CareQuality Commission

Rose Villa Care Home Limited

Rose Villa Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 12 February 2018 and was unannounced. At the last inspection in January 2017, the provider was in breach of three regulations of the Health and Social Care Act 2014. These related to risk management in safe, consent in effective, and governance in well-led. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when, to improve the key questions of safe, effective and well-led to at least good. We checked to see that the action plan had been completed and found improvements had been made in all three areas. The provider was now compliant with the three breaches of regulations.

Rose Villa is registered to provide care for 36 people who need nursing care and who may be living with dementia. Fifteen of the 36 placements are allocated as an interim care service for those people who may need support to prevent hospital admission or rehabilitation following discharge from hospital. The building is two large Victorian houses and has three floors serviced by a passenger lift. There are bedrooms for single and shared occupancy on each floor, and a large communal space divided into two lounges and a dining space on the ground floor.

Rose Villa is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a registered manager in post. 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.

Governance of the service had improved. The quality assurance system consisted of audits, checks, observation of staff practice, meetings and surveys. The audits were completed on a range of topics and shortfalls identified from them and from the meetings and surveys were addressed in action plans. The provider's representative completed visits and spot checks of the service; they spoke to people and completed a check of the environment. This helped to ensure the provider had oversight of the service.

We saw risk management had improved. A range of risk assessments were completed and these were checked more frequently and kept up to date. A new heating system had been installed which had removed the risk of cold bedrooms and the need for electric heaters.

We found the registered manager and staff had a much improved understanding of mental capacity legislation and the need for consent. People had assessments of capacity and best interest decisions made on their behalf if they lacked capacity; documentation regarding best interest decisions had improved. Appropriate applications had been made to the local authority when people's liberty was deprived due to their lack of capacity and need for continual supervision.

At the last inspection, we made a recommendation about ensuring care plans were more person-centred and monitoring charts were accurate. Whilst this had improved in several of the care plans we assessed, there remained some shortfalls and we have made a recommendation that these improvements continue.

Staff knew how to safeguard people from the risk of abuse and harm. They had completed safeguarding training and had policies and procedures to guide them. They were clear about the alerting procedures to the local safeguarding team.

Staff were recruited safely and in sufficient numbers to meet people's needs. A health professional told us some people had mentioned they had various waiting times when they used the call bell. This was discussed with the registered manager to address.

People told us staff were kind and caring and respected their privacy and dignity. People could remain at Rose Villa Nursing Home for end of life care. The service had recently become part of a project to improve end of life care for people, which included additional training for the registered manager, nurses and care staff.

People's health and nutritional needs were met. We saw people had access to a range of community health care professionals and contact was made by staff in a timely way. People liked the meals provided and there were choices and alternatives on the menus. Staff provided support to people at mealtimes in a patient and sensitive way.

People's medicines were managed in a safe way and they received them as prescribed.

Activities provided for people had improved since the last inspection with the addition of two activity coordinators. There was a range of activities which people saw as meaningful and helped to provide social stimulation.

Staff had access to a range of training, supervision, appraisal and support. This helped them to feel confident when providing support to people. Staff said they could approach the registered manager and nurses if they had concerns about people's needs.

There was a complaints procedure and people felt able to raise concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The management of risk had improved and assessments had been carried out to ensure any areas that posed a risk to people could be minimised.

Staff knew how to safeguard people from the risk of abuse and harm. They had completed training and had procedures to guide them.

Medication as was managed safely and people received their medicines as prescribed.

Staff were recruited safely and were employed in sufficient numbers to meet people's needs.

The service was clean and tidy and staff knew how to prevent the spread of infection.

Is the service effective?

Good

The service was effective.

There had been improvements in staff's understanding and implementation of mental capacity legislation. When people lacked capacity to consent to care, best interest decisions were made in consultation with relevant people.

People's health and nutritional needs were met. They had access to a range of health professionals when required. Menus provided choices and alternatives and people told us they liked the meals.

Staff had access to training, supervision and appraisal to help them feel confident when supporting people.

Is the service caring?

Good

The service was caring.

People told us the staff approach was kind and caring. We

observed this in practice and also saw staff maintained people's privacy and dignity.

People were provided with information about the service available to them and staff gave explanations about care tasks prior to carrying them out.

