M Jalal

Rose Villa Nursing Home

Inspection report

132 Tipton Road
Sedgley
Dudley
West Midlands
DY3 1BY

Tel: 01902219091

Date of inspection visit:
21 April 2016

Date of publication:
22 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

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.

After this comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breach. We undertook this focussed inspection on the 21 April 2016 to check that the provider had made and sustained the improvements they had told us they would make.

This report covers our findings in relation to those requirements. It also covers some additional information that we looked at on the day. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rose Villa Nursing Home on our website at www.cqc.org.uk.

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, 15 people were living at the home.

There was a manager in post, but she had recently being 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.

The provider had failed to take responsibility and address a number of areas highlighted on the action plan that they had submitted to us.

Staff were not provided with the information they required to meet the needs of a number of people living at the home, as care plans and risk assessments were not in place, leaving people at risk of harm.

A number of people were admitted to the home in a short space of time, without the correct paperwork in place to enable staff to support them appropriately and safely.

Staff felt supported by the manager, but there was no formal staff supervision taking place and staff training had not taken place.

Staffing levels at night were highlighted by the manager as unsafe, the provider responded to the manager's concerns and increased the staffing at night by the end of the inspection.

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?

Requires Improvement

The service was not consistently safe.

Staff were not provided with all necessary information they required to meet people's needs and keep them safe from harm.

The manager and staff raised concerns regarding the staffing levels in the home and their ability to support people safely.

Is the service well-led?

Requires Improvement

The service was not well led.

The action plan that had been submitted by the provider had not been met.

The service had not benefitted from consistent or effective leadership. The manager in post had been with the service for only a short while and they were not registered with us to manage the home.

Audits in place had failed to identify areas of concern that were highlighted during the inspection.

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 21 April 2016 and was unannounced. The inspection was carried out by one inspector. The service was inspected against one of the five questions we ask about services: Is the service well led? This was because the service was not meeting this legal requirement at our last inspection on 6 October 2016. Due to concerns we saw on the day, we also looked at risk management and staffing levels, which come under the question, Is the service safe?

We spoke with the provider, the manager, three care staff, one relative and one person who lived at the home. We also spoke with representatives from the local authority. We assessed progress against the action plan that had been submitted by the provider following the last inspection. We looked at the care records for all 15 people living at the home, quality audits and recordings of accidents and incidents.

Requires Improvement

Is the service safe?

Our findings

One person told us, "Yes I feel safe" and a relative told us, "It's not too bad, [relative's name] tells me she's ok, I think she's ok". One person told us (when asked if they had to wait long to be supported), "I haven't had use the call bell at night, so I couldn't comment on that". A member of staff told us, "We need more staff to give us more time to get a handle on things and to spend time with clients".

We saw that over a period of 16 days, the provider had arranged for 10 people to be admitted to the home and for six of those people, there was no care plan or risk assessment paperwork in place. A member of staff raised their concerns regarding the lack of information available to them and told us, "I don't think we are catering for residents' needs" and another member of staff said, "I'm still getting to know people, it's been a bit of a challenge". A member of staff told us they were aware that one person was a risk of choking and they had noted this on the person's daily records. However, they pointed out that a nurse had continued to serve this person food that would have increased this risk. We saw that the nurse had written a care plan that stated the person could have a normal diet, which was incorrect. We immediately raised this with the manager and contacted the local authority in order to raise a safeguarding concern in respect of this person. The manager told us she had instructed to nurse to write the care plan and did not know that it had been written incorrectly. This meant that despite the manager providing the correct information to staff, the manager could not be confident that staff followed the guidance given, which left people at risk of harm.

We saw for another person, pre-assessment information from their social worker highlighted that they may exhibit behaviours that presented a risk to themselves and others. There was no care plan or risk assessment in place for this individual. The lack of information and documentation for people meant that staff were not equipped with all the necessary knowledge they required in order to meet the care needs of the people they supported, which in turn, left people at risk of harm.

The manager told us that following the recent number of new admissions to the home, she had met with the provider and requested more staffing to be put in place in order to meet the needs of the people living at the home and keep them safe from harm.

We saw that arrangements were in place to recruit additional staff and were ongoing. However, we noted that at night, there were only two staff on duty to support 15 people, the majority of which required hoisting. This meant that if both staff were supporting one person, there would be no other carers available to meet the needs of other people in a timely manner . The manager told us, "I don't think people are safe at night. I've been told by the provider that I can't use agency". We bought our concerns to the attention of the provider on the day of the inspection. Following our conversation, the provider advised us that staffing levels would be increased for the night shift with effect from that day by one additional member of staff. The manager and the provider told us they considered this arrangement would ensure people living at the home were safe.

