M Jalal

Rose Villa Nursing Home

Inspection report

132 Tipton Road
Sedgley
Dudley
West Midlands
DY3 1BY

Tel: 01902219091

Date of inspection visit:
16 June 2016
17 June 2016

Date of publication:
27 July 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 6 October 2015, at which a breach of legal requirements was found. This was because systems and processes were not in place to effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of people living at the home, including the maintenance of accurate records in respect of people living at the home.

We carried out a further focussed inspection of the service on 21 April 2016 to check that the provider had made and sustained the improvements they had told us they would make. At this inspection we found that the provider had failed to make the improvements they told us about. We also identified some other concerns which we raised with the provider on the day.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediately action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to being the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Rose Villa Nursing Home provides accommodation and nursing care for up to 27 older people or people with physical disabilities. At the time of our inspection, 11 people were living at the home.

There was a manager in post, but she had recently been appointed and was not registered with the Care Quality Commission. 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.

Fire risk assessments were not in place to ensure staff were aware of their roles and responsibilities in the event of a fire. The call bell system on the first floor was not fit for purpose and did not enable staff to respond to people's needs in a timely manner.

Not all risks assessments in place for moving and handling involving equipment had been completed in line with the manufacturer's guidelines, leaving people at risk of harm.

People's medical conditions were not always treated appropriately by the use of their medication.

People were not adequately protected from the risk of infection control and requirements of a recent infection prevention action plan had not been met.

People were not supported in a timely manner as staff were required to cook meals as well as care for people. A shortage of nursing staff meant the manager regularly worked on shift to cover staff absences and was unable to drive forward the improvements required in the home.

Staff did not receive an induction and training that provided them with the knowledge and skills they required to safely meet the needs of the people they supported.

People did not receive a choice of meals and the quality of food provided was poor and not nutritious.

Staff gained people's consent before providing them with care and support, but lacked knowledge of legislation protecting people's rights.

People were supported to access healthcare services, but some staff failed to pass on information regarding people's healthcare needs to new staff coming onto shift.

People were supported by staff who were caring and kind, but people's dignity was not always maintained.

People were not involved in the planning of their care or asked how they preferred to be supported or spend their time. There were no activities taking place in the home and no stimulation for people on a daily basis.

There was a system in place to record people's complaints, but there was no information available advising people how to do this and people were not aware of it.

People spoke highly of the manager and felt supported by her, but felt that she lacked support from the provider.

The provider had failed to take responsibility for the day to day running of the home and to offer support to the manager and the staff. The provider had failed to ensure the requirements of the action plan that was in place had been fully met.

We found six breaches 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 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?

Inadequate

The service was not safe.

Fire risk assessments were not in place and there were no emergency plans for staff to follow in the event of a fire.

There were not enough staff to meet the needs of the people living at the home.

People had not received their medication at the right time or in the correct way.

Systems were not in place to ensure adequate infection control measures were in place.

Manual handling risk assessments did not hold the correct information to keep people safe.

Is the service effective?

Inadequate

The service was not effective.

Staff did not benefit from an induction that prepared them for their role.

Staff did not receive training to provide them with the skills to meet peoples' needs effectively.

The quality of the food was poor and not nutritious.

Staff had a limited understanding of Deprivation of Liberty Safeguards [DoLS].

Communication between shifts was inconsistent.

People were supported to access healthcare services.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were supported by staff who were caring and kind.

People were not involved in the planning of the care or asked how they would like their care to be delivered.

People were not always treated with dignity.

Is the service responsive?

Inadequate

The service was not responsive.

People were not involved in the planning of their care and their preferences were not taken note of.

Daily routines were task led and not designed around people's needs and preferences.

There were no activities taking place.

There was a system in place to record people's complaints.

Is the service well-led?

Inadequate

The service was not well led.

The service did not benefit from consistent or effective leadership and the provider failed to support the manager and staff.

The provider failed to invest in the service and take responsibility for the concerns raised.

Audits in place which had identified areas of concern, had not been acted upon.

