Metropolitan Housing Trust Limited

Rosswood Gardens

Inspection report

4,6 & 8 Rosswood Gardens
Wallington
SM6 8QZ

Tel: 02086478193
Website: www.metropolitan.org.uk

Date of inspection visit:
13 April 2021

Date of publication:
20 May 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Rosswood Gardens is a residential care home providing personal care to 11 people, two of whom were in hospital at the time of the inspection. The service can support up to 16 people. People using this service have a learning disability and/or autism. Rosswood Gardens is comprised of three adjoining properties.

People's experience of using this service and what we found
People were not adequately protected from risk and supported to remain safe. Risks to people's safety had not been appropriately assessed or mitigated. This included environmental risks as well as individual risks to people's safety. People were not adequately protected against the risk of infections. Staff did not consistently adhere to the governments' guidelines about how to minimise the risk of catching and spreading the COVID-19 virus. There were no cleaning schedules in place and there were a lack of checks and audits to ensure an enhanced level of cleaning during the COVID-19 pandemic.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. The provider had failed to robustly assess the mental capacity of people and put in the appropriate level of restriction to maintain balance between independence and safety. Staff did not adhere to the Mental Capacity Act 2005 and assessments were not undertaken when staff thought a person may lack capacity to make certain decisions.

Care and support did not always reflect current guidance, standards and best practice. Care plans and risk assessments provided conflicting information and lacked vital information about people and their needs. People were not adequately supported to maintain a healthy, balanced diet and staff did not access and follow appropriate healthcare support and guidance.

The provider did not have a consistent approach to supporting staff to maintain their professional skills or knowledge of best practice. Staff training was in place however staff's completion of mandatory modules was inconsistent.

There was a lack of oversight and management at the service. The registered manager was absent from the service due to ill-health and another senior member of staff was off shielding due to the COVID-19 virus. Whilst these key members of staff were absent from the service, there was insufficient oversight from the provider to ensure good leadership at the service, support to staff and ongoing review of the quality and safety of service delivery. The provider's procedures for obtaining feedback from people about their care had not been implemented at the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or

autistic people.

This service was not able to demonstrate how they were meeting the underpinning principles of right support, right care, right culture. The service was not inclusive and did not empower people to achieve good outcomes. People were not adequately involved in the design and delivery of the service. They were also not adequately involved and consulted about day to day decisions. The staff did not engage with people in line with the principles of the Mental Capacity Act 2005 and care and support was not adequately reviewed or personalised to meet people's changing needs.

People received their medicines as prescribed and safe medicines management processes were in place. Staff were knowledgeable of safeguarding adult's procedures and were working with the local authority to implement recommendations following a recent concern raised. There were sufficient numbers of staff on duty to provide people with support.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 9 January 2019).

Why we inspected
We received concerns in relation to the support people received, particularly in regards to their diet and nutrition and also about staff's adherence to the Mental Capacity Act 2005. The service had also had a significant outbreak of the COVID-19 virus. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Requires improvement. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the Safe, Effective and Well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person-centred care, safe care and treatment, need for consent, staffing and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards

of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Rosswood Gardens

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was undertaken by two inspectors.

Service and service type
Rosswood Gardens is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Rosswood Gardens does not provide nursing care.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was not available at the time of our inspection.

Notice of inspection
We announced this inspection on the morning of our site visit due to the COVID-19 pandemic. This helped us assess the risk to the inspection team and enable the team to wear appropriate Personal Protective Equipment (PPE) during the inspection.

What we did before the inspection
We reviewed the information we held about the service including statutory notifications received about key events that occurred at the service and minutes from meetings between the provider and the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

During the inspection
We spoke with four people about their experience of the care provided. We spoke with four members of staff including the operations manager and care workers. We undertook general observations of the environment and interactions between staff and people using the service. We looked at four people's care records and records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at additional management records including training, supervision records, quality assurance records and reviewed an additional care record for one person. We also received feedback from three people's relatives.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Relatives felt their family members were safe and well cared for. However, we found that people were not adequately protected from risk and supported to remain safe.
- The front door to the service was not secure. People could easily come and go from the service. Staff did not have adequate procedures in place to ensure people who had been assessed as not being safe to access the community independently, did not go out without staff support.
- There were risks within the environment that had not been adequately assessed or mitigated. We saw some windows were not adequately restricted leaving people at risk of falling from height. Chemicals were easily accessible in the garden shed. We asked the operations manager to address these risks immediately and they confirmed the chemicals had been removed, and work was due to take place the week after our inspection to ensure windows were appropriately restricted.
- There were additional risks within the environment including free access to kitchen knives, access to the kettle and access to the iron. In some people's risk assessments, it was identified that some people were at risk of self-injury or aggression towards others and others were unsafe to use the kettle unsupervised due to the risks of scalding. There was no overall environmental risk assessment in place and individual risk assessments did not address all of the concerns we identified.
- People's individual risk assessments were not specific and did not contain detailed information about how to keep people safe. We saw one person's mobility had reduced. They had a hoist in their room, used a wheelchair and staff told us they required the use of a belt to help with transfers. However, there was no moving and handling risk assessment available in their care records. Other people had specific dietary requirements and there were no nutritional risk assessments and for one person with dysphagia (swallowing difficulties) there was no choking risk assessment or management plan in place.

