Rose Villa Care Limited

Rose Villa

Inspection report

138 Brook Lane
Sarisbury Green
Southampton
Hampshire
SO31 7EW

Tel: 01489885323
Website: www.rosevillacare.co.uk

Date of inspection visit:
25 January 2023
01 February 2023

Date of publication:
29 March 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Rose Villa is a residential care home providing personal care to up to 20 people. The service provides support to older people, some of whom are living with dementia. At the time of our inspection there were 16 people using the service. Accommodation is a mix of single and shared rooms in a converted and extended premises.

People's experience of using this service and what we found
We had concerns about the providers understanding of the Mental Capacity Act 2005 and records associated with this.

We were not assured that the provider had clear oversight of the service or that CQC had been notified of all significant events in the service including safeguarding concerns. Audits had not identified the shortfalls we found at inspection. Records had not always been accurately completed.

People were cared for by staff trained to identify signs and symptoms of abuse however we were not assured the provider had taken steps to alert the safeguarding authority of all concerns. Some risks to people had not been fully addressed however environmental risks and the premises had been well managed. Staff were safely recruited and there were sufficient staff deployed to meet people's needs. Medicines were mostly safely managed; however we were concerned that tablets were being counted in a busy area of the service and spoke with the registered manager about this.

The premises were very clean and a programme of further refurbishment would improve this. The premises were being updated to enable easier cleaning of flooring and to redecorate We were assured that current guidance in infection control and visiting care homes was being followed. Some areas of the premises were dimly lit which was not ideal for people living with dementia.

Some assessments needed additional details about how to support people should they be in crisis, but most care plans were informative of people's needs. Staff received training when they commenced at Rose Villa and updates as needed. There was a focus on supporting staff to achieve qualifications to enable their progression.

A nurse practitioner completed a weekly ward round and addressed any health concerns for people. There were some difficulties in obtaining input from some healthcare professionals.

The service was mostly well-led and the registered manager was working to achieve a more professional approach to service provision. There was a clear management structure and clarity about roles within the service.

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

Rating at last inspection
The last rating for this service was good published 27 January 2020.

Why we inspected
The inspection was prompted in part due to concerns received about medicines, staff conduct, training, awareness of heath conditions and the conduct of the nominated individual. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe, effective and well-led only

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this report. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to notification of significant events in the service, consent, governance and safeguarding. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Rose Villa

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of 3 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. A second Expert by Experience contacted relatives of people using the service by phone to obtain their feedback.

Service and service type
Rose Villa is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Rose Villa is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with the registered manager, the office manager and the head of care as well as senior care assistants, care assistants and the cook. We spoke with 10 people living at Rose Villa and 1 visiting relative. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We used the 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 with us.

We looked at 6 care records, multiple medicines records and documents relating to the management of the service.

Following the inspection, an Expert by Experience spoke with 8 relatives to get their feedback about the service.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. The rating for this key question has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse
• We were concerned some potential safeguarding incidents had not been alerted to the local authority. We found a person had disclosed they believed they had been abused to staff; however, the registered manager had not realised this should be reported. Additional concerns about safeguarding can be found in the well-led section of this report.

This was a breach of Regulation 13 of the Health and Social Care Act 2007 (Regulated Activities) Regulations 2014.

• Staff had received training in safeguarding and understood how to identify and respond to allegations of abuse.
• Staff had a clear understanding of safeguarding and told us, "[I've] completed training and am vigilant in looking out for any possible abuse. I would report to the registered manager and use the whistle-blowing procedures if needed." A second staff member said, "Safeguarding is looking out for residents' welfare, working in a person-centred way and treating people with dignity. I would report any abuse to the [registered] manager and can report to the safeguarding team."
• People and their relatives felt safe at Rose Villa. One person told us, "I suppose I do feel safe, I've never given it much thought." A relative answered when asked of their family member was safe, "Yes, safe, very safe."

Assessing risk, safety monitoring and management
• Some risks associated with people and their needs had been assessed and to an extent mitigated. However, we were not assured that all risks associated with people had been fully assessed and managed. For example, one person had repeatedly made comments that could impact on their personal safety. This was mentioned in a brief pen picture of the person on the front page of their electronic care record. This information was not found in risk assessments or care plans within their care record. The registered manager advised us this was historic and there had been no recent incidents. We found incidents over the last year including 2 just 3 months before our inspection.
• The premises were well maintained and all relevant servicing and safety checks were undertaken as per requirement. Environmental risk assessments had been completed along with assessments concerning fore and water safety risks for example.

Staffing and recruitment
• Staff were safely recruited and all required pre-employment checks had been completed including

obtaining references, obtaining a full employment history and completing a Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• There were sufficient staff deployed to meet people's needs. We saw staff able to spend quality time with people as well as attending to their basic care needs.
• Relatives were assured people were supported in a timely way. A relative told us, "When he calls the bell they are always there." A second relative told us, "They are so good, they have a pad on the floor." The provider had positioned a pressure mat by the person to sound should they get up from their chair. This was to alert staff they needed support.
• If there were not sufficient staff on duty due to late sickness for example, the head of care and registered manager would support with care tasks to ensure people were safe and happy.