Rose Villa Nursing 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 was planned to check 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 16 and 17 June 2016 and was unannounced. The inspection was carried out by two inspectors.

Prior to the inspection, we met with representatives from the Local Authority. The Local Authority informed us that there was a suspension on placements at the home. The information they shared with us was used in the planning of the inspection.

We spoke with the manager, six members of care staff and a registered nurse. We spoke with one relative and four people who lived at the home and a representative from the local Clinical Commissioning Group. We also contacted representatives from the local authority and the fire service during the course of the inspection, who arrived on site to conduct their own investigation into the circumstances we had found. Due to concerns bought to our attention regarding infection control, we also opened up this key line of enquiry and spoke with an infection prevention nurse following the inspection.

We carried out a number of observations, including observing manual handling techniques and a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We looked at the care records of six people, eight medication administration records, records of accidents and incidents, health care records, recordings of handovers, and a number of policies and procedures.

Inadequate

Is the service safe?

Our findings

Staff told us they were unaware of emergency procedures and had not received training in fire safety. One member of staff said, "No I haven't been told", and another member of staff said, "I'm not aware of any procedure to follow if there was an emergency". We observed that one of the fire exits in the home was difficult to open. We raised this with the manager, who also had difficulty opening the fire exit. Once open, we saw that the exit away from the building was locked by a padlock and the manager told us she did not have the key. There was no fire risk assessment in place and no instructions for staff to follow in the event of a fire. We looked at other areas relating to the environment of the building in terms of fire safety and came across a number of concerns. We raised our concerns with the manager, she told us, "I'm not sleeping at night for thinking, how am I going to get my residents out if there was a fire". We immediately contacted the Fire Safety Inspection Officer and they arranged to visit the home that day.

For those people whose bedrooms were situated on the first floor, staff were unable to respond to their calls for assistance [via their call bells] in a timely manner. We saw that on the first floor, the call alarm system did not identify which room required assistance. A member of staff told us, "If the alarm goes off upstairs, you can't read which room it is, it's in Chinese, you have to go downstairs and look at the panel to see who's calling". The manager told us she was very concerned regarding the safety of residents and the ability of staff to respond to these calls quickly. She told us, "I raised this with the provider five weeks ago and he said he'd look into it. He told us he'd ordered a replacement but we're still waiting".

At our last focussed inspection on 21 April 2016, a number of safeguarding concerns were raised due to the lack of risk assessments in place for a number of people living at the home. At this, our most recent inspection, we saw that some improvements had been made in this area. Staff spoken with were able to describe to us the risks to the people they supported, on a daily basis. One member of staff told us, "Person's name] has a tendency to walk without their frame so you have to be aware you need to put the frame in front of her". We saw that risk assessments were now in place and were reviewed on a monthly basis.

We saw that some staff, but not all, had recently received training in manual handling and staff told us they were aware what slings to use for each individual. People's care plans and risks assessments did not hold the correct information for staff to follow when supporting people with moving and handling. For example, we saw that one person's risk assessment identified a medium sized sling, but guidance from the manufacturer identified a small sling would be sufficient, based on the person's weight. We observed this person being hoisted and saw that the sling was incorrect, placing them at risk of injury.

We reviewed eight medication administration records [MARS] and found that people did not receive their medicines as prescribed. The provider had not ensured that the necessary safeguards were in place to ensure medication was administered safely and there was insufficient guidance in place for staff on how to prepared and administer medication. For example, we saw that for one person, their antibiotics were being administered with their lunch, instead of an hour prior to eating, thus making them ineffective. For another person, who should receive particular medication when they became agitated or distressed, there was no

information available to staff to indicate when this medication should be administered and what triggers or behaviour to look out for. We found for six separate medications, the amount given and marked on the record did not tally with what was in stock. We were unable to evidence whether or not these medications had been given. We saw that the manager had conducted medication audits and had identified problems, but no action had been taken as a result of the audit. Policies for medicine management required updating and there was no system in place to assess the competencies of the nursing staff.