Staff maintained confidentiality and personal records were stored securely.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There have been improvements in care plans, and summaries of people's care needs contained more information. However, some information was missing in two of the care plans we looked at and the recording of monitoring charts was inconsistent.

The provision of activities had improved and was much more structured. People told us there was sufficient activities and meaningful occupation for them.

There was a complaints procedure and people who used the service felt able to raise concerns. Staff knew how to manage complaints.

Is the service well-led?

Good

The service was well-led.

The quality monitoring system had improved with audits and checks identifying areas to be addressed. Any shortfalls were included in action plans. There were meetings and surveys as part of quality monitoring.

The registered manager encouraged an open culture where people felt able to express their views.

The registered manager had developed good relationships with other professionals who supported people who used the service.

Care Quality Commission

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 12 February 2018 and was unannounced. The team consisted of two adult social care 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. The expert-by-experience had expertise in caring for an older relative who lived with dementia.

The provider had completed a Provider Information Return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We checked the PIR and also our systems for any notifications that had been sent in as these would tell us how the provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection, we spoke with local authority safeguarding, contracts and commissioning teams, and also health commissioners about their views of the service.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at lunchtime. We spoke with seven people who used the service and three people who were visiting their relatives. We spoke with the registered manager, two nurses, a nurse assistant, two care workers, an activity coordinator and a cook. We received information from two health care professional following the inspection.

We looked at five care files which belonged to people who used the service. We also looked at other important documentation relating to them such as medication administration records (MARs) for 11 people and monitoring charts for food, fluid, weights and pressure relief. We looked at how the service used the Mental Capacity Act 2005. This was to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included four staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the environment.

Good

Is the service safe?

Our findings

At the last inspection in January 2017, we had concerns about the management of risk, which had not always been identified and steps put in place to minimise it. At this inspection we found improvements had been made. A new heating system had been installed and bedrooms were much warmer for people; there was a reduced need for people to have their own portable heating appliances. There were plans to ensure bedroom doors on the upper floor had door guards so they could remain open for ease of access for people who used walking aids. This will reduce the need for people to prop doors open with items. We have asked the registered manager to inform us when this has been completed.

People had assessments of risk completed for areas such as nutrition, fragile skin, self-medication, constipation, moving and handling, falls and the use of bedrails. The risk assessments were evaluated and updated when required. Each person also had a plan which provided information and guidance to staff and other professionals on the mode of their evacuation from the building in emergencies. These personal emergency evacuation plans (PEEPs), described how much support and any equipment the person required.

Staff had received training in how to safeguard people from the risk of abuse and harm. There were also policies and procedures to guide them should they have any concerns. In discussions, staff were clear about the different types of abuse and what to do if they witnessed abuse or poor practice. The registered manager had contacted the local safeguarding team for advice, discussed issues with them and made safeguarding referrals when required.

People told us they felt safe in the service. Comments included, "I like having people around; my belongings are safe", "There's carers around", "We're well-looked after" and "The girls do everything, I feel safe in bed too." A relative said, "I think they are very well cared for; the staff are lovely. She is very safe here."

Comments from health professionals included, "Safe care delivery."

We found medicines were managed well. Medicines, including controlled drugs, were stored safely and appropriately at the correct temperature. They were administered to people as prescribed. When we checked the medication administration records (MARs) we saw there were no gaps in administration and medicines were recorded when received into the service. There were systems in place for checking and ordering stock, so people did not run out of medicines, and for the safe disposal of them. We saw protocols were in place for the majority of medicines prescribed on an 'as and when basis'; these gave staff clear guidance when making judgements about the need for administration. However, we did find some missing protocols and the registered manager told us they would check the records and ensure all were in place.

People who used the service told us they had no concerns about their medicines and they were able to access pain relief when required. Some people who used the intermediate care service were supported to manage their own medicines in readiness for their discharge home. We observed the nurses administer medicines to people and this was completed in a safe, calm and unhurried way.

There were sufficient staff employed to meet people's needs although one person told us there had at times been a delay when they pressed the call button; they appreciated staff could be busy and came as soon as possible. Other people said staff responded promptly within five minutes. Visitors told us there were always staff around and they had no difficulties in finding one when required. Staff rotas indicated a range of staff with differing skill mix were on duty day and night. There were ancillary staff for catering, activities, domestic and maintenance tasks which enabled nurses and care staff to focus on treatment and care tasks. In discussions, staff were confident they could meet people's needs and told us the staffing levels were good. They confirmed when people were allocated a 'one to one' support, this was provided. A health professional told us staff could be hard to find at times and some people admitted to the intermediate care service had reported longer than expected waiting times when they called for assistance. This was mentioned to the registered manager to address.

