Rose Villa Care Home Limited

Rose Villa Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

Rose Villa Nursing Home is registered to provide accommodation for a maximum of 36 people who need nursing care, some of whom may be living with dementia. It also provides an intermediate care service (ICS) for those people whose admission to hospital may be prevented by receipt of additional care and also to facilitate an early discharge from hospital. The people who used the ICS had access to hospital doctors and consultants, therapists and nurses to provide assessment, treatment and rehabilitation.

Rose Villa is located in a residential area, on a main road that leads into the city centre. There is good access to public transport, local facilities and amenities. The service is located over three floors and has a selection of bedrooms for single and shared occupancy. There is a large communal room on the ground floor which is divided into three distinct areas; two sitting room areas and one for dining in. There is a selection of bathrooms and toilets on each floor.

The service had a manager in post as required by a condition of registration with the Care Quality Commission (CQC). A registered manager is a person who has registered with CQC 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.

We undertook this unannounced inspection on the 27 July 2016 in response to concerns raised by a member of the local safeguarding adult's team and we focussed on specific areas. At the last inspection in March 2015, the service was rated as 'Good' in all five domains of Safe, Effective, Caring, Responsive and Well-led. As we have not completed a full inspection, we have not changed the overall rating for the service. However, we have changed the ratings in the three domains assessed which were Safe, Responsive and Well-led, from 'Good' to 'Requires Improvement'. We will be monitoring the service and completing a further inspection to check on progress with the areas of concern we found on the day.

At the time of the inspection there were a total of 17 people who lived in Rose Villa and 15 people who used the ICS.

We found people had not always received their medicines as prescribed. There was also an issue with recording of medicines which made it difficult to assess if people had been given them or had them applied such as creams and ointments. There was a lack of guidance for staff when people were prescribed medicines 'as required'.

We found some areas of the environment such as sluice rooms, linen rooms and store cupboards required cleaning and tidying to ensure good infection prevention and control.

The shortfalls in medicines management and infection prevention and control meant we had concerns in these areas. You can see what action we have asked the registered provider to take at the back of the full

version of this report.

The CQC had not received all notifications for incidents which affected the safety and wellbeing of people who used the service as required by registration regulations. This had been a misunderstanding by the registered provider and registered manager and they told us they would forward all required notifications in future. We have written to the registered provider to remind them of their responsibilities in this area.

We found there was a quality assurance system in place which consisted of audits and seeking people's views. However, the shortfalls in quality monitoring and checking that up to date and accurate records were in place for people who used the service, meant we had concerns in these areas. The registered manager told us they would review some of the audits in place to make sure they were more robust and enabled a thorough check of the environment and records. You can see what action we have asked the registered provider to take at the back of the full version of this report.

People gave us positive comments about the care provided to them. Some shortfalls in person-centred care planning and risk assessment documentation, and on some occasions the delivery of individualised care was mentioned to the registered manager to address with staff.

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.

People had not always received their medicines as prescribed and there was a shortfall in recording which made it difficult to assess if topical medicines had been applied to them such as creams, ointments and eye products.

There were areas of the service which required cleaning and systems putting in place to ensure good infection prevention and control.

We have changed the rating of this domain from 'Good' to 'Requires Improvement' and will follow up these concerns with another inspection.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People who used the service told us they were happy with the care they received from staff although we observed some aspects of the delivery of person-centred care could be improved.

The care plans and assessments for people who lived in Rose Villa contained more person-centred information and guidance for staff in how to provide individualised care than for those people admitted into the intermediate care service. The registered manager is to speak to staff about care delivery and produce more personalised information for these people.

We have changed the rating of this domain from 'Good' to 'Requires Improvement' and will follow up these concerns with another inspection.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a quality monitoring system in place; however, this had not been sufficiently robust in identifying shortfalls in the

environment, infection prevention and control and records.

Some records had not been accurately maintained and updated which meant there was the risk important care could be overlooked.