We observed that the environment appeared clean and there was a domestic cleaner on site six days a week, who worked 9.00 am to 2.00 pm. A member of staff commented, "There is too much work for the domestic, he does his best, if we have a couple of minutes we will do some cleaning". We observed that staff wore protective clothing when supporting people and when working in the kitchen. There were policies and procedures in place relating to infection control but staff were not aware of these and had not received training on this subject. Following our inspection, the infection control team told us they had visited and had a number of concerns regarding infection control issues at the service and had shared their feedback with the manager. For example, they found that one member of staff was not aware of the purpose of a machine that was used to disinfect commodes and had not been using the equipment available to do this.

This is breach of Regulation 12 (1) a, b, c d, e, g, h of the Health and Social Care Act 2008 (Regulated Activities) 2014

Staff spoken with had not received training in safeguarding people, but were aware of the different types of abuse people may be at risk of and told us the manager encouraged them to raise any concerns they may have. We saw that accidents and incidents were recorded but information was not always passed on to the following shift and recording was inconsistent. A member of staff said, "If I saw an accident or incident I would put it in the accident book and inform the nurse". We saw that an incident had taken place which meant a safeguarding report should have been made to the local authority, but staff had failed to do this. This meant that people were at risk due to staffs' lack of understanding and training in respect of their responsibilities to recognise, report and act on abuse.

One person told us, when asked if they felt safe, "Yes and no. My door is permanently open". Another person said, "I've been here a while, I do feel safe" and another person told us, "I am quite comfortable here, I feel safe". A relative spoken with told us they considered their loved one to be safe in the home. A person told us, "Sometimes there's not enough staff". Staff spoken with told us they did not think there were enough staff on duty to keep people safe and support people in a timely manner. One member of staff told us, "I don't think there's enough staff, if there was a cook and someone to do the laundry, then there would be enough staff to do things with people. Majority of residents need hoisting to the toilet and it takes time".

We observed that staff were busy and on a number of occasions we saw people were kept waiting because staff were busy supporting other people or working in the kitchen. We saw that one person was at risk of slipping off their chair and we had to call staff out of the kitchen in order to support the person and prevent them from falling. We discussed staffing levels with the manager. She confirmed that there was no system in place to determine staffing levels in the home. She told us she was having to work shifts to cover a nursing vacancy which left her unable to manage. We saw that despite assurances by the provider, the manager continued to work on shift for long periods and was not given the opportunity to 'manage'. She told us, "[Provider's name] had initially agreed for us to use agency staff after the meeting with the local authority, but when he saw the bill he said, 'no more agency'".

Staff told us that prior to commencing in post the provider obtained references and a valid DBS [Disclosure and Barring Service] to ensure they were safe to work with people. We were unable to verify this information

as we were told staff files were not held on site.

Inadequate

Is the service effective?

Our findings

People were supported by staff who had not received an induction or training that prepared them for their role. Staff told us that their induction consisted of being shown round the building and being told to read policies and procedures. One member of staff told us, "I was told to read the policies and procedures in my own time, but I've never had the opportunity to do it". We saw that there was an Employee Handbook, but staff spoken with did not recognise this and told us they had not been given a copy. We saw that some staff had recently received training in first aid and manual handling. However, we were told the company who provided the training had not received payment and had therefore withheld the certificates and refused to train the remaining staff. We saw there was no training matrix in place and no evidence of staff training taking place.

Staff highlighted to us areas where they or their colleagues lacked training and the risks this posed to them and the people they supported. For example, staff had not received training in fire safety and were unaware of the procedures to follow in the event of an emergency. Staff had not received food hygiene training, but were expected to cook for people living in the home, on a daily basis. A member of staff told us, "I have to work in the kitchen, but I've never done food hygiene training, I know the basics of course, but it's not right". Staff had not received training in infection control, which meant people were at risk of infection, a point which was highlighted in a comment by another member of staff. They told us, "I think staff need more training. There's little things they do, like leave pads on the floor; why can't they put them in the bin straight away? I feel everyone needs to go on training, I don't feel people are listening". Staff were able to tell us about people's care needs but told us they felt they needed more information and training. One member of staff told us, "I need to know more information about [person's name]. I'm not sure if they have dementia or not or what is the right thing to say to them sometimes". Staff told us that they had not received supervision and were therefore not given the opportunity to discuss their performance and learning in a formal setting with the manager, but all commented that the manager was supportive and observed their practice.

