Care Quality Commission

Autism Plus Limited

Rosefern Residential Home

Inspection report

2 Seamer Road
Scarborough
North Yorkshire
YO12 4DT
Tel: 01723 378431
Website: www.autismplus.co.uk

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Ratings

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

Overall summary

Rosefern Residential Home is located in a residential area within a mile of Scarborough town centre. It provides care and accommodation for people with a learning disability. Accommodation is provided for up to 12 people in single bedroom accommodation over three floors. There is a small yard to the rear of the home and a park and shops are close by. There is no passenger lift. When we visited there were eight people living at Rosefern Residential Home.

The home 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.

We carried out an inspection of this service over two days on 14 and 16 October 2014. The visit on the first day was unannounced.

We last inspected Rosefern Residential Home on 13 December 2013. At that inspection we found the home was meeting all the regulations that we assessed.

Summary of findings

At this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to care and welfare, respecting and involving people and monitoring the quality of the service.

There was a well-developed system of care planning. However we found improvements were needed to ensure people received consistent care that met their needs. Although staff knew about people's special dietary needs nutritional assessment and dietary monitoring was not sufficiently robust to identify people's changing care needs in a timely way. Observation of the building suggested that the access around the building was unsuitable for people living there with increasing mobility problems.

People were not encouraged to be fully involved in their lives and receive the right range and level of support to maximise their potential. Although staff were kind they appeared to have a low level of expectation about people's abilities and achievements. People were not actively consulted about the running of the home and we found improvements were needed to ensure people's confidentiality was protected and their privacy, dignity and independence were promoted at all times.

Effective management systems were not in place to assess, evaluate and improve care of people in a systematic way. Greater emphasis was needed to increase and maintain people's independence, their social roles and empowerment in line with good practice guidance and the organisation's statement of purpose. Information about the home needed to be updated and developed in an easy read or a pictorial format to aid people's understanding of the activities and choices available to them. This information would also be of benefit to prospective residents.

However, people told us they felt safe and they liked the staff. There was an established staff team who knew people well. Health and social care staff spoke positively about the service, the registered manager and the staff team.

Although the home had not need to make any safeguarding alerts in the past year the registered manager demonstrated a good awareness of safeguarding processes and knew how to follow local safeguarding protocols if needed.

Appropriate recruitment procedures were in place to make sure that suitable staff were employed and staffing levels were adequate to meet people's care needs. Staff had received medicines training and we saw people had their medicines at the times they needed them, and in a safe way.

Staff understood their responsibilities under the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). The registered manager was able to give numerous examples of how they had involved independent advocacy services to help and support people. A mental capacity advocate (IMCA) and the health care and social care professionals we spoke with confirmed this was a priority in the home.

People had access to a range of health care and social care professionals including GPs, occupational therapists, community psychiatric nurses, and telecare and speech and language therapists.

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. Safeguarding policies were in place and staff had received training on these.

Health and social care professionals were positive about the care people received and confident in management and staff.

Appropriate recruitment procedures were in place to make sure suitable staff were employed. Staffing levels were adequate to meet people's care needs.

Satisfactory systems were in place for the safe storage, recording and administration of medication.

Is the service effective?

Requires Improvement

The service was not effective. Despite adaptations the access around the home was not suitable for people with increasing mobility problems.

People's nutritional needs were identified however dietary monitoring for people who were at risk of being malnourished required improvement.

Staff had followed the Mental Capacity Act 2005 Code of Practice and Deprivation of Liberty Safeguards when decisions were made on people's behalf.

People had access to a range of health care and social care professionals including GPs, occupational therapists, community psychiatric nurses, and telecare and speech and language therapists.

Is the service caring?

Requires Improvement

The service was not caring. We found that staff were knowledgeable about the people they supported. People were well dressed and staff spoke quietly and kindly to people.

However we also observed examples of where people's confidentiality was not protected and people's privacy, dignity and independence was not promoted at all times.

Is the service responsive?

Requires Improvement

The service was not responsive. Although care plans were well developed we found that the routines and regime of the home were task based. People were not receiving person centred care in line with their assessed care needs.

