Marist Sisters

Villa Maria

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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**

Summary of findings

Overall summary

This was an unannounced inspection carried out on 13 and 14 February 2017. This inspection was brought forward due to a number of safeguarding incidents reported by the provider. The previous inspection was undertaken on 1 August 2016 and found breaches in legislation relating to medicines management, care planning and risk management, staff supervision and appraisal and management of the service.

Villa Maria is owned by the Sisters of the Marist Congregation. It provides accommodation and personal care for up to 29 older people and is suitable for those with poor mobility. At the time of the inspection 21 people were living at the service, the majority of whom were Sisters of the Marist Congregation. The service is a detached purpose built building and it is set within large gardens overlooking the sea in Hythe and within walking distance to local amenities. Bedrooms are set over three floors with access via a passenger lift. Each person has a single room, with ensuite and there are further assisted bathrooms. People have access to two large lounges and further quiet seating areas, a dining room, conservatory and chapel. There is a well maintained garden, set on a slope with a level paved access around the building and pretty flower tubs and baskets. There is parking available.

Following the last inspection the registered manager resigned and a new manager, who was previously the deputy manager, was appointed in January 2017. 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. At the time of the inspection the manager was not registered with the Commission.

People spoke positively about the service they received and were satisfied with the care and support provided.

Most risks associated with people's care and support had been assessed, but there was not always clear or up to date information about how staff should manage these risks in order to keep people safe. There was conflicting information and practices about monitoring people's health needs to ensure they remained well.

People may be at risk of not have all their needs consistently met as there was not sufficient numbers of competent, skilled and experienced staff on duty. The use of agency staff was high and these staff did not know people and had not all had a thorough induction or read people's care plans. People told us they felt staff were caring although there had been some incidents of poor practice were people's dignity had not been respected, which were being investigated. Most of the staff showed care and compassion towards people and respected their dignity and privacy.

People received their medicines when they should, but the medicines policy and competency assessments could be improved to help mitigate risks.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. People's rights were restricted and not all had been considered for a DoLS. The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Staff did not always follow the principles of the MCA to ensure they were acting legally and in line with people's wishes.

There were audits and checks undertaken, which were meant to identify shortfalls and where improvements were needed. However these had not identified all the shortfalls found during the inspection. Due to trained staff shortages the manager was required to spend time undertaking care and support tasks, which took them away from their management role. There was no deputy manager and staff shifts lacked leadership.

People were involved in the assessment and the initial planning of their care and support and some had chosen to involve their relatives as well. Care plans reflected people's preferred routines. Although the method used to update care plans could make it difficult to ascertain people's current needs. People told us their independence was encouraged wherever possible.

People could choose from a varied menu and enjoyed their meals. People attended regular chapel services each day and in addition there were opportunities to join in a range of activities, which people enjoyed. People did not have any concerns, but felt comfortable in raising issues. Their feedback was gained both informally and formally.

Management had an open door policy and they took action to address any concerns or issues to help ensure the service ran smoothly.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

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.

Risks associated with people's care had been identified, but there was not up to date guidance about how to keep people safe.

People may be at risk as there not sufficient numbers of competent, skilled and experienced staff on duty.

People received their medicines when they should. However the medicines policy and competency assessments could be improved.

People were protected by robust recruitment processes.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not fully protected to maintain good health and welfare as staff opinions, practices and records differed in relation to monitoring people's health.

Staff demonstrated a lack of knowledge about peoples' needs and sufficient numbers were not deployed that were competent, skilled and experienced in order to meet people's needs

The manager had submitted two DoLS application, but others needed to be considered. The manager and staff lacked a good understanding of the principles of the Mental Capacity Act 2005.

People enjoyed their meals and had a varied menu with a choice of meals.

Is the service caring?

Requires Improvement

The service was not always caring.

There had been some incidents where people had not always been treated with dignity and respect, but the provider had taken action once they were aware of this. Most staff demonstrated

care and compassion.

People's end of life wishes were not always detailed in their care plans.

Staff encouraged and supported people to maintain their independence where possible.

People were relaxed in the company of the staff. The service had a community feel.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were person-centred and showed their preferred daily routines. However finding current information about people's needs was not always easy.

People felt comfortable if they needed to complain, but did not have any complaints. People had opportunities to provide feedback about the service they received.

