The Villas Care Homes Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 25 and 26 July and was unannounced.

The Villas Care Homes Limited provides residential and nursing care for up to 16 people with mental health needs or a learning disability. At the time of our inspection there were 15 people using the service. Accommodation is provided over three floors with access via two stairwells or a passenger lift.

The overall rating of Requires Improvement, which was awarded following the CQC's previous comprehensive inspections of 15 and 16 June 2016 and focused inspection of 14 September 2016, was displayed within the service. The Villas Care Homes Limited has made improvements within the individual key questions. Is the service effective? Is the service caring? Is the service well-led? The service has retained its overall rating of Requires Improvement.

The Villas Care Homes Ltd has a registered manager. 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 registered manager's appointment had had a positive impact on the quality of the service being provided. However we found additional improvements were needed to ensure the reviewing of the quality of the service continually ensured that the service being provided was of a good quality, and met the required expectations of the CQC and external stakeholders.

The recruitment of staff was not robust. The provider's policy and procedure for staff recruitment was not consistently adhered too. Staff recruitment records did not always contain sufficient detail or information to determine the applicants' suitability for the posts they had applied for. This had the potential to put people at risk. The nominated individual and registered manager accepted that they had not adhered to the policy and procedure and spoke of their commitment to ensure improvements were made.

People's safety and well-being was promoted through the pro-active management of individual risk. This was achieved through the sharing of information and agreed strategies for promoting people's choices in their day to day lives. People were supported to have choice and control over their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People's medicine was managed safely by nursing staff. Audits were undertaken on a range of topics, which included medicines and maintenance of the environment to ensure people's safety was promoted and maintained.

We found people's safety, welfare and needs were met as there were sufficient staff employed who had the relevant experience and training in providing care and support to people. Staff were supervised and had

their competence to perform their roles assessed. Communication between the management team and staff was open and enabled the sharing of information.

People contributed to the development of meal choices with staff support. People's needs with regards to their diet were respected and supported, which included dietary requirements to support individual health needs. People were supported, where necessary, in the promotion of their health and welfare by attending routine and specialist appointments with health care professionals.

People's individual communication needs were understood by staff, and there was clear guidance for staff on how to support people to express their views about their care and support and make day to day decisions.

The registered manager and staff met the needs of people by encouraging them to share their views and opinions. People were involved in the assessment and reviewing of their care needs, which included the role of staff in promoting people's independence. People took part in a range of activities at the service and within the wider community, which included visiting local eateries and shops which reflected people's independent lifestyle choices and diverse needs.

People's views as to the quality of the service were sought and comments reflected people were satisfied with the care provided. A range of audits were undertaken to assess environmental factors within the service along with audits to ensure people's needs were being regularly reviewed and being met.

External stakeholders in some instances had noted improvements as to the quality of documentation within the service which recorded people's needs. The nominated individual and registered manager informed us they were working with a range of external stakeholders to bring about further improvements to the service.

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 had not always been safely recruited which meant people were at risk of being supported and cared for by people who had not undergone a robust recruitment process.

People were protected from abuse because staff had an understanding of what abuse was and their responsibilities to act on concerns

There were sufficient numbers of staff to promote and maintain people's safety. Risk assessment identified potential areas of risk and included measures to reduce risk whilst recognising and promoting people's rights to make informed decisions about their day to day lives.

People's needs were assessed in relation to the management of their medicine. Where people required support this was provided, which meant people's health and welfare was promoted by safe medicine systems.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the appropriate knowledge and skills to provide care and who understood the needs of people.

Staff had a good understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005. The legislation had been acted on to ensure people's human rights were respected.

People at risk of poor nutrition and hydration had assessments and plans of care in place for the promotion of their health and well-being. People's dietary requirements with regards to their preferences and needs were respected.

People's health and well-being was monitored and staff liaised with health care professionals to promote and maintain this.

Is the service caring?

Good

The service was caring.

People were supported by staff that had access to information which provided clear guidance for staff as to the people's support, required. This enabled staff to develop relationships with people in a caring way by recognising and understand people's disability, age and specific needs.

People were involved in the day to day decisions about their care and support and had opportunities to comments on the service they received, both formally and informally.