Although there had been no complaints in the past year people told us that management would sort out any issues they raised. Health and social care staff were confident that the service would respond to any concerns raised with them.

Summary of findings

Is the service well-led?

The service was not well led. People benefitted from a consistent staff team who knew people well.

Although there were systems in place to monitor the quality of the service some improvements were required to ensure that identified areas for improvement were addressed and the home took account of good practice guidelines.

Requires Improvement

Rosefern Residential Home

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.

The inspection took place over two days on 14 and 16 October 2014 and was unannounced. The inspection team consisted of an inspector, an expert by experience and a specialist advisor who was a clinical psychologist with experience of working with people with learning disabilities and autism. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 14 October 2014 the inspector visited the service with the expert by experience. On 16 October 2014 the inspector and the specialist advisor visited the service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority contracts and compliance team and health watch to ask for their views on the quality of the service provided by the home.

During our visit we spoke with the registered manager, the deputy manager, three members of care staff, and with eight people who used the service. Owing to people's complex care needs we were not able to ask everyone directly about their care. However, we observed the care and support people received which gave us an insight into their experiences. We observed an activity that took place on 16 October 2014 and spoke with a visitor. We looked at all areas of the home including people's bedrooms, the kitchen, laundry, bathrooms and communal areas.

We carried out telephone interviews with a social worker, a learning disability nurse and an independent mental capacity advocate (IMCA). The IMCA role is to support and represent the person in the decision making process to make sure the Mental Capacity Act 2005 is being followed.

During our visit we looked at a range of records including care plans and monthly journals for three people living at the home, recruitment records for three members of staff, staff meeting minutes, maintenance records and audits.

Following our visit we also reviewed other records relating to the management of the home including quality review documents, the safeguarding policy, health and safety policies, staff rotas and the home's Statement of Purpose.

Good

Is the service safe?

Our findings

We spoke with one person who was able to describe their care to us. They told us they felt safe living at the home. They said “If I had any problems I would go to the manager or if she wasn’t on, the deputy and they would sort it out.” We saw leaflets in easy read format about abuse and bullying were displayed in the hall. This included documents telling people who they could speak to if they had any concerns or worries so appropriate action could be taken.

Safeguarding policies were displayed in the office so staff could check how to identify and respond appropriately if they suspected abuse had occurred or was at risk of occurring. A member of staff told us they had completed safeguarding and ‘no restraint’ training. They explained this training had helped them to recognise and address distressed behaviour without the need for physical restraint.

Before our visit the local authority contracts and compliance team confirmed there were no safeguarding or other concerns that they were aware of. The Care Quality Commission (CQC) had not received any notifications in relation to serious incidents, whistle blowing or safeguarding alerts in the past year. Staff we spoke with told us they knew how to make a safeguarding alert and the registered manager was able to give us an example of when she had done this in the case of one person who had received the incorrect dosage of their medicines when they were in hospital.

With regard to safeguarding of people the independent mental capacity advocate (IMCA) said “I think they would respond appropriately. (Name) can display some challenging behaviour but they know how to respond and deal with her well.” Another person said staff were "Very approachable.” A social worker we spoke with said "I have only positive things to say about the service. One client can be demanding on staff time, noisy and disruptive. But things have calmed down considerably.”

Staff told us there were enough staff on duty to keep people safe. The manager told us there were three members of care staff on duty throughout the day with one member of staff on waking duty and a member of staff sleeping in on call at night. We checked the staff rota for a one month period which demonstrated staffing was provided consistently at the levels described to us. There was no ancillary staff employed so care staff also had responsibility for all the cooking, cleaning and laundry tasks. Our observations indicated staff were kept busy throughout our visit but they had time to respond promptly to people’s physical care needs. Staff reported they worked well together as a team and covered for each other during periods of absence. We saw this arrangement worked well in practice when a member of staff had to leave early at short notice on one day.

We looked at three recruitment records. Records showed that all the relevant checks had been completed before staff started working at the home. We saw completed application forms detailing each staff member’s employment history and reason for leaving previous roles in health and social care, together with written references. Each staff member also had an Enhanced Disclosure and Barring Service check documenting that they weren’t barred from working with vulnerable people. This meant that appropriate checks were in place to make sure people were supported by suitable staff.

