Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Rosefern Residential Home

2 Seamer Road, Scarborough, YO12 4DT

Tel: 01723378431

Date of Inspection: 11 December 2012

Date of Publication: January 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Autism Plus Limited
Registered Manager	Ms. Emma Whiteside
Overview of the service	Rosefern Residential Home has been registered by Autism Plus to provide accommodation to person's who require nursing or personal care. They can accommodate a maximum of 12 people.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 11 December 2012, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service and talked with staff.

What people told us and what we found

We visited Rosefern and spoke with three people who lived there. The home specialises in care for people with a learning disability. We were unable to gain the verbal views of some of the people who lived at the home so we carried out some observations on the day of inspection. People were engaged in activities according to their interests and appeared contented and well cared for. We noted that some people went out for one to one time with staff as they had chosen.

People's consent to care was gained and we saw evidence that people received the care they needed. For example we saw up to date plans of care which considered individual physical, emotional and mental health care needs. We saw risk assessments and that all documentation was kept up to date to ensure people had their changing needs met. We saw that the home consulted with specialists to make sure people had the benefit of expert advice.

People were protected from harm and the risk of harm through staff training and risk assessments. The service also referred safeguarding incidents to the local authority and to CQC as required. Staff had training in the Mental Capacity Act (2005) and Deprivation of Liberty safeguards (DoLS) to ensure people's rights were protected.

There were sufficient staff on duty to offer safe and personalised care.

The home had a complaints procedure, we saw that the home dealt with complaints appropriately and people told us that they knew how to complain.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

We spoke with three people who lived at the home but their feedback did not relate to this standard.

We saw that the service had systems in place to gain and review people's consent. Assessments of capacity to make a decision regarding care were recorded in care plans and these were kept under review. Staff understood that for people who required significant decisions to be made on their behalf they would need a 'Best Interests' decisions recorded. These are decisions which are made by a multidisciplinary team to ensure people's rights and best interests are protected. We saw written evidence that some people had 'Best Interest' decisions in place to protect their welfare. We also saw written evidence that one of the people who lived at the home had used the services of an Independent Mental Capacity Advocate (IMCA). This was a person appointed to ensure that the person's views and interests were represented in a decision making process about medical care.

We saw that staff had undergone training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) so that they had information to ensure they could protect people with regard to consent issues. We spoke with three members of staff who understood that capacity could fluctuate and that they must assume a person had capacity unless this was assessed otherwise. They also understood that the person could decide to withdraw consent to care or treatment whenever they wanted to.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care treatment and support that met their needs and protected their rights.

Reasons for our judgement

We spoke with three people who lived at Rosefern. Their comments indicated that they were satisfied with their care at the home. One person told us he was happy at Rosefern and had settled in well after admission.

We were unable to gain the views of some of the people who lived at the home verbally, so we carried out observations which gave us information about how staff interacted with people. We saw that staff interacted in a way which showed they knew people and their needs well. Staff chatted with people about their day to day lives and people appeared relaxed and confident.

We spoke with staff who told us that their priority was to offer people a personalised service. We saw written evidence that the service consulted with people and if appropriate, their families. This showed that the service considered the support networks around each person.

We looked at four care plans with associated documentation. Needs assessments and care plans had been completed with the person. We saw information about the person, their likes and dislikes, their personality and what was important to them including interests and significant relationships. People had easy read versions of their care plans where appropriate to ensure they understood what was written down about the care they needed and those who were able had signed their agreement to plans and risk assessments.

A schedule of activities was available throughout the week for those people who benefited from having a structure to their day. A number of people regularly attended a day centre, clubs and had individual interests to follow. For example, some of the people at the home attended 'The Mustard Seed Club' where activities and trips out were organised. Some of the people who lived at the home enjoyed attending Church with support. Others went out of the home to pursue individual interests such as horse riding. This ensured people were involved in the community around them and had access to a variety social situations. The home had organised a number of Christmas events including a choir coming to the home to sing carols and a Christmas party during the holiday period.

A number of the people cared for at Rosefern had complex needs. These had been

covered in detail, with specific instructions about how to ensure people were cared for safely and were enabled to live a full and interesting life. We saw that people's medical conditions were researched and that plans were in place to ensure people were cared for appropriately.