This is a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

One person told us, "The food is awful. The person doing the cooking is rubbish, they have not been trained properly. There's no choice". Another person said, "I go out and buy my own [food]" and another person told us they thought they had eaten cauliflower cheese for lunch, when in fact it was fish pie. We saw at mealtimes that people were not offered a choice of main meals. There was no chef and care staff were responsible for cooking meals. One member of staff said, "I didn't come into this job to cook; why haven't we got time to sit with people and talk with people?" The manager told us that recently the provider had agreed to advertise for a cook to be employed at the home.

Staff told us they were unable to follow menu plans as they had to go with what was available in the kitchen. One member of staff told us, "The food is not good. I spoke to the manager about it. I told her, I am going home at night, worried about what I'm going to feed them [people living at the home]. The manager said she'd speak to [provider's name] and I know she did, but nothing changes". Another member of staff said, "I wouldn't eat the food we put in front of people, it's not right". We saw that the kitchen stored tins of 'basic

brand' food and were told the freezer contained similar brand items. A member of staff said, "It's not nutritious, we just go and look at what's in the cupboard and say to each other, what can we cook today?" They told us, "We found some gammon in the freezer today, so we're doing that". We observed that efforts were made by staff to make the lunch look appetising, but everyone was given the same meal and there was no alternative on offer. Staff told us that the only fresh vegetables that were available were potatoes and one member of staff told us, "[Provider's name] complains about us using too many [potatoes]". The manager told us she was not involved in ordering the food and told us the provider arranged for food to be delivered to the home every week. One member of staff told us, "[Person's name] said, 'I would love some strawberries'. I felt awful, why can't they have strawberries, it's not much to ask".

This was a breach of Regulation 14(4)(c) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

A relative told us they had no concerns regarding their loved one's care. They told us, "[Person's name] is much happier now that there are more people here". People who were able to communicate with us, told us they were happy with their care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and re helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can received care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principals of the MCA.

We saw that the manager had made DoLS applications for a number of people. The manager told us, "Some people have dementia and because they can't say they want to leave we are making the assumption they may want to, so we're putting a DoLS in place". Staff had limited understanding regarding this. The manager acknowledged this and told us she wanted to provide additional training to staff in order to improve their understanding. We observed that staff obtained people's consent prior to supporting them and were able to provide us with a number of examples in relation to this, for example, one member of staff told us, "[Person's name] is always trying to get out of the building so you have to know where he is. I'll say to him, 'come back to the lounge, have a cup of tea' and it usually works", but another member of staff said, "I'm not aware of anyone who is deprived of their liberty".

Staff spoken with told us that communication between shifts was usually good. All staff spoken with told us they had been made aware that the needs of one individual in the home had changed [they now required a pureed diet as they were at risk of choking]. We saw that handover sheets were in place and staff told us these worked well. However, we saw that in some instances, communication between different staff and shifts was inconsistent and information was not always shared between staff, resulting in people being left at risk of harm. For example, one member of staff told us, "I came in today after being off shift for a week, I asked the night nurse if there was anything I needed to know and she said 'no'. When I looked back at the handover sheets I found out that one person had passed away whilst I was off and the other now needs a soft diet as they're at risk of choking". Staff told us that it depended on which member of staff handed over to them as to the quality of the handover. This meant that the manager could not be confident that all staff were passing on important information between shifts, which could leave people at risk of harm.

One person told us, "Oh yes, they will call the doctor if I need him, they're very good at that". A member of staff described an incident where they were concerned about a person's eyes. They told us they mentioned

their concerns to the nurse and their GP was called immediately. We saw that a number of people were being monitored for weight loss. Referrals had been made to the dietician and GP and the manager had instructed staff to fortify people's meals to address the issue. The guidance provided by the team had been included in the person's care records and staff spoken with were aware of this. We also saw on people's care files referrals to the GP, dentist, optician and tissue viability nurses and where guidance was given this was noted in people's care records. The information was not always shared resulting in staff not being made aware of the most up to date information regarding people's care needs.