Individual risk assessments were in place to support people in their daily lives. Guidance was available for staff about what to do in the event of an emergency in the form of individual risk profiles for example, in case of the risk of fire. General risk assessments were kept regarding the safety and suitability of premises. Records showed that the deputy manager completed a range of safety related checks such as first aid, infection control and medication and these were audited by the registered manager. We looked at a range of maintenance certificates relating to the safety of the home including gas safety checks, fire alarm system checks and electric safety and these were all up to date.

When we visited staff told us no-one living at the home was currently responsible for managing their own medicines (we sometimes call this self-medicating). We spoke with one person who said “For safety reasons my medicine is kept in the locked cabinet. I have it at morning and night and the staff remind me.” As part of our inspection we spoke with the deputy manager who was responsible for overseeing medicines in the home. We found they had a good understanding of what medicines needed to be taken and when.

We observed medicines being administered at lunchtime. The deputy manager was observing the practice of another

Good

Is the service safe?

member of staff who was still in training to make sure people received their medicines safely. We saw medicines were administered appropriately and recorded on the medication administration record (MAR). We checked the medication records for two people whose care we had looked at during our visit and saw that they received their medication in line with their care plan. For example, we saw a member of staff sat beside one person and patiently waited for them to take their medicines quietly reminding and prompting them until they had taken them. Staff described the medicines training they had undertaken which included e-learning, training from the dispensing pharmacy and a two day training course on medicines at a local hospice. This showed us that appropriate arrangements were in place to make sure that staff received training on how to handle medicines safely and securely.

Requires Improvement

Is the service effective?

Our findings

People told us that they received support with their health needs. One person said "I have an appointment on Thursday for an eye test and a check up at the dentist in November. I go on my own but staff would go with me if I wanted."

We saw in the PIR the provider planned to make some environmental changes to meet people's changing care needs. However, the registered manager told us that building control legislation prevented them from installing a passenger lift or stair lift as planned. We heard three people had moved to ground floor rooms as a result of their increased health care needs. A fourth person was due to transfer from the top floor into a room on the first floor once alterations had been completed. This reduced the number of stairs people had to negotiate but was not ideal in the long term. We spoke with a social care professional who told us they were involved with one person who had reduced mobility. We asked about the suitability of the building for the person they supported. They said "They keep people, and are doing the best they can with what they've got."

The PIR indicated that further planned improvements included new boilers and bathrooms. When we visited the registered manager told us that the new boilers were due to be fitted although they did not have a timescale for this work. We saw new bathroom facilities had been created on the ground floor and vacant rooms on the top floor were being decorated. However, we saw areas which needed further attention. The entrance between the two lounges had a step which could be a tripping hazard as it didn't have a hand rail. Plasterwork on the ceiling to the ground floor bathroom needed repair. We saw exterior woodwork and paintwork needed attention and fabric on the dining room chairs was shabby and stained. The fan in the ground floor WC was not working and we pointed this out to the registered manager on the day.

Staff told us that people had their own preferred seats at mealtimes and we observed some people sat together and some alone. There was no cook and one member of staff said everyone was expected to take a turn which had been a big learning curve for some but they now enjoyed it. Staff told us that meat and vegetables were sourced locally and one person living at the home told us "I go to the butchers on a Saturday and buy the meat." Another person said "The meals are very nice. There is a choice of menu and I choose what I want."

Staff we spoke with were aware of special dietary needs. They told us that one person needed a special diet due to gall bladder problems and another person needed food cut small due to a possible choking hazard and this agreed with the information supplied by the manager. Records confirmed the Speech and Language Therapy (SALT) team were consulted if necessary. One member of staff said eating and drinking was monitored and they recorded people's dietary intake. However, the record we saw was not sufficiently detailed for people at risk of being malnourished to identify if further intervention was required.