The provider was in breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- People were not adequately protected against the risk of infections. Staff were not consistently adhering to the current government guidance about wearing personal protective equipment (PPE) due to the COVID-19 virus. We observed staff not wearing their masks when in the office and one staff member was not wearing their mask appropriately when speaking with us.
- Whilst staff were aware of the importance to social distance to help reduce transition of the COVID-19 virus, this was not being observed. We saw an activity taking place in the lounge where social distancing could not be adhered to and no measures implemented at the home to help with social distancing.

● There were no cleaning schedules in place and no records of what cleaning had been undertaken to ensure a clean, hygienic environment was provided that reduced the risk and spread of infection.
● The carpets at the service were worn which meant they could not be adequately cleaned. However, the staff told us the carpets were due to be replaced and this was happening the week after our inspection. They also told us a deep clean was due at the service including cleaning of curtains and other soft furnishings but were unable to tell us when this would take place.

The provider was in breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were sufficient numbers of staff on duty to meet people's needs.
● Staffing levels were appropriate to meet people's needs, both during the day and at night.
● People told us staff were accessible and they felt well supported by the staff team.
● We did not review recruitment procedures during this inspection, but we will do so at our next comprehensive inspection.

Using medicines safely
● People received their medicines as prescribed. There were clear processes in place for the safe storage, recording, administration and disposal of medicines.
● Protocols were in place to advise staff of when to give people their 'when required' medicines and at what dose.
● Medicine management errors were reported and followed up appropriately to ensure the person's safety and learning from the incident.

Systems and processes to safeguard people from the risk of abuse
● Staff were aware of safeguarding adults' procedures and had received safeguarding adults' training.
● There were reporting systems in place which ensured any safeguarding concerns raised were reviewed by a member of the management team so that any potential learning could be identified.
● Staff liaised with the local authority's safeguarding adults' team when concerns were raised and were in the process of implementing the recommendations made.

Learning lessons when things go wrong
● There were processes in place to record and report any incidents or accidents that occurred. These were reviewed by a member of the management team to identify any learning and reduce the risk of recurrence.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The provider had failed to robustly assess the mental capacity of people and put in the appropriate level of restriction to maintain balance between independence and safety. Staff did not adhere to the MCA and assessments were not undertaken when staff thought a person may lack capacity to make certain decisions.

● Whilst staff had received training on the MCA, some staff told us they did not fully understand the requirements of the MCA or DoLS. Therefore, some staff were unsure about what they should do to make sure decisions to keep people safe were made lawfully and in the person's best interests. We spoke to the operations manager who was overseeing the service in the registered managers absence. They told us staff required refresher training in this area, and this would be made a priority.
● We reviewed people's care records and found there had been no recent assessments to determine the level of capacity each person had. Staff were unsure about what decisions people had the capacity to make and there was a risk that people did not have sufficient choice and control over aspects of their daily living.
● At the time of inspection there were no DoLS in place. We were concerned that people who lacked capacity to access the community independently were at risk of harm as the level of restriction in place to keep them safe was not sufficient. The local authority had arranged for a best interest's assessor to attend the service the following week to review two people's care.
● We saw that individual restrictions were in place, including the use of bed rails for one person. These restrictions had not been assessed and there was a risk that people's liberty was being unlawfully restricted.

We also saw reference to blanket restrictions in people's support plans including the closure of the kitchen at night. The operations manager told us blanket restrictions were not in place and they would ensure the paperwork was updated to reflect this.

The provider was in breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care and support did not always reflect current guidance, standards and best practice. Care plans and risk assessments provided conflicting information and lacked vital information about people and their needs.
● People told us they had lived at Rosswood Gardens for several years and were happy there. However, during this time there had been no clear reassessment of their needs. This meant that care plans and risk assessments did not always reflect people's changing needs over time.
● We were informed of a person's needs that had changed and they required manual handling support with use of various equipment. This person's care plan and risk assessment did not identify equipment required or a manual handling assessment for staff to follow. This placed the person at risk of harm due to a lack of guidance on how to support them safely, effectively and according to their preference.
● Another person's care records stated they required a food supplement as they were underweight. However, this person's newly updated risk assessment stated they were overweight and required staff to identify a target weight and support them to achieve it. This information was contradictory and there was a risk diet and weight could be mismanaged.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they enjoyed the food at Rosswood Gardens. However, we found people were not always supported to maintain a healthy and balanced diet.
● This inspection was undertaken following concerns of people not gaining access to appropriate nutrition. The concern included that the provider was not following professional guidance for people's varying dietary requirements.
● There were various dining areas throughout the three adjoining homes with free access to kitchens during the day. However, some kitchen cupboards were to remain locked. This was due to risks associated with people ingesting food items such as spices. However, we found these cupboards were not always locked so the risks were not always eliminated.
● Staff told us people were involved in creating a weekly food menu which took into consideration the recommendations made by a dietician. However, when we spoke to people, they informed us of various meals that had been prepared which did not include these recommendations. People also did not know what they were due to have for lunch or dinner that day or where to find this information.
● Care records stated some people required a "soft diet" but there was no further information on how this should be prepared or why this was in place. This meant people could have been placed at risk of choking if their food was not prepared correctly.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
● Staff did not always effectively carry out care or treatment as directed by healthcare professionals.
● There was support from external healthcare professionals for people such as speech and language therapy, psychology and dietetics however, guidance provided was not always followed. Care records did not contain information on which professional was involved for each person or what had been recommended. This meant people may not be supported according to their needs.
● During our inspection one person approached the inspectors and began pointing to their teeth and

