were opportunities for staff to undertake additional qualifications if they wished. Staff supervisions should have been undertaken quarterly with staff, however, not all staff had received regular supervisions in line with the provider's policy. Staff communicated effectively through a staff communication book and at handover between shifts. There was an induction programme for new staff where they could meet with other new staff from other services. People had sufficient to eat and drink. They went out food shopping twice a week and completed accessible shopping lists. These enabled people to choose what they wanted to eat and drink. People were supported to prepare their own meals. Access to healthcare services was available to people and they received ongoing health support. They visited healthcare professionals as needed. Mental capacity assessments were in place for people and they were assessed at admission to the service. Their capacity assessments were reviewed regularly. People had been assessed appropriately with regard to Deprivation of Liberty Safeguards (DoLS) and we found the home to be meeting the appropriate legal requirements.

People were cared for by staff who knew them well and were warm, friendly and respected their privacy. People had positive behaviour support plans in place. Care records gave detailed information about people and these ensured that care was personalised to meet their needs. Where they were able, people were involved in the planning of their care through monthly meetings. Communication tailored to the individual needs, for example, use of sign language or with photos.

People received care that was personalised to meet their needs. Activities were organised that enabled people to be activeaccording to their needs. People preferred activities to be organised in such a way that structured their days, so they knew what was happening on any particular day and when. People's preferences and choices were recorded in their care plans and they were involved in making decisions about their care with their keyworkers. This involved setting of goals which people worked towards achieving to develop their independence. People were supported to stay in touch with their families and those that mattered to them and many visited their relatives on a regular basis. The service had not received any complaints within the year. When complaints were received, the provider had a policy in place which described what action would be taken and how complaints would be followed up.

Residents' meetings were held and people were involved in the development of the service. People had been asked what they thought about the service through service user satisfaction questionnaires. Relatives had also been asked for their feedback and no concerns were received. Staff were aware of the whistleblowing policy and what to do if they had a complaint or concern. The service was led by a registered manager who was actively involved in the service. The provider visited on a monthly basis and was involved in the future planning for the service. Information was shared across the organisation between management and staff and people worked in a collaborative way. People who lived at the service were supported to achieve their goals. The service had a range of robust quality assurance processes in place that measured the quality of the service delivered and identified any improvements that might be needed to improve the quality of care. The service worked in partnership with other agencies, for example, local authorities and healthcare professionals.

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 service was safe.

People were supported by staff who knew what action to take to promote people's safety. There were enough staff available to support people and all had the necessary pre-employment checks undertaken prior to starting work.

People's risks were assessed and there were behaviour support plans in place to ensure staff knew how to meet people's needs safely.

Medicines were ordered, stored, administered and disposed of safely. Staff were trained in administering medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received e training, but it had not been updated when required. Staff supervisions had not always been completed in line with the provider's policy. There was a comprehensive induction programme for new staff.

People had adequate nutrition, went food shopping with support and could choose what they wanted to eat. People had access to healthcare services to ensure good health and well-being.

Mental capacity assessments were in place and the service had complied with the requirements of Deprivation of Liberty Safeguards (DoLS). This ensured people's consent to care and treatment was sought in line with their wishes and legal requirements.

Is the service caring?

Good

The service was caring.

Staff knew people well and had developed caring relationships with them.

Care records provided staff with information about people and they were involved in the planning of their care.

Communication was accessible so that people could feed back to their keyworkers about their care. People had the privacy they needed.

Is the service responsive?

Good

The service was responsive. People had care that was personalised. People were able to access activities in the community and their preferences and choices were recorded in their care plans. They were involved in decisions about their care.

People were supported to stay in touch with those that mattered to them.

Summary of findings

When complaints were received, the provider dealt with these promptly and had a policy in place to address complaints.

Is the service well-led?

Good

The service was well led.

People were encouraged to be involved in developing the service. Residents' meetings were held and service user questionnaires were completed. Relatives were also asked for their feedback.

Staff were aware of the whistleblowing policy and knew what action to take.

The registered manager and provider were actively involved in planning for the future needs of the service. There were t quality assurance processes in place.