We found staff were recruited safely. There were robust procedures in place to ensure employment checks were carried out prior to staff starting work. These included application forms to assess gaps in employment history, references and a Disclosure and Barring Service (DBS) check. The latter involved a search for any criminal record and helped the provider make safer recruitment decisions.

The service was clean and safe. Domestic staff adhered to cleaning schedules and all staff had completed training in infection prevention and control. Staff had access to personal protective equipment such as gloves, aprons, hand gel, liquid soap and paper towels. Those people who used the service, and visitors who were spoken with, all told us bedrooms and communal areas were clean and hygienic.

The provider had a business continuity plan which described the actions to take in emergency situations and where, in the first instance, people would be evacuated to. There were emergency telephone numbers for electricians and plumbers and the location of items such as water valves, electricity fuse boxes and torches. Equipment used in the service, such as hoists, the lift, bedrails, fire-fighting items, gas and electrical appliances and the nurse call system was checked and maintained. Hot water outlets were monitored to ensure the correct temperature to prevent scalding incidents and stored water was checked to ensure there was no bacteria.

Good

Is the service effective?

Our findings

At the last inspection in January 2017, we had concerns that staff did not have a clear understanding of the implications of the Mental Capacity Act 2005 (MCA) and the need to record assessments of capacity and best interest decision-making. We found improvements had been made in this area.

The 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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the registered manager had made nine applications to the local authority for DoLS, four of which were authorised and the remainder were awaiting assessment. This showed us the registered manager was more aware of the criteria for DoLS and had acted appropriately.

Since the last inspection, most care staff, the registered manager and one nurse had completed MCA/DoLS training. There were still some staff to complete/update their training and the registered manager was monitoring this. In discussions, staff had a good understanding of the need to obtain consent prior to care tasks. Comments included, "There are no restraints, only if someone was in danger" and "We ask people and explain what we are going to do." There had been a multidisciplinary meeting for one person who used the service to discuss consent issues and develop a plan to safeguard them when they became unwell. Staff confirmed the care plan for the person had information to guide them; they described how they supported the person and the action they took when they declined important care.

People who used the service told us staff asked for their consent to cares and confirmed they were able to make their own decisions. Comments included, "I press the call bell at bed time and they assist me to bed. I have meals in own room but sometimes I go downstairs", "I ask staff and they get me up", "I make my own choices; nobody tells me. I get to go out with family" and "I choose; I can stay in bed if I like and choose where I sit." Relatives said, "They are their choices; they can eat where they want" and "As far as I know they get asked."

Records showed people had access to range of community health care professionals when required such as GPs, specialist nurses, emergency care practitioners, dieticians, speech and language therapists, chiropodists and opticians. Staff or people's relative supported them to attend hospital appointments. Staff were able to describe how they prevented pressure ulcers from forming and what action to take should they suspect a person's health was deteriorating. A health professional told us, "They seem very keen to do everything to improve diabetes control; if there are any problems, they are keen to contact me for advice."

Those people in receipt of intermediate care services had input from physiotherapists, occupational

therapists, pharmacists and nurses. They completed assessments and devised plans of care which the staff at Rose Villa helped to carry out with people. The intermediate care service was designed to rehabilitate people to their previous or optimum level of ability. Prior to discharge, people would have a home visit to see how they would manage and to check if any equipment was required.

People confirmed their access to health services and said, "The chiropodist and optician visit regularly", "I've seen a few doctors. I'm here on respite and I've seen a physio; I have a plan in place", "I've seen a doctor and have been back and forwards to hospital for appointments" and "The nurses pop in and see me." Relatives said, "They saw a GP recently about a bad cough and is seeing a physio; they keep in touch with me" and "They would call one [GP] if they needed to; we have taken them to their own doctor."