People were not socially isolated. They were able to attend regular chapel services held each day and a range of other activities and get-togethers.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The manager was not registered with the commission and had to spend time on non-management tasks. There was no deputy manager and staff lacked leadership on shift.

The audits and systems in place to monitor the quality of care people received had not identified shortfalls found during this inspection and were not totally effective in driving improvements in a timely way.

Management demonstrated an open and positive culture within the service, which was focussed on people. Staff were aware of the provider's core values and management strived to ensure these were followed through into their practice.

Villa Maria

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 and 14 February 2017. The inspection team consisted of two inspectors on 13 February 2017 and an inspector and pharmacist inspector on 14 February 2017.

The provider did not complete a Provider Information Return (PIR), because we carried out this inspection before another PiR was required. 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. Prior to the inspection we reviewed other information we held about the service, we looked at the previous inspection report and notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection we reviewed people's records and a variety of documents. These included six people's care plans, risk assessments and daily records made by staff, medicine records and policy, accident and incident reports, three staff recruitment files, staffing rotas, training, supervision and appraisal records, servicing and maintenance records and quality assurance records.

We spoke with eight people who were using the service, the manager, the head of the provider's compliance team, the administrator and chef, five members of care staff and an external training provider who was providing training during the inspection.

Before the inspection we received feedback from two social care professionals who had had contact with the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Villa Maria and when staff supported them. One person told us they felt safe because there were staff around at night so they knew they were never totally alone. Other people felt the service was safe and that staff kept an eye on them when needed and one person said, "I'm as safe as can be, I've no worries on that score as I'm in the middle of a convent". Despite people's positive comments we found improvements were needed to ensure people were always cared for safely.

People did not have their needs met by sufficient numbers of competent, trained and experienced staff. In addition to the manager there were five care staff on duty 8am to 2pm, four care staff 2pm to 8pm and three members of staff on waking night duty 8pm to 8am. Turnover of staff since the last inspection had been high and at the time of this inspection the provider had only 16 care staff employed to cover these shifts, therefore there was high use of agency staff. Staff were supported by housekeeping and domestic staff, a maintenance person and an administrator. Most people felt there were enough staff on duty. However one person told us staff could take a long time to respond to their call bell especially at night, but said, "I can't complain though, because sometimes they do come almost immediately". During the inspection staff responded when people approached them or when call bells sounded and were not rushed in their responses. However during the inspection and on other occasions the manager was required to administer medicines as there were not sufficient numbers of staff trained in medicine administration on duty. At times during the evening and night a trained person had to be on call and drive in when people required pain relief for the same reason. During day one of the inspection there were three permanent staff on duty and two agency staff. Permanent staff on duty were unable to locate key information about people when asked, such as Do Not Attempt Resuscitation (DNAR) orders and were unclear during discussions about people's health conditions; they referred to other staff on duty who also could not give answers. One agency member of staff was working their second shift at Villa Maria on day one of the inspection and told us they had not had an induction at Villa Maria although they had shadowed an experienced member of staff for one shift. Both agency staff told us they had not had time to read people's care plans. One member of staff told us there were not enough permanent staff and agency usage put a strain on the permanent staff because they had to explain everything to them and by the time they had done this they could have done the task themselves. Permanent staff that worked in the day and the manager were doing extra shifts as well as shifts at night to help cover and said they were exhausted.

The provider failed to ensure there were sufficient numbers of suitably competent, skilled and experienced staff to meet requirements. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Previously people were not fully protected against the risks associated with their care and support. Most risks had been assessed, but there had not always been clear written procedures in place to keep people safe. During this inspection we found that risk assessments had been reviewed and additional information added. However since that time one person's mobility needs had deteriorated to the point they now required a standing aid, but the risk assessment had not been updated to show how to move this person safely using this aid. In another person's moving and handling risk assessment there was a handwritten note

at the bottom '(Person) needs assistance with all activities' dated 17/01/17. The moving and handling assessment had various sections about different aspects of moving and handling, but none of these had been individually updated to reflect this comment. For example, 'transfers to bed' still stated 'may need assistance occasionally', which had been recorded on 14/11/16. Staff confirmed that the person was unable to transfer to bed at all now. Another section stated the person 'uses a zimmer', but staff told us the person was no longer able to do so.