We asked the manager how she ensured people were safe in the home, we saw that both she and the care staff worked long shifts. The manager confirmed that she observed staff practice to ensure their practices

were correct, particularly manual handling and staff spoken with confirmed this.

Staff spoken with had some knowledge about the people they supported, but the two care staff on duty that day relied on the senior care and the manager for information. One member of staff had started work that day and another had been in post two weeks. A member of staff told us, "Staffing is low, you have no time". New staff told us they relied on the manager and the senior care to provide them with the information they needed to meet people's needs . We observed the impact this had on both the manager and the senior as they were trying to ensure staff had the information they needed to support people and they were trying to build up their own knowledge as they went along. We saw evidence that staff working at night were not always aware of the risks to people and were not following the care plan information or instructions that the manager had provided.

Requires Improvement

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 this inspection, we found that the issues highlighted had not been acted upon and remained the same.

Following the inspection of 6 October 2015, we asked the provider to submit their action plan to us in response to the above breach. The provider failed to do this and we had to contact them to obtain their action plan, which was then submitted by the manager in post at that time. The provider failed to ensure that subsequent managers who were appointed to the home were in full possession of the facts regarding the day to day workings of the home, which resulted in people living at the home being put at risk of harm. The new manager had not been made aware of the action plan or the need to comply with it by the provider. This meant that the provider had not taken responsibility for the concerns raised at the last inspection and did not take action to ensure people's welfare and safety.

At our inspection of 6 October 2015, there were three people living at the home and for one person, there was no care plan or risk assessment in place. The action plan that was subsequently submitted to us, confirmed that new care plan paperwork would be in place for all people living at the home. At our inspection of 21 April 2016, we saw that there were 15 people living at the home and for six people there were no care records available. The action plan stated there would be new forms in place to assess people's mental capacity, but there was no evidence of this. We saw that staff supervision was not taking place, although staff did confirm that they had had their practice observed by the new manager. We saw that no staff meetings had taken place and staff had not received any additional training that would support them in their role. Despite an action plan being submitted, only one item had been actioned and that was to ensure that body maps were put in place for detailing the application of topical creams. No other areas of the action plan had been acted upon. The provider had failed to alert staff to the requirements of the action plan or taken responsibility for ensuring that the actions were taken, which would result in keeping people safe.

We were told by the manager that the provider had made arrangements for a number of people to be admitted to the home without consulting her first. The manager described one particular incident, they told us, "First we knew about it was when the hospital rang to say they were on their way – next thing, they're on the doorstep". We saw that in a 16 day period, 10 people were admitted to the home, three on one day. This meant that staff were not given time or information in order to establish the care needs of the people living in the home which left people and staff at risk from harm. The provider did not recognise the need for discussion with the manager to make her own assessment as to whether people's needs could be met safely. A member of staff said "[Provider's name] is accepting residents behind her [manager's name] back and not telling us when he's going on assessments". Another member of staff told us, "We had three people arrive in one day. I got told about their dietary needs and also spoke to their family to try and get some information."

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. The provider did not ensure that the manager and staff group had the appropriate support and information required to ensure the care they provided to people was safe and effective. This meant the provider did not consistently promote people's welfare and safety.

We spoke with the new manager who had been in post since February 2016. She told us that at this time, she had not put in her application to become registered manager of the home and was concentrating on meeting requirements of the action plan.

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.

We saw that since the home had been registered in February 2015, there had been a number of managers in post, none of which had applied to become registered manager. This meant that leadership was inconsistent and ineffective and the provider had failed to take action to support and retain managers. The provider was not meeting the conditions of registration.

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

Staff spoke highly of the manager and how supportive she was. A member of staff told us, "We get no supervision or support. [Manager's name] is helping me loads but even a manager needs support behind them". We observed that the manager was supportive to staff and caring to residents, but her time was spent trying to do a number of things at once, [manage staff, write care plans, care for people living in the home] with little support for herself. A member of staff told us they had raised their concerns with the provider, that the manager required support, but was told by the provider that the manager, "Could handle it".

We saw that the provider had failed to display their ratings poster from their previous inspection, which they are required to do so by law. We raised this with the manager and she immediately arranged for this to be put on display.

We saw that the provider had failed to purchase appropriate equipment that would support people appropriately and keep them safe. For example, we noted that some of the chairs in the lounge did not allow tables to be positioned underneath them. We saw one person had their plated meal placed on their lap, as the table could not be placed under their chair in a position to enable them to eat. This made it difficult for them to eat their meal as they were lying at an angle in their chair and their meal could not be placed directly in front of them.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 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.