changing facial expressions as if they were in pain. The staff spoke to the person and said, "you are going to the dentist later". When we asked if they were going to the dentist, staff said they did not know. This demonstrated that people's health needs were not always prioritised.

The issues above showed there was a lack of vital information and assessment of people's needs, people were not adequately supported to maintain a healthy, balanced diet and staff did not access and follow appropriate healthcare support and guidance. The provider was in breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- The service did not have a consistent approach to supporting staff to maintain their professional skills or knowledge of best practice.
- Staff training was in place however, staff's completion of mandatory modules was inconsistent. Training in topics relevant to people's current needs such as positive behaviour support, epilepsy, moving and handling, medication and infection prevention and control were not always completed. This meant people were being supported by staff that may not have the right skills and knowledge to provide appropriate care and support.
- Staff supervision and support was inconsistent. There had been no supervision or appraisal of staff for this year so far. This type of support is important for staff's personal and professional development. It also ensures that staff are kept up to date with best practice.

The provider was in breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

- The service was not always adapted to meet people's needs.
- Some areas of the service required decoration and repair. The provider informed us that these works were due to take place in the near future.
- Bedrooms were personalised, and people had access to wet rooms if they required this.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; working in partnership with others

- The service was not inclusive and did not empower people to achieve good outcomes. The service was not adhering to the principles within the 'right support, right care, right culture' guidance and people were not empowered to have choice and control.
- There were no proactive systems in place to ensure effective working in partnership with other health and social care professionals to enable good outcomes for people. Staff had not referred people to the local authority DoLS team when they had assessed people as not being safe to be in the community independently. Staff had not proactively referred people requiring support with their diet and nutrition to the dietetics service. The staff were engaging with the local authority and had shared requested information and attended meetings, however, this was reactive to requests from the local authority.

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

- There was a lack of oversight and management at the service. The registered manager was absent from the service due to ill-health and another senior member of staff was off shielding due to the COVID-19 virus. Whilst these key members of staff were absent from the service, there was insufficient oversight from the provider to ensure good leadership at the service, support to staff and ongoing review of the quality and safety of service delivery.
- During 2021 there had been a lack of audits to review the quality of service delivery. There was no infection prevention and control audit in place, the last medicines management audit was done in January 2021, the latest health and safety audit had not identified the concerns we found regarding the safety of the environment and there was no formal effective review of care records.

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

- Whilst people felt able to approach and speak with staff members, there were no formal structures in place at the time of our inspection to obtain feedback from people and their relatives about the service. The provider had systems in place to carry out regular satisfaction surveys, but this had not been done at Rosswood Gardens. Therefore, we could not be assured that people and their relatives were adequately engaged and involved in the design and delivery of the service.

From the evidence above, we were not assured that an effective governance system was in place to review the quality and safety of service delivery. The provider was in breach of Regulation 17 (Good Governance) of the HSCA 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

● The provider's quality assurance team had undertaken an internal audit in March 2021. This looked at all areas of service delivery and identified a number of areas requiring improvement. A comprehensive improvement plan was in place to address the concerns identified. We will monitor the implementation of this plan to ensure items are prioritised appropriately and action is taken in a timely manner to ensure a safe, high quality service is provided. We will further review the implementation of this plan at our next inspection.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager was not available at the time of our inspection. However, the operations manager was aware of the requirements of the service's CQC registration and submitted statutory notifications about key events that occurred.

● The management team were aware of the duty of candour and we saw when incidents did occur these were discussed with people and their relatives.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people received care and treatment that was appropriate, met their needs and reflected their preferences. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured they provided care and treatment in accordance with the Mental Capacity Act 2005. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people received safe care and treatment. Risks to people's health and safety had not been adequately assessed or mitigated. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there were appropriate systems in place to assess, monitor and improve the quality and safety of the service.

Regulation 17 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff received appropriate training and support to enable them to carry out their duties. Regulation 18 (2)