One assessment stated that the person required half hourly observations and to be 'turned' once at night to reduce risks. The assessment said the person had been known to try and get out of bed and that was why the observations were in place. The manager told us this information was not correct and the person was not on 24 hour observations. Records showed that observations were undertaken during the day only.

The failure to have accurate information for staff in how to provide safe care and minimise risks meant that staff may fail to recognise a risk or could provide inappropriate or unsafe care. This is especially relevant as some permanent staff were not fully aware of people's needs and the service used a high number of agency staff who did not know people's needs.

The provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. This is a continued breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our last inspection found that medicines were not always managed safely. There had been a high number of medicines errors and guidance for medicines taken on a 'when required' (PRN) basis was not always available.

Since our last inspection staff had updated and improved guidance for people taking pain relief medicines PRN and body maps were used to record where creams and medicine patches were applied; this enabled people to receive the best outcomes from their medicines.

We observed a medicines administration round and found that staff administered medicines safely and in a caring manner. Medicines were signed for by staff after they were given and there were no missed doses seen on the medicines administration records (MAR) charts. Some people were self-administering their medicines and appropriate assessments had been carried out to ensure this was safe. There were safe arrangements in place for people to take medicines with them when they went out or on holiday.

Due to the high number of errors that had occurred at the time of the last inspection, the provider had changed the assessment process for staff administering medicines. Although staff had been assessed as competent to administer medicines safely, some staff had not been assessed for each type of medicine, for example, scalp applications, or inhalers. This meant that the provider could not ensure that all types of medicines could be administered safely by all staff.

Recommendation: Staff administering medicines are competency assessed for the types of medicines relevant to the service.

We saw that staff reported medicines errors and completed reflective learning records. However, managers had not always followed these up, or documented any actions taken to help reduce the risk of reoccurrence. There was evidence of learning being discuss during meetings, although the provider's policy did not include this process. The provider also has a Duty of Candour (to be open and honest) to inform the person or their representative when an error has occurred; the policy did not include this which meant staff may not

understand their responsibilities. However, we were told by the manager that people were informed if there was an error.

Recommendation: The provider's policy should make provision for the learning from medicines errors and near misses and ensure the person or their representative is informed that an error has occurred.

Medicines were stored safely and securely. Quantities of medicines received into the service were recorded on the MAR charts and balance checks matched records. Medicines, including those requiring refrigeration were kept at the correct temperature. All medicines were within their expiry dates and there was a process in place for recording and disposing of unwanted and expired medicines appropriately.

Medicines requiring special storage and closer monitoring were managed in line with legal requirements.

Medicine safety alerts (national alerts regarding faulty products) were received by the manager and action was taken if required.

There were individual personal emergency evacuation plans (PEEP) in place in the event of a fire. However when we viewed these at the last inspection they did not all contain information about how the person would be evacuated from the building, should this be necessary although this information was included in the provider's full evacuation plan. The registered manager at the time agreed to contact the Fire Safety Office (FSO) to clarify whether the information was required to be in the individual PEEP. However this had not been done and the new manager agreed to contact the FSO.

People were protected from abuse and harm. During the inspection the atmosphere was quiet and relaxed. Staff were patient and people made their needs known. Staff had received training in safeguarding adults; they were able to describe different types of abuse and knew the procedures in place to report any suspicions or allegations. There was a clear safeguarding policy in place. The manager was familiar with the process to follow if any abuse was suspected in the service; and knew the local authority's safeguarding protocols and how to contact the local authority's safeguarding team.

People were protected by robust recruitment procedures. We looked at three recruitment files of staff that had been recruited since the last inspection. Recruitment records included the required pre-employment checks to make sure staff were suitable and of good character.

People benefited from a spacious purpose built home, which was homely and well maintained. People all had their own bedrooms, which had an ensuite. These were light, warm and personalised. There were two very spacious lounges and other seating areas where people could spend their time. There was also a dining room and separate conservatory with views to the sea and the service had its own chapel. Since the last inspection one bedroom had had new flooring and had been redecorated. Gardens were well maintained although on a slope, but there were level paths around the building, which people used. There were records to show that equipment and the premises received regular checks and servicing, such as checks on fire alarms and fire equipment, hoists, the lift, electrical wiring and electrical items.

Requires Improvement

Is the service effective?