Plans were 'person centred' which meant they focused on the person and their particular wishes. The care document focusing on each person with the people most important to them gave staff useful information about people's interests and support networks. The plans covered discussions with people about their future goals, hopes and aspirations. Action points were then recorded to ensure people were enabled to work towards these goals. Plans were supported by pictorial and photographic images to help people to understand their records. We saw evidence that the plans were regularly reviewed to make sure the care was right for current needs.

Specialists had been consulted where necessary to ensure people had the benefit of expert advice and knowledge. For example, we saw evidence of consultation with a speech and language therapist and records of consultation with the consultant psychiatrist. We also saw evidence of referrals to general practitioners and district nurses. All consultation was recorded. Advice was incorporated into care plans to ensure people received the care they needed.

Risk assessments were included where needed and were specific to each individual to minimise the risk of harm. These were updated in line with the care plans.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

We spoke with three people who lived at the home. Their comments did not relate to this standard.

We spoke with three members of staff and the registered manager. Staff understood that they would report any suspected abuse to the manager or person in charge. Staff also understood their responsibilities with regard to safeguarding and knew that the local authority would take the lead in any investigation. They told us they had received safeguarding training. We saw written evidence that training had taken place and that this was kept up to date. This ensured that people were protected from harm and the risk of harm.

Staff told us that they had received training in The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). We saw evidence that this training had taken place. This ensured that staff understood how to involve people appropriately in decisions about their care. We also saw evidence of capacity assessments on individual files. We saw how decisions for people with limited capacity were made by a multidisciplinary team to ensure they were in a person's best interests.

We saw evidence of notifications sent to the Care Quality Commission (CQC). Safeguarding concerns were forwarded to the correct authority to ensure people could be protected. Plans were in place to ensure risks were minimised.

We saw that the registered manager carried out Criminal Records Bureau checks (CRB) on staff to ensure that the home did not recruit anyone who was known to be unsuitable to work with vulnerable people. We saw that CRB checks were carried out and that staff shadowed an experienced member of staff until the CRB check was returned with no concerning information.

We saw that some staff had training in challenging behaviour. The registered manager told us that they did not need to use restraint and that staff concentrated their efforts on non physical interventions if the need arose. We saw records of how staff had dealt with situations which had been challenging and noted that the service had very few incidents where people became agitated or needed extra support.

The provider responded appropriately to any allegation of abuse.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

We saw rotas for staffing levels from the weeks commencing December 3rd 2012, December 10th 2012 and December 17th 2012. The registered manager told us that there were always three members of staff on duty each day, sometimes more depending on the needs of the people living at the home and what they wanted to do. Sometimes the manager was on rota to offer care and was not supernumerary. The home was caring for nine people and staff told us that they felt there were enough staff on duty. The provider may wish to note however, that both the registered manager and the staff on duty told us that the home benefited when the manager was supernumerary. When the manager was on rota to offer care she did not have as much time to keep up to date with records to ensure people received a safe service.

We saw rotas for night staffing. There was always one member of waking night staff and one who slept over. In addition there was always a member of staff on call in case of emergencies. The registered manager told us that the home did not need to use agency staff. They usually managed to cover any sickness or holiday with their own staff. Autism Plus had a 'staff bank' which the home could call on if existing arrangements failed. However, the manager told us that it was likely that if such a situation arose she would use local agency staff because of the home's physical isolation from other Autism Plus services and staff.

There were enough qualified, skilled and experienced staff to meet people's needs.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately

Reasons for our judgement

We spoke with three people who lived at the home but their feedback did not relate to this standard.

We saw that the home had a complaints policy and procedure. The policy was in a user-friendly format with large print and pictorial explanations. Staff told us that the home investigated any complaint within a set timescale but that there had been no complaints to investigate since the last inspection. We saw that the complaints policy was in the service user guide, which is an information document for people about the service, its aims values and philosophy. The complaints procedure contained up to date contact details for CQC so that people could contact someone outside of the home if they were unhappy with the way a complaint had been dealt with.

People were made aware of the complaints system. This was provided in a format that met their needs.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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