During lunch we observed that people were provided with adapted cutlery and plate guards as necessary. We saw that people were not hurried and the staff were available to help where necessary. However, we observed people's choices and preferences were not always sought in an appropriate way. For example, we saw staff served food in the same quantities to everyone, with no consultation with individuals about what they wanted on their plate or portion size. Menus were not produced in an easy read or picture formats which would help people understand the choices available. When observing the lunch time meal the person cooking came into the dining room and speaking generally to the people in the room asked "What would you like to drink?" Only one person was capable of replying and they said they wanted a cold drink. The member of staff said "Right cold drinks all round then." Because people were not asked individually in an accessible way they were not given a proper choice of drink. The carer then brought round two bottles of drink for people to choose from but they were both sweet and fizzy so a proper choice couldn't be made.

The registered manager showed us an individual staff training planner and training log. She told us that staff had access to the electronic system to view the organisation's policies and procedures. Policies covered such areas as health and safety, safeguarding, prevention of infection, equality and diversity, Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The registered manager showed us their personal development plan and

Requires Improvement

Is the service effective?

said these were in place for all members of staff as part of their training plan. Staff said the registered manager was very good at highlighting suitable courses and supportive of staff attending them.

Staff completed an induction programme in line with Skills for Care common induction standards. These are the standards people working in social care need to meet before they can safely work unsupervised. The registered manager said new staff were working towards a level 2 certificate in preparing to work in adult social care. Newly appointed staff completed a minimum of two reviews during their probationary period to make sure they were developing in the role and were supported to provide the right care.

Staff received supervision sessions and the manager said they held staff meetings on a monthly basis in which staff could discuss changes in legislation and good practice. We saw the dates for these were highlighted on the staff rotas. Staff confirmed the manager was very good at keeping them up to date and confirmed they held staff meetings on a regular basis.

We found the registered manager had a good understanding of the MCA and DoLS. The MCA covers people who can't make decisions for themselves or lack the mental capacity to do so. DoLS are part of the MCA to make sure people living in care homes are looked after in a way that does not inappropriately restrict their freedom. The IMCA confirmed staff followed the correct procedure to ensure people's rights were protected. She said "Staff are good at recognising the need for an IMCA referral." A learning disability nurse said "Very clued up on MCA and when to involve an IMCA. For example at hospital appointments when any treatment is suggested the manager is quick to ask for IMCA involvement."

From care records we saw people were all registered with local GP surgeries. Community teams were engaging with people regarding their specific health care needs. Examples included occupational therapists, community psychiatric nurses, and tele care and speech and language therapists. Health and social care professionals we spoke with did not raise any concerns about people's health care needs being met within the home. We spoke with an independent mental capacity advocate (IMCA) who said "Staff are really good at looking after people's welfare and appointments and following up."

Requires Improvement

Is the service caring?

Our findings

Staff said they knew that people's privacy and dignity was very important. However we observed some practice which demonstrated a lack of staff awareness about people's confidentiality and their privacy and dignity. These matters were a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

On our arrival staff did not introduce us to people living at the home. We were concerned that we had to introduce ourselves and people did not have things explained clearly to them. However, when we asked to look round we noted that the registered manager went to check with people first before we viewed their rooms.

We found staff did not always protect people's confidentiality and promote their privacy and dignity. On one occasion we heard two members of staff discussing a person (not present) in the hearing of other residents. Washable continence pads were placed on all the chairs in one sitting room, which clearly indicated that people had a continence problem. We asked the deputy manager to explain why these were used on people's chairs and she told us it was for infection control purposes. We saw lists giving details about residents were displayed prominently near the front door and near the head of stairs. Staff explained this information formed part of the planning arrangements in case of emergency. We identified that day to day practices needed reviewing so that staff had the opportunity to highlight practical ways of improving people's dignity and protect their privacy.

When we visited it was hard to identify how decisions and choices were made in the home. We spoke with one person who said "We don't have meetings they just ask us things." With regard to outings they said "I didn't go on holiday this year, I used to."

During our visit we saw that staff were kept busy and there was little interaction at times between members of staff and people living at the home. We saw numerous occasions when staff failed to take the opportunity to involve people and encourage their independence. Staff appeared to spend most of the morning cleaning, preparing lunch and completing paperwork rather than involving people in any purposeful activities. We saw one person lay on the sofa in the lounge for more than an hour with no interaction from staff and another three people watched television for most of the morning with minimum interaction from staff. We observed one person who was exploring a box of sensory items on their own. This person was salivating excessively but no intervention was made to assist them or change their damp top.