Requires Improvement

Is the service caring?

Our findings

People's dignity and respect was not always maintained whilst receiving care and treatment. One person told us that the bedroom door was always propped open and staff often didn't knock before entering their room. Two members of staff told us that one of the bathroom doors on the ground floor had a tendency to open if not locked on the inside. They told us that this had happened on a number of occasions whilst someone was sitting on the toilet. They also told us they hadn't raised this with the manager or the handyman in order to get the problem addressed.

This is a breach of Regulation 10(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People told us that they were not involved in their care planning and had not been asked how they liked to be supported. One person told us, "They [staff] have never asked my opinion on anything". People told us they were able to choose what time they got up in the morning and when they went to bed, but there were no opportunities for the people living in the home to discuss how they wished to be supported or any other issues they may wish to give their opinion on.

We asked if anyone living in the home preferred to be supported by a female or male carer. A member of staff told us, "[Staff name] will always ask if the ladies are happy for him to support with personal care, and if they say no, then someone else will help".

One person told us, "I don't think the staff are awfully kind", adding, "I have to remind them that they are a bit rough when they are handling me". But other people spoken with talked positively about the staff. One person said, "Oh yes, they [staff] are very good" and another said, "They do listen to me". A relative spoke positively about the staff who supported their loved one. We observed people welcomed staff who sat next to them, holding their hand. At lunchtime, we observed a member of staff supporting one person to eat, and gently stroked their hand and spoke to them at the same time.

We saw that when staff did interact with people, they did so in a caring manner. Due to lack of training, staff could not always find the appropriate words/actions to use when supporting people with a dementia. Staff meant well, but their language to some people could be deemed inappropriate and childish. For people who had difficulty expressing themselves due to their dementia, staff were able to describe to us how they communicated with them, for example, one member of staff told us, "You can usually tell [person's name] is ok, as he smiles, you have to make sure you make eye contact with him and go with his facial expressions".

We observed, as staff walked through the home, people being greeted and acknowledged by staff and being referred to by their preferred names. People were dressed appropriately for the time of year and told us they had chosen their outfit for the day. Staff told us relatives could visit at any time and we saw visitors were welcomed into the home.

We were told that one person living at the home had an advocate visit them on a regular basis. The manager knew how to refer people for this service if required.

Inadequate

Is the service responsive?

Our findings

At our last comprehensive inspection in October 2015, we saw that people had not been asked how they would like to be supported when they first moved into the home and they were not involved in their care plans. At this inspection, we saw that these concerns remained. People were not involved in the pre-assessment of their care or their care plan process. When we asked a member of staff if people were involved in planning their care, they told us, "No, not really". At our focussed inspection in April 2016, we saw that the provider had arranged for a number of people to be admitted to the home without the agreement of the manager. This meant the manager was unable to conduct a pre-assessment of people's needs and at that inspection, we saw a number of people did not have a care plan in place.

At this inspection, we saw that all people living at the home had their care needs noted and staff spoken with were able to describe to us the care needs of some of the people who they supported and in some cases, people's life history. However, one person told us, "I don't think the home is very personable. They don't know my history. They don't know what I need". We saw that the manager had worked hard to put care plans together. The manager told us she picked up information regarding people and their needs and preferences as she went along. She told us, "Everyone has a care plan now, but I need to arrange reviews with relatives and I intend to do this". However, one member of staff told us, "I still need to know more information" and told us she hadn't had the opportunity to read the person's care plan. Another member of staff told us, "I've been told where the care plans are, but I haven't been asked to look at them. I did see one when I first came in and they were a bit rubbish, but I know the manager has been working on them".

This is a breach of Regulation 9(1) (3a) (3b) of the Health and Social Care Act 2008 (Regulated Activities) 2014

We observed that the daily routine of people was not designed around people's preferences, but was task led. One member of staff said, "On a good day we get everyone toileted before lunch".