People were supported by staff who were committed understood their role in the promotion of people's rights and who listened to and respected people, in order that their privacy and dignity was promoted.

Is the service responsive?

Good

The service was responsive.

People were involved in the assessment and on-going development and reviewing of their care and support needs which focused on their lifestyle choices and promotion of their independence. This recognised a commitment by the registered manager to provide a service that was able to meet people's individual needs.

People were encouraged to maintain contact with family and friends and were supported to access resources within the wider community.

People had a range of opportunities to raise concerns and their right to raise concerns was emphasised.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

A registered manager was in post whose approach had brought about improvements to the service being provided. However, further improvements were needed to ensure people received a service that ensured people received consistent good quality and safe care.

The nominated individual and registered manager were working

towards addressing the shortfalls identified by external stakeholders.

The nominated individual had appointed and made changes to the staff team to support the registered manager in carrying out their role. This had had a positive impact on the quality of information in people's care records.

The Villas Care Homes Ltd

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 checked 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.'

The inspection took place on 25 July 2017 and was unannounced. The inspection was carried out by an inspector. We returned on 26 July 2017 accompanied by 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. Their area of expertise was people with mental health needs.

We gathered and reviewed information about the service before the inspection. This included the Provider Information Return (PIR). 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 also reviewed notifications we had received from the provider. Notifications are information about key incidents and events within the service that the provider is required by law to tell us about.

Prior to our inspection we received information from external agencies, which included the brokerage team of Derby City Council and the Derbyshire Fire and Rescue Service.

We contacted local health and social commissioners who fund many of the people using the service to gather their views about the service.

We used a variety of methods to inspect the service. We spoke with three people using the service, two visiting family members, the nominated individual, the registered manager, two members of staff and a nurse. We observed people being supported in the dining room at lunch time and during the day.

We looked at the care plans and records, including medicine records of four people. We looked at the recruitment records of six staff. We looked at staff training records and minutes of meetings for people who used the service and staff. We viewed records in relation to the maintenance of the environment and equipment along with quality monitoring audits.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection we received information of concern from health and social care commissioners about the recruitment of staff. They provided us with information as to their concerns and the actions they had required to be put into place. We found the actions they had requested had been undertaken, which included the appropriate clinical supervision of staff and the seeking of additional employment references. However we identified concerns with the references obtained.

Staff recruitment records for two members of staff were incomplete. We found application forms to be missing or had been completed retrospectively. The references within the records did not always reflect the reference details provided within the application form, nor were they from the applicant's most recent employer. References that were in place were found not to reflect the period of time the reference applied to or the service or organisation that had employed them. The nominated individual and registered manager had not identified the shortfalls and taken appropriate action. This meant people's appointment and suitability for the post applied for had been based on potentially unsafe and unreliable information.

We spoke with the nominated individual and registered manager. They accepted that the recruitment of these staff had not been robust and said they would seek appropriate references. They told us they would review their practice to ensure the provider's policy and procedure for the safe recruitment of staff was adhered to.

The records for four other members of staff showed they had been recruited in line with the policy and procedure. Staff had completed an application form and attended an interview. Prior to being employed records showed they had an enhanced Disclosure and Barring Service (DBS) check and two valid references. (A DBS is carried out on an individual to find out if they have a criminal record which may impact on the safety of those using the service).

We found there were sufficient staff to keep people safe. At our previous inspection in September 2016 we found staffing levels whilst promoting people's safety were not sufficient to enable people to be supported to access the wider community. The registered manager had made staff aware of the need to support people in this area. People's records showed people were being supported to access the wider community. During our visit staff supported people who required support to attend appointments with health care professionals.

Staff we spoke with told us there were sufficient staff to meet people's needs, with four members of care staff on duty during the day and three at night, who work alongside a nurse.

People we spoke with had a different perspective about what being safe meant. One person we spoke with when asked if they felt safe, told us, "The home is safe day and night." They went onto tell us they had been at the service for many years and always felt safe. For another person, safety meant their ability to go out. They told us. "It's safe to go out to knitting class on a Thursday."