We have changed the rating of this domain from 'Good' to 'Requires Improvement' and will follow up these concerns with another 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 focussed inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the quality of the service in specific areas such as the management of medicines and care practices.

This inspection took place on 27 July 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Prior to the inspection, we checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection we also spoke with the local authority safeguarding team as concerns had been raised with them about the management of medicines and two specific care practice issues.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at lunchtime. We spoke with five people who used the service and one relative. We spoke with the registered manager and the overall general manager.

We looked at four care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as everyone's medication administration records [MARs], accident reports and monitoring charts for food, fluid, weights and pressure relief.

We looked at a selection of documentation relating to the management and running of the service such as quality assurance audits. We completed a full tour of the environment and checked bedrooms, bathrooms and toilets, communal areas, the laundry, storerooms and the sluice rooms.

Requires Improvement

Is the service safe?

Our findings

People told us they felt secure in the service and their surroundings were clean. Comments included, "It's been alright, yes I felt safe", "Yes, they look after me", "Oh yes, I feel safe", "Well, it's quite pleasant living here" and "It's always clean and if you use a commode, it's emptied straight away."

During the inspection, we looked at how people's medication was managed. There were separate files for people who lived in Rose Villa and for those who used the intermediate care service. We saw some people's medicines had not been administered as prescribed. For example, according to one person's medication administration record (MAR), they had a medicine prescribed weekly, which they had declined when offered to them on one occasion. There was no record staff returned later in the day or the next day to offer the medicine again. The day following the inspection, we were informed by a relative that their family member had not received a specific medicine for 20 days; although the person had not experienced any ill effects, they were seen by a consultant and their medication adjusted. There were large gaps in the application recording of one person's eye ointment, another person's aperient and eye drops and several people's creams and ointments; it was difficult to establish if these were recording or administration errors. We saw some people had duplicate MARs which made it confusing for staff and was a potential for errors. For example, on three people's MARs, we saw staff had signed twice for the same items; again it was difficult to establish if this was an administration or recording error.

A concern had been raised regarding pressure area care for one person and a health professional had requested a barrier cream to be applied to them a set number of times per day. The person was, on occasions, non-compliant with the prescribed regime; however, it was difficult to check this because staff did not always record when the cream had been applied, offered or refused. We checked the person's monitoring charts, daily notes and MARs which confirmed this lack of recording.

There were also recording issues such as a lack of protocols for medicines prescribed, 'when required' or which had a variable dose; these would give staff clear instructions as to the specific number of tablets or sachets to give the person and the length of time between doses. Staff had handwritten some instructions on MARs but omitted important information and there was no counter signature as a checking mechanism. On some occasions, medicines had not been signed in as received into the service and amounts had not been always been carried forward to the next MAR. There was one occasion when the dates on one person's MAR were obscured; instead of obtaining a new MAR at the start of the next month, staff had hand written dates on the boxes below which were not designed for that purpose.

Medicines were stored in trolleys secured to the walls on one of the corridors. There was a thermometer in the trolleys to ensure medicines were stored at the correct temperature. Medicines requiring alternative storage were held in a locked fridge or specially secure cabinets. We saw the registered manager had contacted people's GPs to check what medicines could be used as part of 'homely remedies' and these were clearly stated in their records.

Not ensuring people received medicines as prescribed as a breach of Regulation 12 (g) of the Health and

Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the registered provider to take at the back of this report.

We completed a tour of the environment and found some areas of concern which could potentially impact on infection prevention and control. For example, on the ground floor, a store cupboard used by nurses had a three tier plastic drawer system which held shelf-limited items for suction machines and oxygen cylinders. The drawers were dirty, one had damp paper towels in it and some items were out of date; other shelves in the store cupboard were untidy and a blood monitoring machine had two used cotton wool balls inside. A second store cupboard held large stocks of food supplements, some of which belonged to people who had left the service or who had died. A third store cupboard on the second floor was full of stock items which also had a shelf limit; there was no system of checking and rotating these items and some were out of date.