People's nutritional needs were identified on admission and they were weighed in line with risk assessments, either weekly or monthly. We saw care plans provided staff with the level of support people needed and the type and texture of food and fluids. People's nutritional needs were met and there were positive comments about the meals provided. Comments included, "The food is lovely. Shepherd's pie is my favourite and I get a choice", "Brilliant food, I've no complaints; it's all lovely and there are choices", "The food is good; they know my likes", "The Yorkshire pudding and beef is lovely" and "Fantastic food; there's enough and they know what I like. I don't like fried fish so they do me smoked or poached fish on Fridays." Visitors confirmed their relatives were happy with meals and said, "They like most food; they are a vegetarian and they choose what they want", "They eat a lot better here than at home" and "They like the food here and are eating very well."

We observed the lunchtime experience was calm and unhurried. Staff delivered meals covered and on trays to people who chose to remain in the lounge area; others ate their meals at the dining tables. Staff were supportive at meal times; they sat next to people and assisted them to eat in a patient and encouraging way. People were offered an alternative when they declined to eat the main meal and we saw differing portion sizes were provided to them. The food looked well-presented and appetising. The cook visited people during lunch and asked them if everything was alright. The cook received information from care staff about people's dietary needs and preferences and had a board in the kitchen as reminders for catering staff.

The training records showed staff had access to a range of training considered to be essential by the provider. This included, safeguarding, moving and handling, health and safety, infection control, fire safety, MCA/DoLS and equality and diversity. Seventeen out of 26 care staff had gained a National Vocational Qualification, or equivalent, in care. Qualified nurses had support with revalidation of their practice for registration and there were additional clinical training courses such as medication management and the use of syringe drivers. The records indicated some gaps in training but these had been identified and planned for in 2018. The registered manager told us they were sourcing training in wound care, catheterisation, end of life and diabetes management for nurses.

People who used the service told us staff knew how to look after them. Comments included, "I have a hoist; there are no problems and always two carers."

Staff told us they felt supported by senior staff and confirmed they had received supervision and appraisal. The registered manager told us they or the qualified nurses were available to provide support to care staff on a daily basis and in 2018 they wanted to increase the amount of formal supervision sessions for each member of staff.

There had been some attempt to make the environment more dementia-friendly with signage on toilet and bathroom doors, notice boards to inform people, for example of the days menu and bedrooms were

personalised. There were grab rails in toilets, bathrooms and corridors and a range of moving and lifting equipment to assist people with mobility difficulties.

Good

Is the service caring?

Our findings

People who used the service told us they liked living there, the staff were kind and caring, and they respected their privacy and dignity. Comments included, "It is brilliant; the staff are nice. They have time and often come up and have a word", "As far as care homes go, it is one of the best; I get looked after", "It's very pleasant; the staff are all very nice, kind, caring and helpful but usually busy", "It's good; the staff are brilliant and I have a good laugh with them. If you want something they are soon with you; the girl did my nails this morning", "It's good; I get on well with them [staff] and they let me know what is going on" and "All the girls look after me; there's a lot of nice people here. I wouldn't be anywhere else."

Relatives were also complimentary about the staff. They said, "Excellent; no problems at all re the staff. They help them as much as possible to be independent", "Friendly, warm and lovely staff; they are encouraging them to be independent" and "They are very well cared for; the staff are lovely. They are very, very caring; all have been splendid."

Comments from health professionals included, "Staff are friendly and approachable and we have observed good practice regarding privacy and dignity."

We observed staff provide support in a positive way throughout the day; they were friendly and approachable when people asked them to fetch things from their bedroom or they requested a cup of tea. They were attentive and checked people had everything they needed, they responded to call bells in a short time, they reassured people and comforted them when they were anxious. We observed staff chatted to people during tasks such as supporting them to transfer from a wheelchair to a comfy chair and they checked people had eaten sufficient food before taking plates away at lunch. Staff all reported they were busy and would like to have more time with people but said they did their best to sit and chat whenever possible.

People who used the service were appropriately dressed in clean clothes and footwear. Staff had paid attention to brushing people's hair, ensuring they had their dentures in and were wearing glasses when required. Some people were offered clothes protectors at mealtimes. There was a hairdressing salon on the first floor.

Staff knocked on people's bedroom doors before entering and in discussions they were clear about how they promoted privacy and dignity. One member of staff said, "We make sure we keep people covered up, close curtains and doors and talk to people about what we are doing; give them time and explain things." We observed people in shared bedrooms had privacy curtains and there were locks to toilet and bathroom doors.

