Disabilities Trust

Hollyrood

Inspection report

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Ratings

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

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory feedback. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This was an unannounced inspection.

Hollyrood provides residential care for adults with autism, supporting people with complex behavioural, communication and social needs. On site there were four units or houses which provide support for up to 25 people. At the time of our inspection, there were 24 people accommodated across Pinewood, Ashwood, Cedarwood and Oakwood units. People who used the service had a range of complex needs, including social and communication difficulties, and required a high level of support, either 1:1 or 2:1. The service employed in excess of 140 staff to meet people's needs safely. There

Summary of findings

was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider.

We observed people as they engaged in activities or moved around the home. We saw that staff supported them in an unobtrusive, friendly, dignified and reassuring manner. Safety risks had been identified in the home and people were encouraged to be as independent as possible. Some people were able to prepare and cook their own meals, supported by staff in the kitchen. Care plans included detailed information about people's complex needs and there were clear plans in place that showed staff how these needs should be met. People had their own allocated keyworker who co-ordinated all aspects of their care. People were involved in their assessments and reviews and, where they were able, to express their preferences and choices. Potential risks were identified and planned for and action that was required to be taken. People's care plans were regularly reviewed and this demonstrated that their most up-to-date needs were met. Relatives confirmed that they had been involved in reviews of their family member's care. For example, one said, "Hollyrood is excellent at looking after [X]".

Meetings were organised for people so that they had the opportunity to communicate what mattered to them. We saw that people's rooms were personalised and furnished in line with their personal preferences. Multi-disciplinary meetings comprising clinical and care staff were organised quarterly so that people's care and support could be reviewed. Staff received essential training as well as planned additional training. They completed an induction programme and work shadowed other staff to learn about their role.

People had activities scheduled on a daily basis and many accessed the Learning Centre. The Centre provided a range of activities and opportunities for people to be creative, achieve qualifications, keep fit and have fun. They were also encouraged to participate in the community and could undertake work or volunteering or attend college. People were supported by staff who knew them well. Hollyrood had a complaints policy and procedures in place and families were asked for their views about the service through questionnaires.

The registered manager was well established and was supported by assistant managers who each had responsibility for different areas. People were encouraged to be as independent as possible and were supported by staff to engage with a range of daily activities that were tailored to meet their needs and preferences. Staff meetings were held regularly and staff were able to feedback their views through questionnaires. We observed that staff were caring of each other as well as of residents and that communication was productive, open and friendly. One health professional said, "Dedicated staff will go the extra mile to help people improve. If I need to speak with a support worker they will spend time talking outside of paid hours".

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People were supported by staff who understood their responsibilities in relation to safeguarding. Staff knew what to do if safeguarding concerns were identified.

People's care records included behaviour support plans and detailed risk assessments and were reviewed monthly.

Medicines were managed, stored and administered safely. Staff were trained and competent in the administration of medicines.

The service was appropriately assessing people under the requirements of Deprivation of Liberty Safeguards (DoLS). People's capacity to make decisions, in line with the Mental Capacity Act 2005 (MCA) was regularly reviewed.

Good

Is the service effective?
The service was effective.

People were able to express their views and what mattered to them at meetings planned for them. People's rooms were furnished and decorated according to their personal preferences and requirements.

Health and social care staff meetings took place on a quarterly basis at which care and clinical staff reviewed people's care. Separate review meetings were organised for families.

Training was scheduled for staff throughout the year and was refreshed as needed. There were opportunities for staff to undertake additional qualifications.

Good

Is the service caring?
The service was caring.

People were supported in a relaxed atmosphere by caring staff in a friendly and relaxed way. We observed that they were treated with respect and dignity.

People were communicated with in a way that suited them.

Where people were able, they could be involved in reviews of their care and their relatives were also involved. Each person had their own keyworker who knew them well and co-ordinated all aspects of their care.

Good

Is the service responsive?
The service was responsive.

People were encouraged to undertake a wide range of daily activities and had opportunities to participate at a dedicated Learning Centre, either on site or in the community. Lifelong learning, employment opportunities and community activities were aspirational and carefully planned to meet people's choices and promote their independence.

Good

Summary of findings

People were involved in making decisions with support from their relatives or best interest meetings were organised.

There was a complaints policy and procedure in place and questionnaires were sent to families so that their views could be sought. The complaints policy was posted up in one of the communal areas and was written in an accessible way.

Is the service well-led?

Good 

The service was well-led.