Rosewood

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 checked 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 21 October 2014 and was unannounced. One inspector undertook this inspection.

Before the inspection, we reviewed information we held about the service, including previous inspection reports, a fire risk assessment for the premises which had been received within the last year and a review of any notifications received. A notification is information about important events which the provider is required to tell us about by law.

We observed care and spent time looking at records, including four care records, four staff files, medication administration records and other records relating to the management of the service.

On the day of our inspection, we spoke with one person using the service, the registered manager, the senior team leader and two care staff. After the inspection, we contacted two healthcare professionals (a dentist and GP) to ask for their views and we spoke with one relative.

Rosewood was last inspected on 7 November 2013 and there were no concerns.

Good

Is the service safe?

Our findings

People were supported to understand what 'safe' meant and to be as independent as possible. For example, a member of care staff referred to people positively and said, "Let them make certain decisions, like crossing the road. I'll be there".

Staffing levels were assessed, monitored and sufficient to meet people's needs at all times. One relative told us that when arrangements had been made for her son to have a holiday, that the number of staff to accompany him was assessed to ensure his safety. She told us, "His safety is looked after very well". People needed 1:1 support for the majority of the day and we observed staff providing this level of support. Staff rotas also confirmed this. The registered manager told us that they had a stable staff base and that agency staff were not required. Should any shortfalls in staffing levels occur, then the service could use bank staff who knew people well and who were employed by the provider. Staff rotas showed when staff were due to undertake training, so that levels could be monitored and sufficient staff be available to administer medicines or transport people to appointments. A relative said, there were sufficient numbers of staff saying, "Yes, I think so. Always quite a few staff around".

All staff had received safeguarding training and this was updated annually. Staff were able to describe the different types of abuse and the action they would take if they suspected abuse was happening. They told us that they would refer any concerns they had to the registered manager or to the local safeguarding authority.

The service followed safe recruitment practices. Staff records showed that appropriate checks had been undertaken by the service, including criminal records checks, to ensure that staff were suitable to work with people.

Risks were managed so that people were protected and their freedom was supported and respected. People were assessed on their capacity to manage their own finances. Records of people's finances were reconciled weekly and recorded. One person was able to have his own bank card and manage his own money, with support from staff.

People had behaviour support plans which described different behaviours that they might display and what actions staff should take. These plans also included information on what physical interventions staff might need to use as a last resort if other methods, such as verbal reassurance, had been unsuccessful. When physical intervention was used, a risk assessment gave details for staff of any interventions that could be used. Staff were trained in the use of physical interventions. This ensured that people were not physically restrained unless it was necessary to keep them safe.

Risk assessments were in place across a number of areas, for example, environmental, behaviour, people at risk of leaving the service or becoming locked in their room and moving and handling. There were individual arrangements in place for how people should be evacuated in the event of an emergency. Risk assessments were reviewed every four months at joint meetings, where a range of professionals from the service would re-evaluate and re-assess people's risks. Staff confirmed that they were knowledgeable about risks and knew what action to take. This meant that people's risks were anticipated, identified and managed.

Accidents and incidents were recorded using a computer. Completed forms were then sent to the assistant manager at another location who was responsible for logging and assessing patterns of accidents and incidents and lessons to be learned. There were no accidents or incidents recorded for Rosewood and the team leader confirmed that there had not been any within the last year.

Medicines were managed so people received them safely. There were completed assessments on people's care records which detailed the support they required to take their medicines. Only staff who were trained in administering medicines could do so. Staff were trained through face-to-face sessions and could also access on-line training. Medicine Administration Records (MAR) were completed appropriately and two staff had signed off each entry, in line with the provider's medicines policy. Medicines to be taken as needed (PRN) had to be authorised by the on-call manager, except for Paracetamol. The on-call manager held a list of all PRN medicines that had been prescribed for people. Medicines were ordered in a timely manner and when these were received, they were recorded in a 'medicines in' book; they were also disposed of safely. When people left the service, for example to visit their relatives or on a day's outing, then their medicines were signed out and photocopies of MAR charts completed.

Good

Is the service safe?