Care staff had all completed equality and diversity training. In discussions, staff described how people had different needs and gave examples of one person requiring vegetarian meals and another who had visits from clergy. Staff spoke sensitively about ensuring people were not discriminated against because of specific issues such as age, gender, sexual orientation or other protected characteristics.

People were provided with information on notice boards throughout the service. These included the day's menu, how to make a complaint, newsletters, activities and minutes of meetings. The newsletter included activities, fundraising and outings. There was a service user guide which explained what would be provided to people and what would incur an additional cost such as hairdressing and chiropody.

We saw staff maintained confidentiality. They completed telephone calls and discussions about people's health care needs in private. People's health and care files including medication administration records were held securely in locked cupboards in an office. Records were also held in computerised form and the registered manager confirmed the computers were password protected. The registered provider was also registered with the information commissioner's office, a requirement when computerised records are held. Staff records were also held securely.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in January 2017, we made a recommendation to ensure care plans were accurate and more person-centred.

We found improvements had been made in three of the five care files we looked at whilst two required more information in specific aspects of care. For example, one person required monitoring with food and fluid intake and the care plan referred to using National Institute for Care and Excellence (NICE) guidelines to calculate the amount of fluid they required each day. It said, "Offer lots of fluids, give assistance as required, ensure adequate intake of 30mls per kg and ensure it is written on the chart." However, the amount of daily fluid intake had not been calculated and staff were unaware of the amount they should aim for; recording of their fluid intake was inconsistent. The person had a hand contracture but there was no plan for the cleaning and care of the hand and nails to prevent sores occurring. Their care plan referred to using distraction techniques to raise mood, however, didn't state which techniques worked. There was also a recent incident when a blister had occurred on the person's sacral area but there was no record of the dressing applied. We spoke to the nurse about this and a wound care chart was produced straight away.

There was also more detailed information needed in one person's care plan for catheter management. We saw the wound assessment and care plans for two people were basic and provided limited information about wound care regimes. However, we did see the treatment was working and wounds improving. The registered manager told us they would address the care plans in both these areas.

We recommend improvements continue with the recording of care plans and monitoring charts to ensure up to date information to guide staff in meeting people's needs.

Each person had an assessment of their needs and a care plan produced. There was a needs summary which collated information and gave a detailed overview of the most important aspects of people's care needs. These were mostly kept up to date and enabled care staff to have information at a glance rather than having to read the full care plan.

We saw people who received the intermediate care service at Rose Villa continued to have their needs assessed by health professionals prior to admission. The care plans were also produced by the health professionals and care staff within Rose Villa carried out the plan and delivered the care. Therapists wrote the treatment plans for physiotherapy and occupational therapy. People's care and treatment plans were updated when required and multidisciplinary meetings were held weekly to discuss progress and respond to people's changing needs. There was a 'getting to know you form' which was to be completed with people using the intermediate care service and their relatives. This gave staff personal information and preferences for how the person wanted to be cared for whilst they were in the service.

People said they were happy with the care provided. Comments included, "It's all okay; I'm happy with the care", "Yes, they do everything they can" and "They are doing more for me here than at the last home. I can have a shower here now." We observed several people at the dining table were ready to be supported back

to their comfy chairs but staff response to this was slow. This was mentioned to the registered manager to address with staff.

There were mixed comments from health professionals regarding communication and the responsiveness of care and nursing staff to the changing needs of people who used the service. For example, one health professional told us the registered manager and members of staff contacted them for advice quickly, and were proactive in seeking support for people. Another health professional told us staff response to changing needs could be improved. They also said that when the registered manager was not present, communication with the nurses was not as good as expected; they had difficulty in identifying who had defined responsibility. This was mentioned to the registered manager to address.

The registered manager told us people could remain at Rose Villa Nursing Home for end of life care. The service was taking part in the community palliative care teams 'homes project' and was working towards obtaining the Gold Standard Framework in end of life care. The registered manager and another nurse were part way through training courses in end of life care. The people who used the service were part of the community palliative care team's 'virtual ward' and were discussed on a monthly basis via skype or during face to face meetings. The registered manager told us they were awaiting dates from the palliative care team for the care staff to attend end of life training. In discussions, staff were clear that time was needed to support people at the end of life. One member of staff said, "TLC [tender loving care] is given on a one to one basis; it is a precious moment so we have to give time. For example, with [Name of person] I helped him to the end as family couldn't be there. The nurses do the 'just in case' medicines and carers keep people comfortable."