People lived in a home that was well-led by a registered manager who encouraged people to work collaboratively across the organisation to provide an holistic approach. Care was personalised and empowering, enabling people to take control of their lives and make decisions and choices.

Staffing levels were appropriate. Permanent staff were supplemented by agency staff who knew people well.

Quality assurance audits were undertaken to ensure the service delivered a high level of care in line with their business plan.

Hollyrood

Detailed findings

Background to this inspection

Hollyrood was last inspected on 23 July 2013 and there were no concerns. We inspected the four units on site and looked at people's bedrooms, kitchens, bathrooms and communal areas. We visited the Learning Centre, operated at the location by the provider, and other activity areas, such as the gym and pottery, within the grounds.

Two inspectors undertook this inspection.

We reviewed the Provider Information Return (PIR) and previous inspection reports before the inspection. The PIR was information given to us by the provider. This enabled us to ensure we were addressing potential areas of concern.

We observed care and spoke with people, their relatives and staff. We also spent time looking at records, including three people's care records, three medicines administration records (MAR) sheets and records relating to the management of the home.

On the day of our inspection, we spoke with one person living at the service, two relatives, two care staff, one member of staff from the Learning Centre, three assistant managers and the registered manager. We also spoke with three relatives after our inspection. It was not appropriate for us to speak with the majority of people at the service due to their complex needs. However, we were able to observe people during the course of our inspection.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

Some people who lived at Hollyrood were able to prepare and cook their own food at mealtimes and staff supported them to do this. Potential hazards had been identified in the kitchen, for example, people who were unsafe to use a cooker, were not able to access all the kitchen equipment. We saw there were chopping boards in the kitchen that were colour coded to ensure segregated preparation of vegetables, fish and meat in line with food hygiene requirements. The manager told us that Hollyrood had a Food Hygiene rating of 3, which was satisfactory. There were plans in place to improve the kitchen fixtures and fittings.

The manager told us that people were assessed on the support they required prior to moving into Hollyrood and that their support was reviewed every three months to check that it was still appropriate. We were told that eight people required 2:1 support when they were off site. At the time of our inspection, the manager informed us that they had a high level of staff vacancies and that they were in the process of recruiting new staff. Safe staffing levels were ensured as agency staff were also employed to provide people with the support they needed. Where agency staff were used, the manager told us they always tried to use the same staff so that they were familiar with people and their individual support needs.

Staff we spoke with were aware of their responsibilities in relation to safeguarding. They were able to describe to us the different types of abuse and what might indicate that abuse was taking place. We saw records which showed that staff were trained in safeguarding as part of their essential training and that there was a safeguarding policy in place which guided staff on action that needed to be taken. The manager and assistant managers were clear about when to report concerns and the processes to be followed to inform the local authority and CQC. One relative told us, "Problems? They [the staff] deal with as best they can". Where people were at risk of self-injury or harm, we saw that there were systems in place to record their behaviour, including positive behaviour. These behaviour records could be accessed by other clinical staff, for example, the psychologist who monitored behaviour.

Care records included information for staff on how to respond to people's behaviour. For example, we saw a behaviour support plan that gave detailed information about the person's behaviour, the triggers that might result in challenging behaviour and steps on how to minimise or prevent this. There were clear plans in place that illustrated strategies to be followed and how verbal or physical aggression towards objects or other people should be handled. Care records included risk assessments based on people's personal living areas as well as communal space and their daily routines. These risk assessments clearly described the action that needed to be taken in order to mitigate the risk and support people safely.

We looked at accident and incident reports and spoke with the assistant manager who was the lead member of staff in this area of work. They described how they logged all accidents and incidents and how these were rated according to severity and whether it was a health and safety issue or a safeguarding concern. We were told that all staff were able to report accidents and incidents and saw examples of reports completed by staff. Where accidents or incidents were logged, appropriate follow-up action had been taken and this was recorded. We saw that occurrences and patterns of accidents and incidents were monitored so that trends could be identified and necessary steps taken to prevent future occurrence.

We were told that care plans were reviewed on a monthly basis and updated if necessary. Each person had a keyworker who knew them well and co-ordinated all aspects of their care, including updating their care records. Records confirmed that monthly updates had taken place.

We looked at the management of medicines. We found that the service had up to date policies and procedures in place to support staff and to ensure that medicines were managed in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately. This included the administration of controlled medicines. Medicines that were required to be refrigerated were kept appropriately and we saw that temperatures relating to refrigeration had been recorded daily. We spoke with the assistant manager who had lead responsibility for the management of medicines. They described how they ordered people's medicines and how unwanted or out-of-date medicines were disposed of and records confirmed this.

