Rose Villa Care Home Limited

Rose Villa Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Rose Villa Nursing Home is a residential care home providing personal and nursing care up to a maximum of 36 people. The service provides support to people with dementia, older people and people with a physical disability. At the time of our inspection there were 25 people using the service.

Rose Villa Nursing home is a large Victorian house and has three floors serviced by a passenger lift. There are bedrooms for single and shared occupancy on each floor, with communal and dining space on the ground floor.

People's experience of using this service and what we found
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff supervision and appraisals were not consistent and did not support staff to maintain knowledge of best practice. Training was inconsistent and did not support staff to meet the needs of people in their care.

The service did not have effective safeguarding systems in place and there was not a consistent approach to safeguarding matters. Staff were not up to date with safeguarding training.

Information about risks and safety was not always comprehensive or up to date and full information about risks to people's safety was not always communicated to the staff. People and their families or carers were not always involved in decisions about their care and treatment.

People received the care and support they required to be safe, however, staff did not always have time to respond to people's changing needs. Staff regularly felt stretched and focused on tasks rather than person-centred care.

Governance systems were not reliable or effective. Investigations were not always completed and there was little evidence of learning from accidents and incidents.

Information to support staff to safely administer medicines was not always available. We have made a recommendation about the management of some medicines.

People were not always supported to engage in person-centred activities to help them maintain hobbies and interests. One relative told us "Activities are an issue, [person] would benefit from some activities that suited them". We recommend the provider reviews accessibility of activities.

The provider did not always engage with people who use the service, their families and/or carers, ensuring

their views were acted on to shape the service and culture. Relatives told us there had never been any invitations to attend carers meetings. We have made a recommendation around how the provider obtains the views of all stakeholders including people and their families.

Staff have access to and followed clear policies and procedures on infection, prevention and control that met current and relevant national guidance.

People had access to an outside space and a quiet area to see their visitors. People had choice and access to enough food and drink throughout the day.

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

Rating at last inspection
The last rating for this service was good (published 20 March 2018).

At our last inspection we recommended that improvements continue with the recording of care plans and monitoring charts to ensure up to date information guides staff in meeting people's needs. At this inspection we found improvements had not been made in the recordings of care plans, and care plans did not contain up to date relevant information.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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.

The overall rating for this service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective responsive 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.

Enforcement and recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to person-centred care, safe care and treatment, the Mental Capacity Act 2005, safeguarding, staffing and the overall leadership and management of the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is

added to reports after any representations and appeals have been concluded.

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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Rose Villa Nursing Home

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 was carried out by one inspector and a medicines inspector. An Expert by Experience also spoke to relatives by telephone. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Service and service type
Rose Villa Nursing Home 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 Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 four people who used the service and eight relatives to ask about their experience of care provided. We also spoke with the registered manager, eight members of staff and two professionals. We looked at four care files along with a range of medication administration records (MAR). We looked at other records relating to the management of the service including recruitment, staff training and supervision and systems for monitoring quality.

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. At this inspection the rating 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

- The registered manager did not always follow appropriate processes to protect people from the risk of abuse. They had not followed local safeguarding procedures to report concerns to the local authority safeguarding teams or the CQC.
- Safeguarding training had not been completed by all staff. Staff told us they would report any safeguarding concerns to the qualified nurse on duty, however not all qualified nurses had received safeguarding training.

There was not a consistent approach to safeguarding and matters were not always dealt with in an open and transparent way. This was a breach of regulation 13(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had a whistleblowing policy in place and staff were aware they could follow this to raise concerns.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks associated with people's care had not always been manged effectively.
- Care records were not kept up to date to reflect people's current needs. For example, one person had been diagnosed with epilepsy, however there was no care plan or risk assessment to support staff to manage this.
- Mobility care plans and risk assessments for people did not contain information to guide staff on how to reduce the risk of falls.
- Staff did not always have access to people's risk assessments or information about people's risks was not communicated to staff or others who may need it.
- There was limited evidence of learning from accidents or incidents and there was a lack of action taken when things went wrong.