Our findings

People were satisfied with the care and support received. One person said, "Happy enough and I have everything I need". Another person told us, "I'm so blessed to live here. I have everything I could ever want". Although people were positive about the care they received we found that improvements were needed to ensure people always received effective care.

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 Mental Capacity Act 2005 (MCA). The application procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Previously discussions with the manager identified that some people were restricted and one person had tried to leave the building, although DoLS applications had not been submitted. The manager told us they submitted two DoLS applications during the inspection. However others needed to be considered.

Some people had Do Not Attempt Resuscitation (DNAR) orders in place. However when we asked staff about this information during the inspection they were unable to find it. The folder containing this information for everyone was labelled 'Emergency hospital admission forms and instructions for care' so did not immediately show that it contained DNAR orders. We asked two staff which people had a DNAR and they were unable to give us any names at all. There was information in the end of life care plans to identify if a person had a DNAR order in place, but not the actual order, which emergency services would require. This left a risk that in an emergency this information might not be clear and people's wishes would not be followed.

Two people's care plans stated they did not have capacity to manager their own money, but no mental capacity assessments had been undertaken. People that had been diagnosed with dementia had signed consent forms relating to things, such as medicine management, having photographs taken and attending meetings and although these had been regularly reviewed people's continued capacity had not been taken into account. A bedrails risk assessment was dated 23 November 2016, which stated bedrails should not be used if the person had impaired capacity for decision making and the assessor had indicated they did. There was no evidence of a capacity assessment for this decision or evidence of who had been involved in any decision making. Records showed nominated next of kin were noted as community leaders or Chaplin 'and will make decisions on my behalf'. Community leaders had also signed consent forms, but there were no formal legal arrangements in place to support this although the manager told us this process was now being started. Mental capacity assessments that had been undertaken were for 'all aspects of daily living' and not decision specific. This demonstrated a lack of understanding by staff and the manager in relation to DoLS and the Mental Capacity Act 2005.

The provider had failed to follow the principles of the Mental Capacity Act 2005. This is a breach of Regulation 11 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's health was not fully protected. Records showed that one person had been visited by a health

professional in September 2016 and according to records staff were requested to monitor and record incidents of hallucinations on an incident form and a log. However we found staff had differing opinions about what would be recorded as an incident with one member of staff telling us only bigger incidents would be recorded. Daily reports recorded by staff showed there had been an incident during February 2017, but this had not been recorded on an incident form or the log. This meant when the health professional came to review the person's health they would not have the full information available to base any judgements or treatment.

One person told us they had constant back pain and was clearly in discomfort with their back as they kept repositioning themselves by sitting more upright in their chair and then changing position. The person told us they had pain killers, but that "They don't really do anything". We asked if they had seen the doctor, but they felt they could not really do anything to help them. The person was prescribed two types of pain relief, but was not having the maximum dosage that they were prescribed. In some cases this had been offered and refused. However action had not been taken to refer this person back to the doctor to ensure pain relief was adequate.

Some people were at risk of poor skin integrity and had equipment, such as pressure relieving mattresses in place. However we found that one person's pump was set higher than it should have been for their current weight. There was no current information within the care plan or risk assessment relating to this setting. The manager later told us that this setting was a result of instruction from the community nursing team although there no evidence of this in records. This poor communication puts people's health at risk particularly given the high use of agency staff and lack of understanding showed by staff.

People had their blood pressure taken by staff. Staff told us that the doctor sometimes asked for them to record people's blood pressure for a period of time and then to fax the readings to them. The manager said that blood pressure readings should have been being made for everyone and told us that the doctor reviewed people's medicines based on blood pressure readings submitted by staff and without assessing people in person. Three staff told us they had had no training in using the blood pressure monitor, but "know how to do it". Staff eventually were able to find a chart showing when blood pressure was high or low. One person's blood pressure had been recorded daily or weekly until 28 December 2016 according to records. Staff were unable to say why the readings had stopped other than it might be, because the person had become weak that the blood pressure machine was not producing a reading. Staff were unable to say what action had been taken in relation to this, such as the doctor informed. Staff had not received training and did not demonstrate their competency for a task usually undertaken by the community nursing team and this could put people's health at risk.