MAR charts showed that staff had recorded when people received their medicines and that entries had been

Good

Is the service safe?

initialled by staff to show that they had been administered. Where people refused their medicines, this had been recorded appropriately and appropriate action taken. We were told that no-one received their medicines covertly and that all medicines were prepared in front of the person before they took them. There was no indication to suggest that medicines were used inappropriately to control behaviour.

People had assessments completed with regard to their 'medication capacity' and whether they were able to administer their medicines independently or needed support. The majority of staff were trained to administer medicines, but we were told that agency staff were not allowed to administer medicines. We saw the training matrix which showed that staff had been appropriately trained in the administration of medicines and staff we spoke with confirmed this.

The registered manager had a good working knowledge on Deprivation of Liberty Safeguards (DoLS) and mental capacity. All care records showed that people's assessments of capacity to take particular decisions under the Mental Capacity Act 2005 were regularly reviewed. Staff received appropriate training to meet the needs of people at Hollyrood. One member of staff told us that they assumed everyone had capacity, unless proved otherwise. They said, "[People] have the right to make unwise decisions providing it doesn't cause them or others harm". The assistant manager in charge of overseeing DoLS told us that they had applied to all the local authorities who funded people at Hollyrood.

We were given a copy of an assessment tool designed by the provider that was being used to assess each person. We were told that each local authority had different arrangements and timeplans with regard to the application of DoLS, so that people who used the service were at different stages of the process. A member of care staff described the different types of physical intervention that might be used to prevent harm and keep people safe and the associated risk assessments. In one person's care record, where physical interventions had been used, these had been recorded and an incident form completed. Staff understood 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.

Good

Is the service effective?

Our findings

Meetings had been organised for people who used the service to enable them to discuss issues that mattered and food choices were important to them. We saw that people had chosen what roast meat they wanted to eat and that staff had used a picture board showing a choice. One relative told us that they felt that people were not always encouraged to eat as healthily as they might and said that fast foods, like pizza, were given as options, rather than cooking with fresh ingredients. However, people were able to plan what they wanted to eat and that they were able to shop locally for their food. In one of the kitchens, we saw that the cupboards were well stocked and contained a variety of ingredients, including fresh meat and vegetables. People's individual diets were catered for, for example, one person had a range of gluten free products. People were encouraged to prepare and cook their own food by staff and food diaries were kept to record what people had eaten. One person we met with was going to a nearby town, supported by a member of staff, to collect a takeaway meal they had chosen.

People's rooms were furnished and decorated in line with their personal preferences and needs. This provided them with a safe space where they felt comfortable. Staff told us that people could indicate how they wanted their rooms to be planned. For example, one person's room was sparsely furnished and had no curtains. We were told that options were being explored such as using self-affixing tape for curtains to windows, so that people could pull the curtains down safely if they felt unhappy with them. Other people had their names on the doors of their rooms, had more furniture and had personal items such as photographs, computers and music centres. We saw that people kept their personal toiletries in their room, if it was safe to do so. In one person's care record, we noted that they could become agitated if they could not find things in their room. We saw that plans were in place for staff to support the individual to keep their room tidy to avoid this situation.

A co-ordinated approach to care was promoted through multi-disciplinary meetings which were organised to discuss people's clinical care and review their support and treatment. These meetings were attended by care and clinical staff and took place for each person four times a year, unless urgent, when meetings could be arranged at short notice. Notes recorded a meeting between the staff team and the speech and language therapist which detailed the support that one person needed to strengthen their communication and work towards achieving effective communication. Separate review meetings were arranged for families to discuss their family member's care.

There was a training schedule for staff that had been organised for the year. Each unit had a database which held the names of staff members, their attendance at training and what training needed to be refreshed. The schedule enabled team leaders to have advance warning of training requirements so that they could organise staff rotas appropriately. We saw that foundation training was organised for staff through Autistic Spectrum Partners, a division of the provider. Staff were also able to undertake additional qualifications such as Qualifications and Credits Framework (QCF) Level 3 in Health and Social Care. Managers were encouraged to work towards Level 5. There was a range of 'in house' training available as well as e-learning. We were told that all new staff undertook essential training including fire safety, moving and handling and food safety. One member of staff we spoke with described how they delivered training that empowered other staff with communication, organised workshops, assisted with assessments of service users and created specific resources. They said, "No one size fits all". Another member of staff we spoke with confirmed that they had received essential training which included infection control, MCA, DoLS, food hygiene and physical interventions. They gave an example of when they might use physical intervention to support a person to stop them falling after a seizure. They described their induction training and a booklet they had completed based on best practice. They also had the opportunity to shadow other staff to learn about their role and what this involved. They said that they had to complete a probationary period and that service users met future employees when they were shown around. Records confirmed that staff had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) in addition to safeguarding vulnerable adults training.