We found no evidence that people had been harmed, however, the provider has failed to robustly manage risks relating to the health, safety and welfare of people. This is a breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- There was not enough staff to manage the needs of people in the service. The registered manager did not take a systematic approach to determine appropriate staffing levels to meet people's needs and ensure the

service could be managed safely. Staff told us "There just isn't enough of us, most people require two carers" and, "We [staff] are physically exhausted. Some people just require that extra five minutes and we don't have the time to give it."
● On both days of inspection, we observed there was not enough staff available. Call bells were not answered in a timely manner. People and their relatives told us, "You have to wait a long time for call bells to be answered" and, "They always seem short staffed, it is a nightmare if you ring, they never answer."
● Staff told us they did not have time to read care plans and risk assessments. Comments included "There is a lot of information to take in and we just don't have time" and, "There is an awful lot of care plans, they are mind blowing."

We found no evidence that people had been harmed, however, the provider had failed to ensure there were sufficient numbers of suitably qualified and skilled, competent staff to meet the needs of people. This is a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider is in the process of moving over to an electronic care system which will enable staff to have accessible access to care plans and risk assessments through an iPad.

● Safe recruitment and selection processes were followed, and staff were recruited safely.

Using medicines safely
● Staff did not always manage people's medicines in a safe way. Medication audits were not effective and did not identify errors found on inspection.
● Staff had not recorded the administration of thickening agents (medicines used to thicken food or fluids for people with swallowing difficulties) on people's MAR charts.
● Staff did not have guidance for administering 'as and when required' medicines (PRN).

We recommend the provider reviews its medication audits to ensure the proper and safe management of medicines.

The registered manager responded immediately after the inspection and developed a signing sheet for thickening agents and ensured people on 'as and when required' medication had guidance in place.

Preventing and controlling infection
● 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 responding effectively to risks and signs of infection.
● 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.
● We were somewhat assured that the provider was using PPE effectively and safely
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● One member of staff was identified as not wearing correct PPE while delivering personal care. This was addressed immediately by the registered manager. There was a lime scale build up around some taps in bathrooms, the cupboard where linen was kept required new flooring and there was some exposed pipework in bathrooms. The registered manager responded immediately to address the issues.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes

- The provider had a system in place to support people to have visits from family and friends.

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 the rating 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.

● Principles of the MCA were not followed. There was lack of information in records to show mental capacity assessments and best interest decisions had been completed.
● Where best interest decisions had been made, they did not always involve people, relatives and carers or someone acting on their behalf.
● Consent was not always appropriately sought. People had care plans in place to say they did not have capacity, without this being assessed. This meant it was wrongfully assumed people did not have capacity to consent to any aspect of their care.

The failure to ensure care and treatment was delivered with appropriate consent was a breach of regulation 11(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff were not supported to keep up to date with best practice. Supervisions and appraisals were not consistent.
● Staff had not received the appropriate training to support the needs of people living at the home. For example, no training was provided to support people who had diabetes, epilepsy or required catheter care,

however staff told us they knew people well and who to contact for support.
● Staff told us they felt supported by the managers. Comments included "If I had a problem I know I could go and speak to them" and "They will listen and always make time for you."

The failure to ensure staff received the appropriate training, supervision and appraisals was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care
● Care plans did not always reflect people's current needs. In one person's records it stated they had mental health needs and suffered from self-neglect, however there was no care plan or risk assessment in place to support this. Staff told us "Because we know them, we would just know what to do."
● People were not always referred to specialist services when required. People had been diagnosed with mental health needs; however, they had not been referred to mental health teams for additional support.
● People or their relatives were not involved in decisions about their care. One relative told us "I have never seen a care plan or been invited to any reviews; I know nothing about [Person] care."

We have reported on this under the well-led domain, complete and contemporaneous records were not always accurate, therefore they did not support staff to deliver care and treatment in a way that meets people's needs.

Supporting people to eat and drink enough to maintain a balanced diet
● People's dietary requirements were not always reflected in their care plans. One person required a soft diet, however there was no information in his care plan or risk assessment to support this. This increased the risk of harm.
● People had access to hot and cold drinks throughout the day.

Adapting service, design, decoration to meet people's needs; Supporting people to live healthier lives, access healthcare services and support;
● The environment was suitably adapted to meet people's needs. There was plenty of communal space and bedrooms were personalised.
● Staff knew people well and understood how to recognise if a person's presentation or health had changed and who they would report this to.
● Relatives were confident they were kept informed about any changes to people's health. Comments included "If [Person] is unwell, they are on the phone at once to discuss the best way to proceed" and, "If there was an issue, I know the nursing home would call me because they are so good."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

We made a recommendation at the last inspection to continue improvements with the recording of care plans and monitoring charts to ensure there is up to date information to guide staff in meeting people's needs. Improvements have not been made.