Using medicines safely
• Medicines were stored in a locked storeroom and a trolley that was securely fixed to a wall. Both storage areas were clean and we saw containers clearly labelled with names where boxed medicines were stored.
• Controlled medicines were stored in a separate, secure cabinet. Controlled medicines are subject to high levels of regulation as a result of government decisions about those medicines that are especially addictive and harmful.
• We saw staff administering medicines. They carefully checked they had the right medicine for the right person and dispensed them into medicine pots before offering them to the person.
• Once records of administering the medicines had been completed, staff had to undertake a count of the remaining medicines. The staff member emptied all the tablets from a bottle onto the medicines administration records (MAR) file and counted them. They did not wear gloves and counted the medicines on a surface that had not been cleaned.
• We spoke with the registered manager about counting medicines in a busy room in the service and how this had been approached. They agreed to take steps to improve this practice.

Preventing and controlling infection
• The premises were clean with no malodours. There was a programme of refurbishment that included decoration and replacing flooring. Carpets were being replaced with easier to maintain washable cushion flooring improving hygiene.
• We noted a staff member with long, polished fingernails. We spoke with the registered manager and they advised the staff member had been asked to remove the polish and cut the length of the nails in line with good practice.

• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was supporting people living at the service to minimise the spread of infection.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was responding effectively to risks and signs of infection.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
• A visiting 'pod' was still available in the garden for people to use. It was a summer house with heating and

easy to clean furnishings and could be used should anyone want to. Visits also took place in the home; we saw guests in the dining areas with their family members.
• There was limited space in the service for visits so the provider continued to limit visits to three at a time. This ensured some privacy for people, for social distancing to be maintained and to keep numbers in the service manageable. The restriction of 3 visitors was removed during warmer months as the garden could accommodate several visitors.
• We were assured visitors could access the service frequently and safely.

Learning lessons when things go wrong
• The registered manager reviewed accidents, incidents and near misses records and looked for patterns such as falls at the same time each day or in the same place. Learning from this analysis was shared with the staff team.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection it has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

• We were not assured the provider had a full understanding of the MCA, how to assess capacity and when to use best interest decisions.
• One person had a range of MCA assessments for different decisions about their care provision, all of which stated the person lacked capacity. However, none of the accompanying best interest decisions actually stated a specific decision to be made. One read, 'Do you like to be checked on by the staff at night-time? Is there anything the staff can do for you at night-time to help you sleep?' The decision may have been consenting to night checks or administering medicines to aid sleep but this had not been recorded how the decision had been made in this person's best interest.
• A second person had a generalised non-decision specific statement they lacked capacity which the registered manager removed when we raised this with them. The same person also had the statement 'staff may need to act in my best interests' in 2 of their care plans. We were concerned how this could be interpreted as care records described situations when the person was physically guided by staff from where they wanted to be. There were no plans in place for restriction, restraint or physical interventions.
• The same person had emotional support chart entries on 2 occasions commenting on their distress due to the person they shared a room with, once referring to them as a baby, repeatedly telling them to shut up

and once referring to them as a child, wanting people to be considerate of their needs too. There was no MCA assessment of capacity or best interest decision to consider whether sharing a room was the best option for them.
• Another person had been assessed as needing pureed meals by SaLT however they had refused to eat these and the registered manager had agreed to try minced and moist texture instead. This decision was made on behalf of the person however had no MCA assessment of capacity and no best interest decision.

This is a breach of Regulation 11 of the Health and Social Care Act 2007 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• Meals looked and smelled appetising and people clearly enjoyed them. People were given a choice of meal and dessert just before lunchtime and these were served according to people's nutritional needs.
• Advice was sought from speech and language therapy, SaLT when people were struggling to eat meals of a normal texture.
• There was sufficient seating at dining tables in the conservatory for everyone however only 6 people ate at the tables provided, they had been offered a choice of where to sit prior to their meal. People remained in the lounge for lunch and it was served on tables by their chairs. For some people this was manageable as they had adjustable height 'over bed' tables that could be moved in close to their chairs. For other people, they moved their plates to their laps and ate from there, as their tables were folding 'snack' tables that were not the right height, were not adjustable and could not be moved close enough to eat from. One person's meal looked as though it were about to fall from their lap.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The provider had a digital care system used to assess and create care plans and to record care that had taken place. The registered manager had sought an alternative provider of the software as they were not happy with the current product.
• People's needs had been assessed in several different areas including personal care, continence, communication and mobility. We found some plans needed additional details as to how staff should support people at times of crisis. For example, for a person who was hitting out at staff or spitting, 2 staff should sit them down, there were no specific instructions how this should be done.
• The registered manager had experienced some difficulty with obtaining input from some health professionals and was actively trying to ensure people received the necessary support.
• Most people had care plans that gave accurate and straightforward information to inform care staff how they preferred to receive their care.