The registered manager's approach ensured people's human rights were not breached, as they took these into consideration when making decisions that these were in a person's best interests. For example, the registered manager had made a safeguarding referral to the local authority as they had concerns that a person's decision as to their lifestyle choices was impacting on their health and well-being. The registered manager and staff had also liaised with relevant health care professionals to provide appropriate support and guidance to promote the persons health and keep them safe.

Staff were trained in safeguarding adults at risk as part of their induction so they knew how to protect people from avoidable harm. The provider's safeguarding and whistleblowing policies advised staff what to do if they had concerns about the welfare of any of the people who used the service.

Policies and procedures for the promotion of people's safety were in place. These included information about advocacy services, a policy on safeguarding people from abuse, and a fire policy and procedure which included individual risk assessments for the evacuation of the service in an emergency known as PEEP's (personal emergency evacuation plan).

People's records included risk assessments, which identified potential risk and the measures to reduce the risk. Risk assessments were regularly reviewed to ensure they contained up to date and accurate information. The registered manager and staff we spoke with had a good understanding as to the needs of people and how to support them. This included where people's behaviour may challenge others so that the person's support was managed positively. People's assessments identified potential triggers that may give cause for a person to exhibit behaviour which challenged, which meant staff were able to respond, for example by the use of distraction techniques.

Risk assessments were completed with consideration as to people's rights and choices so that risks were mitigated whilst not placing unnecessary restrictions on people. For example, one person who accessed the community independently had an assessment which provided clear guidance for staff. A document known as the 'Herbert Protocol' (a national missing person's scheme) had been completed which would be shared with emergency services in the event the person did not return to the service. This included information as to potential locations where the person may be found.

Risk assessments had been undertaken for those whose skin was at risk of becoming sore due to pressure. Care plans had been put into place for staff to follow to promote people's skin integrity. Where people required support in maintaining or promoting their independence, safety and welfare staff from the service liaised with physiotherapists and occupational therapists, who assessed and provided the appropriate equipment, for example a shower chair. District nurses were also involved where people required mattresses to promote their skin integrity.

Derbyshire Fire and Rescue Service provided a copy of their report following the outcome of a fire safety visit carried out in June 2017. The report included seven suggested actions, which were to be followed up by the Fire Safety Inspecting Officer of Derbyshire Fire and Rescue Service. We spoke with the nominated individual about the report, they told us four actions had been completed and three were on-going.

There were systems in place that monitored the safety of the service's facilities; records showed external contractors visited the service to check on safety, which included electrical, gas and fire systems.

People's care plans clearly documented the medicine they were prescribed, which included the reasons it had been prescribed, how it was to be administered and information as to potential side effects. We looked at the medicine and medicine records of some of the people who used the service and found that their

medicine had been stored and administered safely. This meant people's health was supported by the safe administration of medication.

People's care plans included information about the medicine they were prescribed which included protocols for the use of PRN medicine (medicine which is to be taken as and when required). This ensured people received medicine consistently. People's medicine was administered by a nurse.

We found the nurse on duty was knowledgeable about people's medicine and the information they provided was consistent with information we had read within people's records. The nurse and registered manager undertook a range of audits to ensure medicines were managed safely.

An assessment of people's capacity to manage their medicine had been carried out, and their responses to questions were included. This evidenced people's capacity or willingness to take part in the assessment. Staff had used pictorial and physical prompts to assist in the assessment of people's capacity. For example, people were shown their medicine. Where assessments had identified the person did not have capacity or they had expressed a wish not to manage their own medicine the registered manager and staff provided the necessary support. In some instances people's medicine was administered 'covertly' (this is when the medicine is administered without the person's knowledge). This was because the people declined to take their medicine and it was in their best interests that they received the medicine.

Good

Is the service effective?

Our findings

A programme of staff induction, which included training, was in place. Staff new to the field of care completed the Care Certificate, which is a set of standards that should provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support. A recently recruited member of staff told us they had received training which had enabled them to meet people's needs.

Staff development and on-going training was in place. Records showed staff had received training in a range of topics to support the health, safety and well-being of people, which included attaining qualifications in health and social care. The registered manager provided us with records that showed there was a programme of training for all staff including ancillary staff.

Staff had competency assessments undertaken on aspects of the care and support they provided to people. Staff were supervised and records showed that as part of their supervision staff were being encouraged to develop their skills. Staff who had worked at the service for many years continued to mentor new staff so as to share their knowledge as to the needs of people to help. Staff told us this promoted effective and consistent care.