- Staff did not have up to date information for people who required support for mental health needs. Care plans were not person-centred and did not give guidance to staff how to support someone who was experiencing difficulties.
- Care plans for people with specific health needs did not give staff enough information to meet a person's needs. One person was an unstable diabetic and there was no information to guide staff on what to do if they became unwell.
- Care plans did not consistently contain detailed information about people's likes, dislikes, interests and personal histories. This meant people could not be supported in line with their assessed needs, however, staff demonstrated they knew people well. Relatives also told us staff knew peoples likes and dislikes.

Care plans were not person centred and did not contain up to date information to guide and support staff. This is a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- Complaints had not been responded to appropriately.
- The registered manager had no records of complaints, they told us they dealt with all complaints verbally. The registered manager had been asked to provide a written response to a complaint received through the Care Quality Commission and there was no evidence of this, or any actions taken.
- People and their relatives knew how and who to complain to. People told us If they were worried about anything, they would tell the manager or the staff.

All complaints should be acknowledged whether they are written or verbal, the provider failed to keep any records of complaints. This is a breach of Regulation 17(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People's activity records did not always identify their preferred activities.
● Not all people could take part in the activities on offer. There was one activity timetable for the service, however, it did not take into consideration people's differing needs. One relative told us "[Person] likes reading and talking to people, but they don't support her with that." A staff member told us "Some people are not able to join in activities because they have mobility issues."

We recommend the provider reviews how activities are provided to ensure there is equality for everyone using the service.

End of life care and support
● People's end of life needs were not always reviewed regularly and did not always involve the person or their relative or carer.
● People had an end of life care plan that described their wishes.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Information about people's communication needs was recorded in their care plans.
● Information was provided to people in a format most accessible to them. Photographic files were held in the dining room with pictures of different foods for people to choose.

Inadequate

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 inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider had failed to implement a robust governance system and did not maintain oversight of the service. Audits were ineffective and did not identify or prompt action to address the concerns we found with the quality and safety of the service.
- The quality assurance arrangements in place did not evidence learning outcomes to improve the service. The registered manager had not carried out any investigations following accidents and incidents including safeguarding concerns.
- Complete and contemporaneous records were not always kept, and staff did not always have the information they needed to care for people.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded immediately after the inspection and put systems in place to ensure oversight of accidents and incidents within the service.

- Staff told us they were a good team and felt supported by each other. Comments from staff included "Everyone tries to be upbeat; the staffing gets you down" and, "We are all friendly with each other, we have all worked here a lot of years."

- The provider had not always submitted notifications about incidents as they are required to do by law.

Failure to notify CQC as required was a breach of Regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009. This is being followed up outside of the inspection process and we will report on any action once it is complete.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- External stakeholders including relatives were not fully engaged in the running of the service. Relatives told us they had never been to a carers meeting or asked to complete any surveys for the service.

● People had regular meetings, however there were no action plans to identify and demonstrate concerns raised and addressed as a result.

We recommend the provider reviews how it engages and reports on actions with stakeholders, including people who use the service and their relatives about their experience and the quality of care delivered.

● The registered manager held regular staff meetings. Staff told us they found them useful, were able to participate and felt listened to.

Continuous learning and improving care; 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
● Accident and incidents were monitored. However, they were not appropriately analysed which made it difficult for the provider to learn from them and reduce the risk of re-occurrence.
● The registered manager was not able to establish how lessons had been learned from incidents and how investigations had been used to drive quality and improve outcomes for people.
● The provider and registered manager were not always aware of their responsibilities under duty of candour. Investigations were not always completed, and outcomes discussed with people or their relatives.

Working in partnership with others
● We saw evidence the registered manager worked in partnership with community professionals and organisations to meet people's needs.
● Two health care professional we spoke with told us they worked closely with staff at the home to provide effective care for people.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred and did not contain up to date information to guide and support staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent the provider failed to ensure care and treatment was delivered with appropriate consent

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to robustly manage risks relating to the health, safety and welfare of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was not a consistent approach to safeguarding and matters were not always dealt with in an open and transparent way.

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

The provider had failed to ensure there were sufficient staff to meet the needs of people.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems were not in place or were not robust enough to demonstrate safety was effectively managed.

The enforcement action we took:

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