There was a staff supervision database located at each house which gave details about staff supervision dates and team meetings. One member of staff confirmed they had a 1:1 supervision meeting every three months with their manager and that they also had an annual appraisal. They told us supervisions were recorded, a copy was then given to them and any changes noted or amendments made.

Good

Is the service effective?

Another member of staff confirmed that they had supervision, usually every eight weeks. They said they were able to discuss any problems and how these might be addressed, with action plans for what should be done. They said, "The office is 'open door', if we have any problems, we can pop in and discuss", adding that they were praised for good work.

We contacted a local medical centre who confirmed that they had regular contact with people at Hollyrood. They said this might involve seeing people brought down to the surgery or when GPs visited. One of the GPs contacted us by email and stated, 'The care provided by staff to the residents at Hollyrood appears excellent. They are very caring and patient with the management of the residents. The needs of the residents can be very complicated and challenging. The atmosphere at Hollyrood appears relaxed and friendly, but the staff behave in a very professional manner'.

Good

Is the service caring?

Our findings

One relative told us that they felt involved with their family member's care. They told us that they could, "Pop down on the off-chance, never different, don't have to prepare, don't change because we're coming" and that they were, "made to feel welcome". Records confirmed that relatives were involved in reviews of care. Another relative we spoke with said, "They do care, they go the extra mile" and that, "Hollyrood is excellent at looking after [X]".

People were involved in a range of hobbies and were able to express a preference. For example, people could go trampolining in the community. We saw in one person's care record that their goal was to achieve a full turn in trampolining. Activities and outings were organised for people and an outing to the beach had been organised recently. One person told us that they had chosen not to go and their decision had been respected. They told us that they hoped to go on holiday again this year to Center Parcs and be supported by members of staff to do this. We saw that meetings were organised for service users. The notes of one meeting at Pinewood unit recorded that people had been asked what they wanted in their rooms and their choice of curtains and blinds.

During our inspection, we found staff were unhurried, friendly and relaxed. We observed one person pushing to get into the kitchen and that they were slightly agitated. Staff told us that this person wanted to go out for a walk and they were supported to go for a walk in the grounds shortly after. We observed this and that their manner was relaxed and calm. It was clear that staff knew people well and that their needs were addressed in a personalised and sensitive way. We observed that people were supported as identified in their care plans.

Staff supported people to move round the buildings safely and in a way that made them feel protected. One person felt threatened by our presence and was led into another area by a member of staff who spoke to them reassuringly. Staff were respectful, sensitive to people's needs and treated them with dignity. They knocked on people's doors before entering. One person had a key to their room which they kept on a cord round their neck. They told us that they locked their room, "When I want some peace and quiet".

Where people were able, they had been involved in their assessments and reviews. Each person had their own keyworker and, from our observations, staff demonstrated that they knew the people they supported very well. The majority of people who lived at Hollyrood had difficulty in communicating what mattered to them. However, systems had been created that enabled people to make choices and decisions about their day to day living. For example, the use of symbols like Makaton could be overwhelming for some and could cause anxiety. (Makaton is a language programme that uses signs and symbols to help people to communicate.) People communicated in a way that they felt most comfortable with and was individual to them. People used photos, pictures or objects to do this.

Care records were stored securely when not in use. Staff told us they kept people's information confidentially and policies and procedures were in place to promote this.

Good

Is the service responsive?

Our findings

People had a daily schedule which listed all the activities they would participate in on a particular day. Where people were unable to recognise the printed word, we saw that photographs were used illustrating different tasks and activities. Some people preferred to communicate with Makaton. Photos or symbols were fixed to people's daily activity books and could be changed around as needed.

One person told us that they liked to go to a pub and that on Wednesdays they went out for lunch. They described their room and how they had set it up to suit their own preferences. They told us that they were able to visit their family regularly. When asked if it was nice living at Hollyrood, they said, "It can be sometimes not", as they would have preferred to live with their family permanently. However, they told us that they liked the staff that supported them.

Where people were unable to make decisions about their care or choices, we were told that their families were involved. Two relatives we spoke with confirmed that this was so. In some cases, best interest meetings could be organised which is where professionals and relatives would get together to make a decision on someone's behalf. For example, financial decisions related to booking a holiday.