Regular staff meetings took place. These provided an opportunity for the management team and staff to share information, enabling them to provide an effective service to meet people's needs. Staff had been asked to improve their records when detailing people's care and support. The registered manager confirmed staff had taken the appropriate action. We found people's daily notes provided clear information as to how people's needs were met and were reflective of their care plans. Staff meeting minutes showed staff had requested training on the writing and reviewing of personalised care plans, which had been provided. This had had a positive impact as people's care plans were comprehensive and provided clear information for staff to enable them to provide the support and care people needed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and 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 2005. 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 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found two people had a DoLS authorisation in place with no conditions attached. DoLS applications had been submitted for a number of other people.

We found people's records contained mental capacity assessments (MCA's) on a range of topics, which included their consent and decision to reside at The Villas Care Homes Ltd. Mental capacity assessments were also in place in relation to other aspects of people's personal care and support, which included medicine administration, financial management and topics related to an individual's health. These had been undertaken in a way that was consistent with the principles of the MCA 2005. For example, they contained clear information as to how the person was supported when being asked specific questions, the questions asked and their response. This assisted staff to ascertain the person's competence to make informed decisions. For example, when determining a person's capacity to manage their finances, coins and notes were used to support the questions posed. The assessments had been signed by the person whose capacity was being assessed. This was an example of a person being effectively supported.

We found people's involvement in decisions and choices about their meals had improved since our previous inspection in June 2016. People's views had been incorporated into their care plans. For example, 'I like to have warm milk poured onto my cereal' and, 'I have sugar on my cereal which I put on myself.' People were now serving themselves their own cereals for breakfast and choosing their toppings for their toast. People in some instances were supported to make their own drinks and snacks within the kitchen. Meetings for those using the service were held regularly. Meetings were used as an opportunity to explore with people using the service their views about the meals being provided. The minutes reflect people were satisfied with the meals

People's individual dietary requirements and preferences were detailed within their care plans. This included people who required diets to support known health conditions such as diabetes. Records we looked at included nutritional assessments which identified where people were at risk of malnutrition or dehydration. Care plans had been put in place which detailed the role of staff in supporting people to promote their health and well-being. The speech and language therapists (SALT) team was involved where people's assessed people's needs had identified they were at risk of choking. The resulting care plans reflected the support people required, which included guidance on the texture of their food and drink.

A person told us how staff accompanied them sometimes when they visited the dentist or doctor.

We spoke with a person's family member who told us how the registered manager and staff had supported them in attaining appropriate health care for their relative who resided at the service. They told us how the registered manager had made a referral to an advocate to act on behalf of the person. Meetings were held involving a range of people, which had resulted in the person's health care being reviewed, which made changes to their treatment. This had had a positive impact and improved the person's health.

Staff responded to people's requests when they expressed concerns about their health and welfare. We observed one person approach the nurse and requested they make a doctor's appointment for them. The nurse arranged an appointment for the person later in the day. Records showed people had timely access to a range of health care professionals, which included doctors, chiropodists, opticians, dentists and dieticians. Specialist services such as diabetic health screening also supported people within the service in the assessment and development of plans to enable staff to provide good and effective care.

Each person had a 'hospital traffic light' assessment, which provided essential information for hospital-based staff to assist them in providing appropriate care and support. The assessments contained information about people's health needs and the professionals involved in their care, along with information as to their prescribed medicine. Personalised information was also included, for example their likes and dislikes along with information as to any individualised communication needs people had.

Good

Is the service caring?

Our findings

People we spoke with were positive about the care and support they received and of their relationships with staff. One person told us, "Care here is good; staff show a lot of care."

People's specific needs were considered when promoting positive and caring relationships between themselves and staff, including when people had limited or no verbal communication. For example, records showed staff were to approach a person with a visual impairment from their rights side and detailed the distance staff should show them objects of reference from to maximise their opportunity to communicate. Care plans in relation to communication reflected how people expressed themselves when they had limited or no verbal communication through the use of gestures, noise and facial expressions. People's preferences as to their communication style were also detailed. For example, 'I prefer one to one communication in a calm manner […] I struggle with sharing attention with others.'