Nutritional risk assessments were in place and for one person this had last been updated on 25 October 2016 to show that the person was now on a fluid chart due to poor intake. There was no information to inform staff what was a desirable target intake or what action staff should take if this was not achieved. Fluid charts had not been totalled by staff to demonstrate this was being monitored, but showed an intake of between 200mls and 900mls each day for the previous eight days. Staff said there was not much they could do if the person did not want to drink. We asked them how they would know if the person had drunk enough as there was no target. One told us they thought the level was 1.5 litres for older people and the other staff member wasn't sure. Soup had sometimes been recorded on the fluid chart so this showed staff were considering other methods to help the person have more fluid.

The provider had failed to do all that reasonable possible to mitigate risks to people's health and welfare. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Discussions with the manager and a senior manager showed the induction in place for agency staff was not clear. There were no records of their induction training at Villa Maria as the manager told us the staff kept these themselves and a copy had not been obtained. One agency worker told us they had received no induction, had not had time to look at people's care plans and had not been given any instruction about what to do in the event of a fire. They did not really know their way around the service and were reliant on other staff for everything. They said they did not really know what they were meant to be doing today and were waiting for instructions and acting on them individually. A senior manager later confirmed this agency worker had not received the induction training.

Staff working in the service told us they had not had time to read people's care plans. Staff were unable to demonstrate knowledge of people's health conditions or competency about tasks they undertook, in order to take action when there were concerns and keep people safe and well. For example, monitoring people's fluid intake, taking people's blood pressure and finding key information requested. Communication was not good and staff had differing opinions about what checks and observations of people were in place. For example, one staff member told us one person had 30 minute observations all the time, the manager told us it was just in specific circumstances and the care plan stated 30 minutes during the day and hourly at night.

Staff training records had not been updated since the last inspection. Although the PiR stated that fire marshal training had taken place and we were told seven staff attended. We were able to ascertain that a few staff required training or refresher training in subjects, such as fire safety, health and safety, food hygiene, first aid, safeguarding and MCA/DoLS.

The provider had failed to ensure there were sufficient numbers of competent, skilled and experienced staff to meet people's needs. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us further training in safeguarding; MCA/DoLS and first aid were booked for March 2017.

At the previous inspection staff had not received appropriate supervision, support and appraisals. Since that time staff had received an appraisal and since the start of 2017 all staff had received a supervision meeting with their manager. Where there were concerns about a staff member's performance additional supervision had taken place.

People comments about the food were positive including "Meals are wonderful and I couldn't ask for better". People told us there was "Plenty to eat and drink" and that they enjoyed their meals. People had their nutritional needs assessed and were weighed regularly. The catering arrangements at Villa Maria were outsourced. People said they could choose what they had. There was a varied menu and people were offered three meals a day with choices available at each meal. The main meal was served at lunch time and a light meal at tea time. The food looked appetising and people said it was "Nice". People, where able and their visitors were able to make drinks for themselves at kitchenettes around the service and other drinks, such as morning coffee and afternoon tea were also served by staff. Some people had seen a dietician and were prescribed meal supplement drinks, other were on a fortified diet. Some people used beakers to aid their independence when drinking and care plans contained information about cutting food into smaller pieces to help people.

Requires Improvement

Is the service caring?

Our findings

One person told us they were "Very lucky to be living here" and that they had "No worries at all". Staff were kind enough to ensure they went to mass each day, by taking them in the wheelchair. They felt that continuing to observe their religion in this way made them feel safe and secure. They felt staff were very caring and looked after them very well. Another person said, "I'm so happy here and they do everything they can for me".

Since the last inspection there had been six incidents of poor care practice reported by the provider, where staff had not demonstrated a caring attitude and had failed to provide care and support that upheld a person's dignity. The provider had taken action once aware of the incidents and members of staff involved were at the time of the inspection suspended from working, whilst investigations continued.

During the inspection we observed one person eating their lunch in their room. However domestic staff were noisily hoovering in their room whilst they ate by banging the bed frame etc. The staff member made no conversation at all with the person and it was not respectful to do this whilst the person was trying to eat their meal.

One person told us they were "OK most of the time", but had had a lot of trouble with night staff recently and was upset as they felt they were not always believed above staff. The person did say things had been better for a little while. They also said that staff could come "almost instantly" to answer their call bell, but other times it could take a very long time.