Staff support: induction, training, skills and experience
• On commencing in post, staff completed an induction and staff new to caring roles completed the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
• There was a wide range of training courses available to staff including equality and diversity, dysphagia and swallowing, COSHH and positive behaviour support. In addition, there was training available in conditions such as dementia and Parkinson's that people may be living with. Staff had also been able to complete an experience and training session on the 'dementia bus'. This is an immersive way of enabling people to understand who someone living with dementia experiences day to day things.
• Staff were encouraged to complete qualification training to enable them to progress within a care setting. Of the 30 staff employed, 25 had NVQ or equivalent at level 2 or above.
• The registered manager held train the trainer qualifications in first aid and moving and handling and also

sought training from external providers including dementia experiences and training for dementia and dignity champions.
• Staff participated in regular supervision or 1 to 1 session with their line managers. In addition, spot checks were completed by the registered manager both during the day and at night.

Adapting service, design, decoration to meet people's needs
• The premises had been converted from a family home and as such had quite narrow hallways and stairs. A lift provided access to the first floor of the home.
• There were signs available to direct people to toilets however these were not dementia friendly and could be improved. Some of the corridors and the stairs were quite dimly lit which may be disconcerting for people living with dementia.
•The provider was in the process of updating the premises, replacing carpet with washable flooring and redecorating.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• There was a regular 'ward round' from the GP surgery. Since the start of the COVID-19 pandemic there had not been a GP visit to the service but there was an allocated nurse practitioner who could prescribe medicines should they need to.
• The registered manager described some issues when seeking input from some healthcare professionals. They had tried to re-refer a person to SaLT which was rejected. They had also tried to get input from the older persons mental health team, (OPMHT). This had been unsuccessful however we found evidence this was to be completed by the GP which the registered manager followed up on.
• The provider had introduced RESTORE2, a physical deterioration and escalation tool to their service. This enabled staff to provide a record of observations, including a base level, to health professionals when concerned the person may be unwell.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

• Providers are required to notify CQC of significant events that happen in their services. This includes telling us when they make referrals to safeguarding teams. We found a safeguarding incident when a person had attempted to harm themselves and to engage peers in helping them harm themselves had been referred to the safeguarding team but not notified to CQC.

• We also found references to 2 safeguarding referrals made to the older persons mental health team that had not been notified in the notes of a deterioration and escalation tool.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

• There was a clear structure in the management team since the new registered manager was appointed. Previously there had been 3 registered managers now there was 1 with a separate management position dealing solely with accounts and administration of the service. There was clarity about responsibility within the service.

• We found some records needed to be improved. For example, some risks to people had not been reflected in assessments or care plans so we could not be assured that all staff were aware. The registered manager told us some records may also have been completed in error. For example, for a person who should have either pureed or minced and moist foods, their records reflected they had biscuits and eggs and toast prepared to a 'regular' texture.

• There were numerous audits regularly competed that were in depth and provided the registered manager with oversight of the service. However, some areas such as checking whether appropriate mental capacity assessments had been completed, or that referrals made had been responded to, were not audited. We found some shortfalls in these areas that needed to be improved.

• Governance systems had not identified the shortfalls we found in safeguarding and risk management. There was no oversight from the provider.

This is a breach of Regulation 17 of the Health and Social Care Act 2007 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• People enjoyed spending time with the nominated individual, they took time to speak with people and

play cards or watch football matches with them which people appreciated. Relatives also spoke positively about the nominated individual.
• Relatives told us they were happy with how the service supported their family members. They received care as they needed it, how they wanted to receive it and appeared happy.
• Staff members had been enabled to develop skills by taking on roles such as being champions in infection prevention and control, MCA or dementia.
• The registered manager had an open-door policy so staff could access them should they need to.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The registered manager understood the duty of candour and was aware when they should apply it should something go wrong.
• Throughout our inspection, the registered manager was open with us and shared information about the service. They listened to feedback, implementing changes as needed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
• Relatives we spoke with had received quality assurance questionnaires from the provider seeking feedback about the service. We saw the returned questionnaires and without exception they all reported positive results.
• Relatives also know how they could make a complaint however had not had reason to do so. If they had any concerns or needed information, they would approach senior care staff or the registered manager and were confident they would get the response they needed.
• Staff members told us they were confident in approaching the registered manager for support or to make suggestions about the service.
• The registered manager had completed train the trainer courses so they could support staff in training at the service and provide refreshers as needed.

Working in partnership with others
• The provider worked in partnership with local health and social care professionals who were involved in supporting people using their service.
• The provider engaged with staff and relatives to obtain feedback in order to inform future developments in 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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of all significant events.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent We were not assured that the provider had a clear understanding of the MCA, when to assess capacity and how and when to make best interest decisions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Some safeguarding incidents had not been alerted to the local authority safeguarding team.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits had not identified shortfalls in the service. Records were not always accurately completed.