However, people told us they liked living at the home. We observed people were well dressed and presented. One person said "I like all the staff they are very nice." Another person said the deputy manager was "The best." One person showed us their room which was highly personalised with a collection of trophies they had one for bowling and an extensive collection of books about sport.

We also saw some compassionate interactions by staff. For example, when we were speaking to one person a member of care staff discreetly adjusted their glasses so they could see better. We observed that the staff spoke quietly and kindly at all times and seemed to know and understand people well. For instance, a member of staff intervened to explain what one person was saying. This intervention assisted us to hold a conversation with the person.

A learning disability nurse told us they carried out a home visit to assess one person before a hospital admission. They said they found staff to be very knowledgeable and able to provide information relating to their drinking which assisted hospital staff to deal with their care needs. They explained that generally they had limited contact with the service but said "My observations when with staff are that they treat people with dignity and respect." A social worker said "I like this service, very caring and helpful. They seem to want to do their best for people". In relation to staff they said "I mostly work with the registered manager and the deputy manager. Both seem very open to ideas and new ways of working."

During our visit we also saw some good practice. For example, we observed the registered manager recognised by their body language that one person was disturbed by the noise of the birds in one room and she moved the bird cage out of the room. We saw a member of staff encouraged one person to go to the toilet before lunch and did this in a firm but calm way upholding the person's dignity and they eventually happily complied. At lunch time a drink was accidentally spilt. The care staff immediately

Requires Improvement

Is the service caring?

saw to the resident. They assured them it was not their fault and took them away to put dry clothes on and only after they had made sure they were alright did they start to clean the mess up.

Requires Improvement

Is the service responsive?

Our findings

Care files were well organised and we saw some evidence of good person centred planning, which emphasised the importance of people's preferences and choices in their daily lives. However, we also found evidence that people did not always experience safe, effective care that met their assessed care needs. These matters were a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Despite people's increased health care needs staff were not using an accredited screening tool such as the Malnutrition Screening Tool (MUST). Although staff we spoke with told us that one person was on a special diet they were not able to fully explain what this meant. We found the advice on nutrition in the home was not sufficient to guide staff properly on the person's dietary requirements. This was of concern because the person had a health need that restricted their diet and all staff had responsibility for planning and cooking meals. Although staff said everyone was weighed on a weekly basis there was no record of weekly weights for this person. The registered manager confirmed it would not be possible to record the person's weight accurately as they would not be able to stand on the weigh scales. We saw from the person's records that they had lost weight but this was identified because their clothing no longer fitted them. However this information had not resulted in a further referral to the person's GP, the dietician or SALT. This meant that satisfactory arrangements were not in place to plan and manage the care of people who were at risk of poor nutrition.

We observed staff used inappropriate moving and handling techniques to transfer one person who used a wheelchair. The dining room had two steps down and we observed how the person was assisted to their seat at lunchtime. Their wheelchair was wheeled to the top of the steps where they were assisted to stand up and encouraged to hold onto a rail. A member of care staff then took a dining chair to the bottom of the stairs and the person managed to get down the steps and into the chair. The member of staff then dragged the chair and its occupant into place at the table. This placed both the person and the member of staff assisting them at risk of harm and was undignified for the person concerned.

People were allocated a key worker to support their care needs. A key worker is a named person who can build up a separate relationship with the person. We spoke with a member of staff who acted as a key worker. They told us they completed the daily record in people's journals and talked to 'their' resident about what they had done and what they would like to do. However we found the journals contained limited detail, which meant they were not being used effectively to develop and shape people's experiences. In addition to people's journals staff were also keeping joint records in communication books and on separate sheets. This made records confusing to check and in some cases they did not provide sufficient information to enable people's care and support needs to be tracked and analysed effectively.