We saw that one person appear to be slipping off their chair. We asked the person if they were comfortable and they indicated they were not. We mentioned this to staff who then hoisted and repositioned the person on three separate occasions within the period of an hour, in order to ensure they were sat safely and were not at risk of falling. The furniture available in the lounge was not suitable to support the person correctly and we observed the person become distressed during the numerous hoisting procedures. On the third attempt another chair was bought into the room and this appeared more suitable than the other furniture that was available. Once the person was repositioned, they remained in position for the rest of the afternoon and appeared more comfortable.

One person told us, "No, no activities, staff never just come and chat to me". We saw that there were no activities planned in the home and little stimulation taking place for people. One person enjoyed reading their books, other people sat in the lounge and watched the television for most of the day. In the afternoon, a member of staff sat with the people in the lounge and engaged them in a conversation, which people enjoyed. We observed another member of staff ask a person if they wanted to go for a walk. The person's face lit up at this suggestion, only to hear the member of staff say, "Well I can't take you today, I'll take you

when I'm back on shift on Sunday". We saw that the person was disappointed at this. The manager and staff all confirmed that there were no activities at the home. One member of staff said, "We are supposed to do activities with people, but we just don't have the time. I played dominoes with [person's name] once, and he really enjoyed it and so did I".

There was no information on display or available to people on how to raise a complaint if they had any concerns. One person told us, "I wouldn't like to make a complaint, it's such a small home, they'd know it was me". We saw that there was a complaints process in place and a system for logging and recording complaints, but there was no evidence that any complaints or compliments had been received.

People living at the home were not given opportunities to express their views about their care. The manager confirmed that feedback from people living at the home and their relatives was not sought. There were no meetings taking place and no surveys were sent out to gather people's views of the service.

Inadequate

Is the service well-led?

Our findings

At our comprehensive inspection of 6 October 2015, we found that the provider did not have systems and processes in place to effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of people living at the home. The provider had also failed to maintain accurate records in respect of the people living at the home. At our focussed inspection of 21 April 2016 to assess the provider's progress against their action plan, we found that the issues highlighted had not been acted upon and remained the same. At this, our most recent comprehensive inspection, we found that a number of concerns that had originally been raised in October 2015, remained in place.

Leadership at Rose Villa was inconsistent and ineffective. There had been no registered manager since the home opened in February 2015. We saw that there had been a number of managers in post, none of whom had applied to become registered manager. The provider is required by law to have a registered manager in place. We asked the manager if she was considering putting in her application with CQC to become registered manager of the home. She told us, "I was, if I had the support I need it wouldn't be a problem, but I feel I am doing all this on my own. I am a strong person and there's only so much a person can do, I try to remain positive for the staff and try to smile and lift them up, but it's affecting my health". The provider had failed to take action to support and retain managers. The provider was not meeting their conditions of registration.

We saw that the provider had not been open and transparent with the manager when they were appointed and had failed to notify them of the requirements of the action plan that was in place. The action plan had been written by a former manager, but the provider had not taken steps to oversee this or ensure the areas of improvement were complied with. We saw that there was an action plan in place in response to an infection control audit that had taken place in 2015. At a follow up visit in April 2016, it was noted a number of areas had been addressed, however there was still work to do. The provider had failed to provide appropriate support to the manager in order to address these areas of concern.

The provider had failed in their responsibility to offer the support and resources required to run the home safely and effectively. This meant the provider did not consistently promote people's welfare and safety. The manager told us, "[Provider's name] has gone away on business for a week without telling me, I don't even have any petty cash available to purchase anything, should there be an emergency". We asked the manager who she could go to for support and she told us, "I don't know, who is there?" adding, "I'm beside myself, I'm going home and I'm worrying about all the things I haven't done". We were told that first aid and manual handling training had taken place for a number of staff, but that the company providing the training had refused to issue certificates and book any other staff onto training, until the provider paid the bill.