Recommendation: The provider should monitor the actions of staff and listen to feedback from people regularly to ensure staff always care in a respectful way.

One care plan we examined contained limited information in relation to end of life care. For example, the care plan only included information about which funeral director to use, who needed to be notified and that the person wished to be interred. There was no information in the care plan about end of life care and how this should be given and what the person's preferences might be, for example, did they wish to stay at Villa Maria rather than be taken to hospital if the situation arose. This is an area we have identified for improvement.

During the inspection we observed how the service had a community feel. People visited one another or went to a person's room to walk down to chapel or afternoon tea in the lounge with them. People were visited by others that were unwell or not able to get out and about and could be given communion so that they were included and their religious wishes were maintained. One staff member told us, "The able help the less able (people)". Another said, "It's like a big family". During the inspection staff talked about people in a caring and meaningful way.

Care plans contained details of people's preferences, such as their preferred name and information about their personal histories. They also contained information about what people could do for themselves to

maintain or encourage their independence. Some people living at Villa Maria were very independent and we saw they often took themselves out for a walk.

Care plans reflected that people should be treated with dignity and their privacy respected. For example, one stated '..on commode … leave and pull door too and give me some privacy' and 'cover me with a towel until ready'.

People had told us previously they were involved in the initial assessments of their care and support needs and planning their initial care. Some people had also involved their relatives. Most people had felt care plans reflected the care and support they received. People either did not require support to help them with decisions about their care and support or were supported by friends and family and no one had needed to access any advocacy services. Details about how to contact an advocate were available within the service.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection there were shortfalls in care plans. Not all care plans were up to date showing people's current needs. Generally care plans varied in detail and required further detail to ensure that people received care and support consistently, according to their wishes and staff promoted people's independence. Some care plans did show people's preferred routine and reflected what they could do for themselves in some areas, but not others so this did not ensure people's independence would be maintained.

At this inspection where care plans had lacked information previously they had been updated and reviewed regularly. Care plans now contained more detailed descriptions about people's preferred routine throughout the day and night. These reflected what the person could do for themselves and what assistance was required from staff in relation to their personal care.

As people's needs had changed some update sheets with key information about the care they needed had been included in their care plan folder. However their actual care plan had not been updated to reflect the changes. This resulted in out of date information in the care plan and staff needing to read all the updates to ascertain the most current information about a person. This is an area that requires improvement, although the risk of people receiving inappropriate care was not high.

We also identified there was limited information within one care plan about end of life care and how this should be given and what the person's preferences might be. This is also an area we have identified for improvement.

Since November 2016 the provider had decided not to take any new admission until safeguarding investigations into alerts had taken place and management had taken action to address shortfalls identified at the previous inspection. Previously people and relatives told us they had been able to come and look round the service before they moved in. In addition their admission had included staff carrying out a pre-admission assessment often during visits to people in their own environment at that time. Information was also obtained from the funding authority or hospital. The care plan was then developed from these assessments, discussions and observations.

People had opportunities to take part in social activities. People were engaged with attending regular church services each day. People's televisions had live links to the services held in the chapel so they could take part remotely if they chose and were able to. One person told us they preferred their own company aside from mass and a cup of tea with others sometimes. There were outside activities and outside entertainers laid on, such as Bingo and people chose whether they wanted to attend. Activities included reading books, word search, quizzes, board games, films, hand care, beetle drive, exercise to DVD, crafts and sing-a-longs. People were not socially isolated, each afternoon people enjoyed coming together in the lounge when they had tea and cake. The current month's activities taking place were displayed on the notice board.

People told us they would speak to the manager if they had a concern or worry. One person told us they had never had a complaint, but felt able to raise anything with staff if needed. There was a clear complaints procedure in place, which was displayed. The manager told us one person had made a complaint since the last inspection about the supply of tissues, which had been recorded and investigated. New arrangements had been put in place to resolve the issue.