The two team leaders employed had worked at the service for many years and had a comprehensive understanding as to the needs of people. Their knowledge had been made available to all staff through the completion of comprehensive records. These detailed people's life histories, including information on their family, education, working life and key events in their lives. This information had been used to provide bespoke care and support that recognised how people in some instances found it difficult to talk about or celebrate particular events due to their experiences. This was an example of how caring and positive relationships had been developed through staff having a good understanding of the past experiences of the people they supported.

A visiting family member spoke to us of the impact the care and support provided by staff had had on their relative. They told us, "I have been kept fully informed about [person's] care, and have attended health care appointments when I can. The attitude of staff is both helpful and supportive." They went onto say, "[Person's] cognitive skills have improved, they are able to converse and string sentences together."

We spoke with a second visiting family member and a health care professional who were at the service to discuss a specific aspect of a person's care. The family member told us they regularly visited and were actively involved in their relative's care.

People's records contained information about people's lives prior to their moving into the service, which included information about their relatives and friends, as well as information as to their hobbies and interests. This information was used to develop care plans to support people's likes and dislikes For example, a person who attended church regularly, continued to do so to maintain their previous links of friendship and support.

People's plans of care were personalised in that they were specific to the person's needs and in some instances signed by the person. People's care plans provided clear guidance for staff as to the views of people and how they wished their care to be provided. For example, one person's records stated 'I like a hot water bottle at night to be filled by staff'.

Staff told us contact with people's relatives and friends was promoted, with relatives visiting the service and people from the service going to relative's homes. This was confirmed by some people who told us they went out with a friend or to the hairdressers or shopping. People were also supported to develop relationships with people to meet their social needs, with the support of staff, for example through attending clubs and events for people with similar lifestyles and experiences.

People's records contained information as to who was important in their lives, which included family and friends. People's diversity was celebrated by sharing information as to people's attributes and personalities. This type of information helped to ensure staff knew the people they supported and were able to provide them with a caring service.

Good

Is the service responsive?

Our findings

On the afternoon of the second day of our visit we saw people taking part in a karaoke facilitated by an external company. We saw and heard people taking it in turns to sing along, supported by staff who danced with people. People seemed to enjoy this activity.

A person told us they were looking forward to the day trip to Skegness later in the year. The minutes of meetings involving people using the service recorded that people had been involved in discussions as to day trips they wished to take part in. Staff told us how they were supporting a person who had expressed a wish to go on holiday by themselves, staff were talking with them and health and social care professionals involved in the person's care to see how the person could be supported to do this.

A family member told us they took their relative shopping and that they enjoyed being involved in cooking. A person using the service told us they enjoyed colouring and taking part in art activities.

The involvement of people in the assessment and development of their care had improved, which meant the support they received had greater emphasis on them as an individual. People's care plans were individualised and reflected the promotion of their independence whilst celebrating their individuality and diversity. For example, one person's care plan reflected how they were managing specific aspects of their own medicine. Whilst other people had been encouraged to improve their independence skills by using the rehabilitation kitchen to make snacks for themselves or cakes to share with everyone. A person's care plan detailed how the person's independence was to be supported by making it clear what the person could do for themselves and the areas they needed support in. For example, 'if you give me my clean laundry to put away I will just put in on my table in my room or on my bed. You need to ask me to put away the clothes with you. Ask me where I would like to put my things and you will need to hang clothes in my wardrobe for me as I struggle to do this.'

People's care plans provided guidance as to how staff needed to respond to any changing needs people had. For example, where a person became 'low' in mood, additional checks were to be carried out by staff to ensure the person was safe, along with guidance for staff on how to encourage the person to take part in activities to improve their sense of well-being.

People's care plans were signed by them and were regularly reviewed with their involvement. A member of staff undertook a four weekly summary of a person's individual care plans, which provided a brief but clear overview as to the person, highlighting any changes in the person's well-being and any actions taken. For example, the involvement of health and social care professionals. The four weekly review also celebrated people's achievements, for example their involvement in daily household tasks, such as baking, setting the tables for meals or doing their laundry.