Medication audits were undertaken by the team leader and stock levels of medicines checked. The registered manager told us that medicines were not used inappropriately to control people's behaviour.

Requires Improvement

Is the service effective?

Our findings

The majority of staff had the knowledge and skills they needed to carry out their responsibilities. Essential training was delivered in a range of areas, for example, fire procedures, mental capacity and deprivation of liberties, food safety, safeguarding and moving and handling. According to the service's training plan, training that needed to be updated annually had not been completed for all permanent staff within the past year. The registered manager agreed that training for some permanent staff had not been kept up to date.

Whilst staff may have undertaken additional on-line training, there was no evidence to substantiate this on staff files. Three members of staff had completed a National Vocational Qualification Level 3 in Health and Social Care. Staff told us that there were opportunities to undertake additional qualifications if they wished. They received specific training from the in-house provider's psychology team on behaviour support, including positive behaviour support and de-escalation of behaviour that challenges.

The team leader told us that he was aiming to organise staff supervisions on a two to three monthly cycle. However, some staff had not received any supervision since much earlier in the year. This meant that staff competency and knowledge was not consistently checked to ensure that people's most up-to-date needs were being met. The provider's policy stated that supervisions should be undertaken quarterly with an annual performance development review for each staff member. Staff told us that they could always ask for a supervision if they needed one and one said, "I can ask [team leader] at any time if I need something". A staff communication book enabled staff to record and update each other on a range of areas. Specific information about people was shared at staff handover between shifts to ensure consistency of care.

One staff member described her induction into the service. This comprised a tour of the service and induction which was arranged by the provider at a central location so that new staff could meet with others from different locations. The training plan showed that new staff who had recently joined the service received their training first and that all essential training had been completed.

People were supported to have enough to eat and drink. Staff went out with people twice a week to buy fresh food. They told us that a shopping list was completed and that there was a checklist using pictures of food, so that people could choose and tick off various items. We saw an example of a shopping list. This meant that people were able to decide what food and drinks they wanted. Menus were then planned for the week which comprised ingredients from various food groups, to support people to have a balanced diet and promote healthy eating.

People were involved in preparation of food. One person liked to make salad, whilst another made a batch of scones every week. Staff said, "Most of the time they stick with things they like". Choices were available if people did not like the main meal of the day and alternatives were available at breakfast and lunchtime. Snacks of fresh fruit and drinks were freely available. There was a range of drinks on offer to meet people's personal preferences. Some people chose to have takeaway meals on an occasional basis. One person said, "Food's nice. I like the food" and that they "Make nice dinners here". He went on to say that he liked lasagne, but did not like green Thai curry as it was too spicy and that he could choose an alternative. Meals were appropriately spaced and flexible to meet people's needs.

People were supported to maintain good health, had access to healthcare services and received ongoing health support. Care records showed that people had regular appointments with their GP, dentist, chiropodist and optician. Health action plans were completed which supported people to stay healthy and described help they could get. These plans had been reviewed and any changes recorded as people's healthcare needs changed. Staff had signed the plans off to show they had read and understood them. This meant that staff were knowledgeable about people's health so that their most up-to-date needs were met.

Health action plans were person-centred and showed involvement from the in-house multi-disciplinary team and people's relatives. (The multi-disciplinary team comprised professionals from a range of areas such as psychology, speech and language and occupational therapy.) People could be involved in their plans if they chose, but most preferred not to be. Staff took people to their healthcare appointments, for example, people had checks at a 'Well

Requires Improvement

Is the service effective?

Man Clinic' to monitor their blood pressure and general health. A relative confirmed that her son had regular access to healthcare professionals and said, "It's all listed, who he's seen".

Consent to care and treatment was sought in line with legislation and guidance. Mental capacity assessments had been completed and detailed information was held in people's care records. Everyone was assessed when they were admitted to the service and assessments were reviewed every three weeks by a clinical psychologist to reflect any changes that might be needed. Everyone had the capacity to make day-to-day decisions, for example, what they wanted to wear or what they wanted to do. A relative confirmed that from their observations staff always asked for their son's consent before undertaking care. The manager told us that, if needed, best interest meetings could be organised. A best interest meeting is where professionals and relatives would get together to make a decision on someone's behalf. This showed that the service was making sure people were involved in the care they received wherever possible.