We looked at the journal for one person and saw that the activities recorded for them over a one month period consisted mostly of them watching videos. During our visit we observed three people in one sitting room with a member of staff. There was a children's DVD on the television but only one person was engaged in watching the film. There was nothing for people to do in one sitting room except watch television which was on all the time we were there. Later we saw one person was lying on the settee. They asked the member of staff to change the channel, which they did. However, the member of staff didn't use this as an opportunity to encourage and show the person how to use the remote control to encourage their independence.

A list of the week's activities was displayed in the hall with people's names against the individual activities. This list along with other information in the home had not been produced in an easy read or pictorial format. The list showed people were offered one activity per person per day. On one day the activity was for a person to collect their magazine from the local shop. We saw a member of staff accompanied the person to go out. We timed the activity and they returned to the home in less than ten minutes. Later that afternoon we sat with the person and we looked through the magazine together while other people were listening to the entertainer. For another person who was due to go on an outing staff had put 'refused' against their

Requires Improvement

Is the service responsive?

name. This information would be more usefully recorded in the person's own file or daily journal so that information can be collected and analysed in a systematic way. This would also assist staff in reporting back to health and social care professionals about people's welfare needs.

We heard that two people went out to a local day centre and another person was supported to attend a local Church group. We saw for one person that an individual activity programme was displayed. However this was typed on a small piece of paper making it hard to read and contained information for staff about the preparation of the person's meals when they went out. It was displayed on a door along with other staff notices such as the staff rota which would be more suitably kept among other staff information in the office.

The manager confirmed she had discussed the importance of activities with staff and this was confirmed in the staff meeting minutes we saw. When we asked staff about activities they said that staffing levels would not allow them to support people to do more in the day. However, we saw plenty of opportunities where staff could have engaged people in meaningful activities and conversation throughout our visit. We raised this with the regional manager who said that fee levels would prevent people from doing activities on an individualised basis.

Although we heard the home had a vehicle we did not see this used during the two days we spent in the home. One member of staff told us people had not gone out because of poor weather. However, when we asked them they were unsure what they would have done if the weather had been fine. We spoke with an Independent Mental Capacity Advocate (IMCA) who said "I've seen people do group activities and they like to do individual things. It's a shame that owing to financial constraints they don't get out a lot more and that was raised at the last meeting I was at but they really make the best of what they've got."

In addition to their monthly journal people's files also contained a personal profile, care plans and capacity assessments with detailed health action plans and a Hospital Passport. This was a document people could take with them if they needed to go to hospital for treatment. It set out people's care needs and preferences and helped other health care professionals provide people with the right care that met their needs. The registered manager completed care plans and annual reviews. The development of the care plans was supported by the organisation's person centred planning co-ordinator who visited on a quarterly basis. We spoke with a social worker who confirmed that the paperwork was good and they relied on this because people could not communicate verbally. All of these documents were developed to help staff understand and provide care in a way that met people's needs and preferences.

Staff told us care plans were up dated regularly and individual needs were written down and shared among staff. One member of staff said "Everyone has their own individual daily routines, people get up and go to bed when they like. Some people like to sleep in and one person likes to be in bed before 8pm." When we visited one person was enjoying a lie in and leisurely start to their morning which confirmed what staff said to us.

People's files contained photographs of some of their activities and pictures were also displayed on the wall. We saw that some information and photographs including staff photographs needed updating. We thought some photographs might better be displayed in an individual folder or album people to enjoy individually because some of the photographs were of previous residents and ex members of staff. As such, they were not relevant to everyone.

We saw in the PIR that they had not received any complaints in the past year. Before our visit the local authority contracts and compliance team confirmed there were no complaints that they were aware of. The Care Quality Commission (CQC) had not received any complaints about the home. Health and social care professionals confirmed they would be confident to raise any issues with staff at the home. We spoke with one person who told us that if they had any concerns the registered manager or the deputy would help them. The IMCA said "More importantly I feel they would listen to me. Staff are vigilant about people's care." The registered manager confirmed the home had not received any complaints in the past year.

Requires Improvement

Is the service well-led?

Our findings

People living at Rosefern Residential Home benefit from a consistent staff team some of whom have worked at the home for a long time. There was a registered manager in post. The registered manager told us that staff knew people well and we found this was evident when we visited.