Prior to the inspection, we attended a meeting with the local authority and observed the provider agree to put in place additional staffing in order to support the manager. The manager told us this was not the case and she had worked the last seven days in a row, 12 hours a day. She confirmed that there still wasn't a cook in post and the staff had to take on this role. She told us she needed another nurse and the provider had told her he would put an advertisement in the job centre. The manager told us, "I've told him [the

provider] nurses don't go to the job centre for work but he doesn't listen".

There was an expectation from the provider that the manager would cover shifts as well as manage the home, but the support structures were not in place to enable her to do this and manage her staff group. We saw that the manager was constantly on shift due to a shortage of nursing staff. This meant it was difficult for her to manage the home and provide staff with the support and supervision they required, despite her best efforts. This lack of supervision and support for staff meant that the manager could not be confident that staff were on board with her vision for the service. This ultimately made it difficult for her to drive improvement as some staff were not willing to engage with the manager in this process.

We saw that the manager had introduced care plan and medication audits and protocols had been put in place to instruct staff in the administration of medicines that should be administered as or when required. However, the care plan audits in place had not highlighted the concerns raised during the inspection. Despite medication audits being in place, the manager did not have the time or the support to address the areas of concern that came to light following audits.

Quality was not an integral part of the home. There was no evidence of investment in the home. The findings of the Fire Safety Inspection, the lack of training and support for staff, the issues regarding staffing and the poor quality food available all indicated that the provider did not invest in the home or offer a quality service. The statement of purpose for the home told us, "The home has been established with a quality orientated approach to the business and a high degree of quality awareness is developed through all levels of staff through appropriate training and leadership of management". We found no evidence of this.

The manager confirmed to us that there was no analysis of accidents and incidents, no quality monitoring of the service and no attempt to obtain feedback on the care provided to the people living at the home. She told us, "I haven't had chance to look at that yet".

This is a breach of Regulation 17(1) (2) (a) (b) (c) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us, "Everything is a challenge – getting support from [provider's name] is a challenge". Staff told us they were stressed and concerned for the wellbeing of the people they supported and their manager. They told us they had raised their concerns with the provider, but felt their concerns were dismissed and not taken seriously. One member of staff told us, "I'm not the only one who has complained [to the provider], some shifts are really difficult, but nothing changes".

Staff spoke highly of the manager and we saw that she was supportive to staff and people who lived at the home. One member of staff said, "I love [manager's name] she is very supportive, she is brilliant, fantastic, so approachable, probably the best manager I have ever had". Staff told us they were concerned about the lack of support the manager received. One member of staff told us, "She [the manager] gets support from us, but not from the provider". Another member of staff said, "[Manager's name] is the home". All staff spoken with said they feared what would happen to the home and the people living there if the manager left. One member of staff said, "It's better when [manager's name] is here. But she works too many hours. When I walk in and know she's here, I feel better"

We saw that staff supervision was not taking place, although staff did confirm that they had had their practice observed by the new manager. Staff told us that a staff meeting had recently taken place, but a number of staff had failed to attend the second meeting arranged by the manager. The manager told us she was frustrated that some staff had failed to attend the meeting, despite arrangements being made to

accommodate both day and night staff. She told us, "I have some very good staff, some staff are bothered, but not all are".

A member of staff told us, "The morale between day staff is brilliant, we are team workers but it feels more divided between night staff and day staff". Another member of staff said, "Morale is not good, it all depends on who you are working with. When you find out who you are working with that day, you will know if it will be a good or bad day. It has an impact on the people living here. Residents shouldn't have to worry about you, but they do".

We saw that the provider had on display their ratings poster from their previous inspection, which they are required to do so by law.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People were not involved in the planning of their care and assessment of their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	Provider failed to ensure people were consistently treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Provider failed to do all that is practical to mitigate risks to people in terms of fire safety, management of medicines, manual handling techniques, infection control, staff skills and competencies

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	People did not receive a diet that was nutritious.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Treatment of disease, disorder or injury	Systems and processes not in place to effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of people living at the home, to maintain accurate records in respect of people living at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Provider failed to ensure staff received an induction and training that prepared them for their role.