Care records showed that people had been assessed with regard to Deprivation of Liberty Safeguards (DoLS). The service had an assessment tool designed by the provider that was being used to assess each person. . Staff understood and were trained in the requirements of the Mental Capacity Act 2005, its main Codes of Practice and Deprivation of Liberty Safeguards. People's human rights were properly recognised, respected and promoted and the service was meeting the requirements of DoLS.

Staff described the different interventions, together with associated risk assessments, that might be used to prevent people from harm and keep them safe.

Good

Is the service caring?

Our findings

Positive, caring relationships were evident between staff and people who used the service. One person said, “Staff are very friendly, kind and thoughtful”. Their relative referred to staff and told us, “You can see they’re all very fond of him” and, “I think he’s very happy there, staff treat him very well”.

We observed exchanges between people and staff were positive and respectful and there was a shared sense of humour. Relationships between people and staff were warm, friendly and sincere. For example, one person had wanted to go on a short holiday and staff were needed to support him at short notice. This was arranged and staff supported him on the holiday, even though they were not due to work that weekend. Staff also drove one person home every three weeks so that he could see his family. People had positive behaviour support plans in place. A care record described the positive behaviour of one person who had bought CDs to give to staff to play in the car. The focus was not just on behaviour that challenged, but also acknowledged when people had behaved in a positive manner.

Care records were extremely comprehensive and provided detailed information about people. For example, their preferred method of communication, personal care needs and their likes and dislikes. Staff said that, “Person centred planning was there for them” and that she, “Knows everyone pretty well, but people can change from day to day”. People could attend a religious service or church if they wanted to, but no-one had expressed interest in this.

Staff knew the people they supported, including their preferences and personal histories. This enabled people to receive personalised care that met their needs and wishes effectively.

People were involved in their care as much as they were able through monthly meetings with their keyworker, who co-ordinated all aspects of their care. Care records confirmed this. Communication was tailored to meet people’s needs, for example, Makaton and pictures were used. Makaton is a way of communicating through the use of symbols and signs , for people who have little or no verbal communication. Goals were set for people to achieve and people were involved in deciding what these goals might be. For example, one person had a goal they were working towards in eating. The goal would be achieved when he could eat and keep his mouth closed. Goal definition charts were completed and recorded the progress made by people to achieve their goals. One person’s care record stated, ‘He has not directly contributed to his support plan, but via close supportive relations and also observation, staff are able to glean his likes and dislikes in terms of physical and mental health and wellbeing’. Once a year, care review meetings took place between people, their relatives and social workers.. Staff said, “People are involved if they want to be” and said that some people liked to be involved, whilst others chose not to.

People had the privacy they needed. Everyone had their own room, which was their own private space. All rooms had an en-suite bathroom. Some people had their own mobiles, laptops and TVs in their rooms. Staff said, “People can go to their rooms when they want to”. They also told us that they, “Always knock at the door, even with [one person] who is non-verbal”.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. For example, one person had a health condition and activities were interchangeable according to his needs. There were weekly activities which were energetic and lively, whilst other activities allowed him more quiet time and were gentle and calming. Staff knew him well and could co-ordinate weekly activities according to how he was feeling. One person said that he liked to go swimming, but disliked doing household chores saying, "Not a fun thing to do really is it?". He added that he never got bored and felt that there was enough for him to do. Weekly planners were organised for everyone and these listed activities and daily routines. Routines were important to people as they preferred structure and felt more comfortable knowing what they would be doing at different times of the day. One person had spent his day shopping and talked about when he caught the bus, the time he went for lunch and when he returned home. People were involved, and had access to, a wide range of activities in the community which they had chosen to do. Activities folders were available in different formats so that people could make their choices, for example, one folder had pictures which could be affixed using Velcro tape.