People's views about the service were listened to and acted upon. For example, within the minutes of meetings of people using the service, it had been requested that a rotary clothes line be purchased and a television made available in the dining room. The points raised had been acted upon.

People we spoke with said they were confident to raise concerns with the staff and a relative of a person using the service said that the provider was approachable and open to their views. Information about raising concerns was displayed within the entrance foyer of the service. The complaints policy and procedure was discussed at the meetings attended by those living at The Villas to raise their awareness on how to raise concerns. The registered manager told us that they had received one complaint within the last 12 months. The complaint had been recorded and investigated and the complainant had received a written response as to the outcome.

Requires Improvement

Is the service well-led?

Our findings

The registered manager's commitment to improving the service was evident as we saw improvements in documentation which reflected people's care and support. Staff had accessed a range of training, which had had a positive impact on people's rights and choices being supported and the effective use of the Mental Capacity Act in ensuring this. However further improvements were needed to ensure policies and procedures were embedded in the day to day management of the service, which included the recruitment policy and procedure of staff. The nominated individual and registered manager fully acknowledged the shortfall in the recruitment of some staff and confirmed lessons had been learnt, which would ensure the recruitment of staff would in future be robust.

We found external stakeholders had identified areas for improvement, these included Derbyshire Fire and Rescue Service and commissioners for health and social care. The nominated individual and registered manager shared an action plan, written by representatives from the Clinical Commissioning Group (CCG) and the brokerage team of Derby City following a visit they had undertaken of the service. The nominated individual and registered manager told us they were working to bring about the improvements detailed in the action plans.

The registered manager, supported by nursing and non-nursing staff, audited people's records as part of their commitment to quality assurance, to ensure people's care and support was being provided in a way that was consistent with their care plans and risk assessments. Audits were undertaken on a range of topics related to equipment and health and safety to ensure any shortfalls were acted upon to bring about improvement. Audits of the environment noted on-going improvements were required, some of which had been completed. We identified areas for improvements to the premises during our inspection visit when we walked around the service with the registered manager. These included potential trip hazards in a corridor and the flooring between a bedroom and en-suite. We also found a bedroom which did not have any curtains, and a further bedroom, where the curtains were too short for the window. The registered manager noted these and informed the nominated individual.

A person responsible for the maintenance of the service was on site and issues were reported and documented, to evidence the work required and when it was to be completed. We found some environmental improvements had taken place since our previous inspection of October 2016, which included the refurbishment of some communal toilets, bathrooms and en-suite facilities. Further improvements were planned, which included a walk in wet room, to better meet the needs of people with mobility difficulties by improving accessibility.

There was a clear management structure in place which included the nominated individual, registered manager and two team leaders. Since our previous inspection a part-time administrator had been appointed to assist the registered manager. The nominated individual regularly visited the service to meet with staff and those using the service. Meetings involving the management team and staff regularly took place and were used as an opportunity to reflect on the service being provided. For example, training had been provided following staff comments that had equipped them with the knowledge to fully document

people's care and support within personalised care plans. This evidenced good management and leadership by the use of a collaborative and inclusive approach to bring about improvement.

We saw that all conditions of registration with the CQC were being met and statutory notifications had been sent to the CQC when required. The PIR that had been submitted reflected on the improvements that had taken place. Areas for further improvement had been identified, and included the on-going refurbishment of the service. Other areas for improvement focused on further developments in the support provided to people using the service. These included the introduction of a commitment to promote people's independence and the introduction of a recognised tool that staff could use to assess and support people in identifying and achieving their goals and aspirations.

People using the service, their family members and external stakeholders were provided with opportunities to comment on the service. We looked at surveys completed by people and relatives who had made positive comments about The Villas Care Homes. In some instances additional comments had been included, for example, 'Staff are very caring and helpful. There is a real sense of homeliness here.' 'I have noticed changes and progress, improving the care home.' And, 'We are most grateful for the help and care [person's name] receives, it's most reassuring, thank you.'

The PIR highlighted positive feedback the registered manager and staff had received from health and social care professionals.

An external stakeholder informed us they had noted improvements since the appointment of the registered manager in the quality of the service, its delivery and organisational paperwork, including the records of people who use the service. They said that additional improvements were required, but had confidence that with the current registered manager in post these would be addressed.