People who used the service had access to a range of activities to help keep them occupied. There were two activity coordinators who worked 30 and 25 hours a week, which meant there were activities seven days a week. They told us when people were admitted to the service, they completed a form to assess their previous hobbies and interests, and what they were physically able to do. They had a planned activity programme (which included one to one and group work), encouraged people to participate and recorded when they took part. The activities included quizzes, bingo, entertainers, discussions about local news and history, manicures, exercise to music, karaoke, arts and crafts, and walks to the park and shops in warmer weather. Contact had been made with a local nursery school and children visited on a monthly basis. Clergy visited monthly but would see people on an individual basis and they had started 'Communioke' where people sing along to hymns.

People were happy with the activities provided. Comments included, "I belong to a church and friends from there visit", "My daughter bought me Alexa [electronic internet supported device] for my room; I can ask her questions and it's almost like company", "Yes, I like bingo and quizzes; there seems to be enough" and "There's singing, hoop games and dominoes; I like to join in and my daughter and sister visit a lot." One person said, "I enjoyed the cheese and wine party recently and the 'Burns Night' party. It's nice; better than the last place. They have two activity coordinators and they ask me what I want."

There was a complaints procedure on display which advised on how to make a complaint and who would investigate it. People told us they felt able to complain and mentioned specific people they would talk to which included the registered manager and overall general manager based in the service. A member of staff said, "People have a right to complain if they are not happy; [Name of registered manager] deals with them and feedback comes down so we can work on things."

Good

Is the service well-led?

Our findings

At the last inspection in January 2017, we had concerns that the quality monitoring system was not identifying issues so that improvements could be made. At this inspection, we found improvements in overall governance of the service.

We saw audits were completed for areas such as medicines management, diabetes, care plans, fire-fighting equipment, pressure ulcer prevention and protection of mealtimes. The environment was checked for cleanliness, tidiness and infection prevention and control. Accidents were monitored to ensure lessons could be learned and to prevent reoccurrence. Observations of staff practice took place, for example during administration of medicines and the dining experience for people. The provider's representative completed visits and spoke to people who used the service and checked the environment. Action plans were developed and completed to address shortfalls.

Meetings were held with people who used the service; we saw the minutes of the meetings held in November 2017 and January 2018. These records showed people were able to express their views about the service and were asked if any improvements could be made. There were also staff meetings which covered areas such as what is expected of staff during the shift, personnel issues, training, activities, cleaning tasks, general respect and staff attitudes.

Recent questionnaires for people who used the service had been completed at the beginning of February 2018. The results showed most people were happy with the meals and care provided. The registered manager had indicated on the analysis that some comments would be discussed with staff in the next team meetings.

The registered manager told us they were supported in their role and could raise issues when required. They described a culture of openness and said staff were not concerned about raising issues. The registered manager was available and had an open-door policy. We also observed they supported the staff team at meal times. There was a general manager on site most days for support and advice to the registered manager and staff as required. There were incentive schemes for staff such as 'carer of the year' with a prize.

Staff told us they could raise concerns with the registered manager and general manager. They also confirmed they were supported in their role. Comments included, "I'm happy working here but it can be manic some days", "They [management team] are very professional and give instruction and information", "They are open and honest" and "It's a pleasant, respectful and relaxed place."

Staff said communication was good within the service. There were shift handovers where information was passed on verbally and in writing, team meetings, one to one supervision sessions and general day to day discussions.

The registered manager was aware of their responsibility to inform the Care Quality Commission (CQC) and other agencies of incidents which affected the safety and welfare of people who used the service. The CQC

had received notifications of incidents in a timely way. The registered manager had also built up good relationships with other professionals and agencies. Prior to the inspection, we received information from health professionals which stated the registered manager had worked well with them to enable admission of a person with complex health and social care needs. They were happy the person had settled well within Rose Villa Nursing Home. Their comments included, "A recent case has been managed very well and the home have been very accommodating and gone the extra mile regarding transition and support. They have shown resilience in problem-solving."

We saw the registered manager regularly accessed nationally recognised guidance and information in order to improve staff knowledge and practice. For example, these included National Institute for Care and Excellence (NICE) guidelines for specific topics and Patient Safety Alerts.