People received care and support in accordance with their preferences, interests, aspirations and diverse needs. The Learning Centre was the hub of Hollyrood and people were encouraged to use this service. The Centre was a dedicated area at Hollyrood where people could participate in a range of activities, some on site and others in the community. We spoke with the manager of the Centre. They said that people chose from a range of 36 activities on offer ranging from pottery and cement moulding, to music therapy and physical fitness. The manager told us about one person who made garden ornaments out of cement and then sold them at local craft fairs. They described how this individual managed the whole process from moulding the ornament, to pricing the finished product and managing the craft stall.

The Centre manager and staff had spent considerable time talking to people about their hobbies and interests and had an inspirational programme in place. There were opportunities for lifelong learning and development. We observed one person working towards a qualification in photography with the support of a member of staff. This meant that they could achieve an external qualification through the Award Scheme Development and Accreditation Network (ASDAN). We were told that two other people were undertaking art courses which they had chosen themselves and were studying at local colleges. Other people had the opportunity to undertake work or volunteering apprenticeships. The manager told us that four Learning Centre staff delivered over 100 hours' worth of activities of learning to people a week. We found the Centre to be innovative and that people were encouraged to excel at a level that was realistic for them. On the day of our inspection, we saw that some people were able to go swimming at the local leisure centre.

Staff knew the people they supported very well and worked with them as individuals. People were encouraged to choose and make their own decisions and improve their independence.

Hollyrood had a complaints policy. The procedure to make a complaint was written in 'easy read' and with Makaton symbols and was posted up in one of the communal areas. Complaints were dealt with effectively and in a timely fashion. We saw that relatives were encouraged to complete questionnaires which were sent out which gave them the opportunity to share any concerns. Records showed that 32 questionnaires had been posted to families in February and 18 completed questionnaires were returned. These showed that overall families were happy with the service. One questionnaire stated, 'All staff are superb and to be thanked for their patience and care'. Hollyrood was also in the process of organising a 'fun day' at the end of July which afforded the opportunity for families to meet with each other.

Good

Is the service well-led?

Our findings

We contacted a social worker to ask their view of the service. They had been involved in the transition of one person into Hollyrood. They told us that their experience 'was very positive'. They told us that during their visits with parents and other relatives that, 'they were very welcoming. Hollyrood staff spent a long time getting to know the young man who moved, visiting his previous placement on several occasions'. They added that, 'I felt it was the most appropriate service for the young man in terms of the support offered, the environment and proximity to his family'.

When we asked the manager what they felt was 'good' about the service, they told us that they were proud of the progress that people made and their achievements based on their challenges. They said, "We provide support; we're not a care home".

As we walked around the different houses that comprise Hollyrood, we observed that people were supported to be as independent as possible and were cared for in a homely environment. The accommodation in the separate houses included communal areas such as kitchen, sitting room and dining room and people had their own rooms which gave them their own private space. 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 that staff knew they people they supported extremely well and had worked hard to build a rapport with them that was genuine.

The management of the service had created an environment that was conducive to promoting people's independence based on their individual aspirations and future needs. Everyone was encouraged and supported towards this with opportunities for life-long learning, work placements and volunteering co-ordinated by the Learning Centre. There were a variety of activities on offer and opportunities available for people to be involved in the community, such as going to the leisure centre or attending college. Hollyrood were also active in their use of volunteers to help with activities such as gardening and painting. The manager had arranged work experience placements, for example, with the police, to enable new recruits to understand the particular challenges faced by people with complex needs such as autism.

We saw that the registered manager played an active part at Hollyrood and that communication between staff was productive, open and friendly. We observed that staff were extremely supportive of each other, both physically and emotionally, in the care they provided to people. We were shown completed questionnaires that had been returned by staff. These asked whether they felt motivated in their work. The majority of staff who returned the questionnaires stated that they felt valued and supported within Hollyrood. One member of staff said, "It's a brilliant place to work - I love it - the variety, you never know what the day will hold. There is an amazing passion in the workforce".

Records confirmed that staff meetings were held in each of the houses throughout the year. Night staff attended separate meetings. We saw notes of a governance meeting which was held to discuss health and safety, Legionella testing, portable appliance testing, safeguarding, accidents and incidents reporting. The area manager had conducted their own internal quality assurance review in July. This addressed areas such as - consent to care and treatment, care and welfare of people who use services, safeguarding, staffing, supporting workers and records. The summary of the review stated, 'The management and staff at Hollyrood work hard to provide a friendly and homely atmosphere for those living at the service'.