People could participate in regular meetings where they had the opportunity to voice their opinions about their care and support and any concerns they may have had. People were asked at meetings about any concerns or changes they wish to make. People also had opportunities to provide feedback about the service provided. People and their relatives were encouraged to complete a quality assurance questionnaire. We saw that previous surveys returned had had positive responses.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager at Villa Maria. Since the last inspection the registered manager had resigned and the previous deputy manager appointed to the post of manager in January 2017. As yet they had not submitted their application to register with the Commission. A person had been offered the deputy manager post following interview and at the time of the inspection the provider was going through their recruitment checks, which meant there was no deputy manager in post. Due to staff shortages the manager was also covering some night shifts and when on duty undertaking medicine administration. This meant the manager was spending time doing tasks which took them away from their management role, but also left staff without any shift leadership and this was apparent during the inspection and when identifying shortfalls during this inspection.

The manager did have support from senior managers from the provider's compliance team who spent a minimum of 30 hours a week at Villa Maria and they had spent time reviewing procedures and processes, but these were not being fully embedded into staffs practice. For example, staff meetings were held and poor practice and procedure discussed, but staff that did not attend had not all read and signed the minutes and the manager told us there was no process in place to highlight this. Communication between staff was poor and there was no allocated shift leader, so staff mentioned things to each other, but these did not go any further. On the handover sheet the rooms were given colours, but there was no information or plan about which room related to which colour and given the agency staff use this was important. Managers gave conflicting information about which processes were currently in place, such as the agency induction programme.

The provider had sent in an action plan following the last inspection, but we found that not all the actions they said they would take had been taken. For example, the Fire Safety Officer had not been contacted about the PEEPS and a traffic light system regarding fire evacuation that was supposed to be put into practice had not been. Following the inspection the provider told us that a decision had been made not to implement the traffic light system.

Records were not easily assessable or could not be found during the inspection. Only a limited amount of past fluid and observation charts in one case could be found and this applied to servicing and maintenance information as well. Staff records in relation to training and current staff working in the service had not been updated. Records made by staff following doctor's visits were not detailed sufficiently to include all areas that had been discussed, such as a person's breathlessness, which had an impact on their health later.

There had been a number of visits and audits by senior management. Records confirmed the last audit had been undertaken in November 2016. These showed that some tasks staff had been asked to complete had not been completed and staff were spoken to. However audits have not identified all of the shortfalls highlighted during this inspection.

The provider had failed to take timely action to ensure that breaches of regulation had been met and the service had improved. This is a continued breach of Regulation 17 of the Health & Social Care Act 2008

(Regulated Activities) Regulations 2014.

A monthly service report was sent from the registered manager to senior management each month in order that they could monitor the service. This detailed people's current care and support needs and any changes or professional input. It also informed senior management about accidents, incidents, safeguarding, care plan and risk assessment reviews, activities that had taken place, where people had been involved in decision making regarding the service, staff sickness, leave, vacancies and agency use, training, supervision and recruitment, compliments and complaints. The provider was a member of the Contractors Health & Safety Scheme (CHAS).

Management demonstrated an open and positive culture within the service, which focussed on people. People and their relatives had completed quality assurance questionnaires to give feedback about the services provided. Responses had been positive. People and relatives indicated they were 'always' or 'mostly' happy with the service they received from the senior team.

There had been a relatives meeting held since the last inspection, where people were advised of the identified shortfalls and how management intended to address these. The manager also met quarterly with the community leaders to discuss any issues or concerns.

Staff felt the manager was approachable and fair. They felt they encouraged staff to speak out with any worries and that the manager usually dealt with these well. Reflective logs were used when staff incidents happened to aid learning and the actual template was being reviewed following suggested improvements by the safeguarding team. Records showed that staff meetings had been held where recent incidents of poor practice, staffing rotas and administration of medicines had all been discussed.

The suppling pharmacist had undertaken an audit of medicines on 12 December 2016. The Environmental Health Officer had visited in 2015 and the service had a 5 star rating (the highest).

The provider had a set of 'core values' and these were displayed around the service. Staff were aware of these as they were asked about the 'core values' at supervision meetings. It was evident the provider strived for all staff to embed these into their practice.

Staff had access to policies and procedures within the service. Some of these were being reviewed following incidents and events at the service.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to follow the principles of the Mental Capacity Act 2005. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to sufficient numbers of suitably competent, skilled and experienced staff to meet requirements. Regulation 18(1)(2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 failed to do all that was reasonably possible to mitigate risks to people's health and safety. Regulation 12(1)(2)(b)

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to take timely action to ensure compliance with the requirements. Regulation 17(1)(2)(a)(b)

The enforcement action we took:

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