Management systems included internal quality audits, team leader meetings and health and safety monitoring logs. Examples of audits we checked included medicines audit, mattress audit, first aid and infection control. These were all up to date. However, there was no evidence to show how the home's audits were used to inform and evaluate information about the quality and safety of care, treatment and support the service provided, and its outcomes.

These matters were a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Our observations showed positive interactions between the registered manager and staff. However, although staff training was in place we found evidence throughout our visit that staff were not effectively promoting person centred care. As part of our inspection we fed back our concerns to the manager about poor practices we observed during our visit. The lack of quality assurance checks meant that the manager or provider had failed to identify these issues before our inspection. We also found evidence that they did not have robust risk assessments in place for nutritional monitoring. This shortfall had put people at potential risk of harm.

The registered manager told us that the organisation used a combination of provider visits and other checks were carried out. These included, for example, visits by an independent company to check on the quality of the service and its safety. However they did not have access to the reports from these. Results of the internal management checks were forwarded to the regional manager each month so they could be confident these checks were being carried out but there was no evidence of issues identified being followed through to ensure they had been addressed.

There was an emphasis upon posting information up on notice boards throughout the home for both staff and residents. Much of this was not produced in an accessible format and was an ineffective way of communicating with care staff and people with a learning disability. For people with autism the use of notices can have an adverse impact on their wellbeing.

We found arrangements for obtaining the views of people who used the service, staff and other interested parties were not being used effectively. The registered manager told us that key workers assisted people to complete easy read satisfaction surveys. They said some people would use body language, gestures or facial expressions to indicate their preferences. Staff had also completed feedback surveys however the manager said these were done some time ago and as far as she was aware the results of these had not been analysed and she had not had any feedback. There was no evidence that the quality of experience of people who use the service or others acting on their behalf was being used by the provider to make improvements to the service.

Following our visit we reviewed documentation relating to the quality monitoring of the service and support arrangements for the home's manager. We saw the quality audit carried out by an independent company dated May 2014, which contained recommendations for example, regarding the statement of purpose, service user feedback and staff feedback. We also found evidence that the home was not working to an action plan in relation to improvements and work was not being carried out in a systematic way.

We also reviewed the British Institute for Learning Disabilities (BILD) Network Annual Report dated 2013-2014. This report was based on information gathered from a number of services run by Autism Plus. The report was used by the organisation to inform them about what was working well across the organisation and areas for further improvement. We found that our findings reflected issues already identified in these reports. People had said for example, that they would like more activities outside the residential setting. It had also being identified that there needed to be more symbols to aid understanding and make important decisions about their lives. There was no evidence to show that action had been taken to improve practices or make changes to the home as a result of these

Requires Improvement

Is the service well-led?

reports. This meant that opportunities to improve the experience of and support for people using the service and facilitate their involvement in how the service was run had not been taken.

The registered manager had responsibility for completing monitoring reports to head office each month. They told us that senior managers visited the home on a frequent basis and knew people living there very well. They confirmed that not all of these visits resulted in a formal written report and the last available report we saw was dated 11 February 2014. In addition the registered manager said that the training manager and person centred co-ordinator visited to help support staff with the development of the service and we saw evidence of this in people's care plans.

One member of staff told us 'It is very organised here'. They said that staff meetings were held every month and staff also had the opportunity in their supervision sessions to be able to raise any issues. One person said "All staff are kept up to date with what is going on, it is brilliant." Another person said "The manager definitely leads well and is very approachable." Management meetings were held each month and the manager said this provided her with a regular forum where they could discuss practice issues with other managers across the organisation.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services We found evidence of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014]. How the regulation was not being met: People's privacy, dignity and independence were not always respected. People's views and experiences were not being taken into account in the way the service was provided and delivered in relation to their care. Suitable arrangements were not in place to provide appropriate opportunities, encouragement and support to service users in relation to promoting their autonomy, independence and community involvement. Regulation 17

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found evidence of a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014]. How the regulation was not being met: People did not experience care, treatment and support that met their needs and protected their rights. Regulation 9.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision We found evidence of a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014]. How the regulation was not being met: Effective management systems were not in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others because systems were not in place to assess, evaluate and improve care of people in a systematic way. Regulation 10