Care records provided detailed person-centred plans that addressed every part of people's care. People's preferences and choices were detailed and information recorded in separate sections of people's files which made them easy to access. There was a traffic light system so that information recorded under 'Red' were important things that must be known about the person, like next of kin, keyworker, religion, medicines, allergies, capacity assessment and brief medical history. 'Amber' was information that was important, like method of communication, personal care needs, managing pain and behaviours. 'Green' was a list of people's likes and dislikes. This ensured that people's individual needs, choices and preferences were recorded and that staff had a comprehensive understanding of how to care and support people in a personalised way. People were involved in planning and making decisions about their care and met with their keyworkers to review their care plans. Relatives confirmed that they were involved in review meetings to discuss their family member's care.

People worked towards achieving goals which encouraged them to develop their independence. The registered manager said that some people might be able to move on to supported living, if appropriate

People could visit their relatives on a regular basis and kept in touch through a variety of methods that suited them. One person regularly called his family on his mobile, whilst another used social media. One person we met was very enthusiastic about Christmas, that he was looking forward to being with his family and had written his Christmas list.

The registered manager described how complaints were acknowledged, investigated and responded to with the complainant. There was an accessible complaints policy for people with Makaton symbols. No complaints had been received by the service in the last year. A relative told us that she had never had to complain, but felt that if she did, it would be dealt with effectively.

Good

Is the service well-led?

Our findings

People were involved in developing the service as much as they were able. Residents' meetings were held informally on a regular basis. People could also express their views individually to their keyworker or to any other staff. One person told us, "It's brilliant here, I would say fantastic".

'Service users' satisfaction questionnaires' had been sent out in April 2014 to 32 people across two locations and 27 responses received. The team leader told us that it was not possible to know how many responses had been received from Rosewood as the results had been co-ordinated from Rosewood and another of the provider's services. The results were positive overall and the team leader told us that any concerns or suggestions received would be followed up and acted upon.

Relatives from Rosewood been asked for their feedback. Only one response to a survey for relatives was received. The respondent did not have any concerns. Another relative confirmed that she had received questionnaires, but did not always remember to complete and return them. She said that she did not really have a lot to do with the manager and added, "I would know if things weren't good. My son's happy".

Staff knew what action to take if they had a concern and the service had a whistleblowing policy. One staff member told us that they would report any concerns to the provider and would also contact CQC. They told us that if they had a complaint they would go to head office first, but added, "To be honest, I think this place is brilliant". "People genuinely care for the people they look after." Staff told us their views of management, "I think they're very good. You would be listened to".

The registered manager described success as, "Service users achieving their goals" and that there was "Evidence everywhere of opportunities to achieve". She said that the service's mission and values were embedded into the recruitment process and added tht there was a culture of 'no blame' and the service learned from mistakes. The chief executive officer of the provider had organised a series of roadshows within the last year. These were open to staff and people who were interested in learning about the future of services that was planned by the provider. The provider undertook monthly visits to the service when strategy and outcomes were discussed. Whilst the registered manager was not always on site since the operational management was undertaken by the team leader, she visited the service regularly and would often be involved with people's activities on Sundays.

There was an open culture in that knowledge and information was shared and developed in a way that encouraged people to work together collaboratively across the organisation. It was clear from our observations that staff knew the people they supported extremely well and had worked hard to build a rapport with them that was genuine.

The service had a range of audits that measured the quality of the service delivered. Medicines audits were undertaken monthly and reviews of people's food and nutrition needs took place. Care records were reviewed and any outcomes or actions that had been identified were checked to ensure that these had been completed. The registered manager said she wanted to, "Drive innovation – no such thing as 'no'" and went on to describe how the service had been creative in supporting a person to fly in an aeroplane for the first time. She added, "What we can do, rather than what we can't do – always striving for one step further". There was an index of audits that had been completed in areas such as service user plan, lifestyle, participation, medicines and nutrition. This ensured that the service had robust quality assurance systems in place to drive continuous improvement.

The service worked in partnership with other agencies such as local authorities, to ensure appropriate support was in place.. We contacted a local medical practice after our inspection to ask for their feedback on the service. A GP told us that they had always been impressed with how well the staff looked after people and that they were 'very efficient, caring and respectful' of them. He said the staff were 'always very helpful with any actions that came from the consultations'.