The linen room was too small for the amount of stock and we saw some towels were thin and frayed; some pillows were lumpy and would be uncomfortable to use. There was a hole in ceiling with electrical wires expose and dust could contaminate clean linen. In the laundry, one washing machine had sheets and clothes in a wash together, despite a note for staff stating these items should be washed separately to avoid contamination. In the sluice room on the ground floor, commode pans had not been washed properly and the floor at the side and back was wet and dirty. The sluice machine on the second floor needed descaling. We saw some wheelchairs needed cleaning.

We saw towelling hand towels in addition to paper towels in one of the communal toilets which could pose a risk of infection when used by several people during the course of a day. We also noted two pedal bins in toilets were broken which meant staff were unable to operate them by foot to avoid hand contact. There was a box of items in one person's bedroom which needed sorting and cleaning.

There were also some other issues mentioned to the registered manager that required addressing. These referred to missing bed rail protectors, lightweight wardrobes not secured to walls, no window restrictor on one person's bedroom window, no lock on one of the shower room doors and some, bedside lockers with melamine exposed which made them difficult to clean.

The registered manager accompanied us on the tour of the building and made a note of these issues so they could be addressed quickly.

Not ensuring a system for good infection prevention and control was a breach of Regulation 12 (h) of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the registered provider to take at the back of this report.

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy with the care received although one person described a moving and handling incident which could have been managed in a more appropriate way. This was mentioned to the registered manager to discuss with the intermediate care service (ICS). They also told us not all staff knew how to look after their needs properly and said, "Some of the night carers don't know what to do. They don't draw the blinds and couldn't put me in bed properly."

Positive comments from people who used the service included, "They do look after us although they haven't a lot of time; they are busy but you can't say you are neglected", "Yes, they are kind and caring" and "[Staff name] is wonderful and will go out and get you some shopping", "You can have a shower if you ask the day before", "They put the buzzer where you can reach it", "They find out how you like things; they found out how I liked my pillows", "I am always asked when I want to go to bed", "The food is very good; we get a jug of orange or lemon and we get plenty of cups of tea or coffee after every meal", "They bring me a cup of tea in the night" and "You can have hot chocolate if you want one."

People told us staff supported them to be as independent as possible. They said, "They will only do what you want them to do and they will say 'are you alright with me doing this' and 'can you do this yourself'", "My clothes are always kept clean; they bring me a bowl of water and I can wash myself", "They help me with things I can't do for myself like helping me to wash every morning" and "They encourage me and will say 'you can do it, you just have to keep at it'."

People told us they would feel able to complain if required. They said, "There are certain staff I would feel comfortable talking to" and "I have no complaints whatsoever."

People told us they would like to see more activities and on the day of inspection, there was little to engage people other than the television. Comments included, "We just sit here all day. We had some singers come and this man played the organ and the physio comes" and "There are only the two televisions to watch." The people who used the ICS sat together and some chatted sociably with each other and were able to occupy themselves. We observed one member of staff promised to take a person into the garden in a wheelchair when they had completed a task; they kept their promise and made sure the person got some fresh air which they enjoyed.

We looked at a selection of care files for people who lived in Rose Villa and also for people who used the ICS. For the people who lived in Rose Villa, there was an assessment of their needs, risk assessments and staff had developed care plans which included lots of personalised information. We saw risk assessments were completed but did not always contain sufficient information to guide staff in minimising risk. For people who used the ICS, the assessments and care plans were developed and prescribed by the intermediate care team, which consisted of nurses and therapists. The staff within Rose Villa delivered the care in conjunction with the therapists. However, these care plans were basic and focussed on the tasks to be carried out; there was little personalised information about how staff were to deliver care in the way people preferred. We spoke with the registered manager about enhancing these care plans with information about people's usual

routines, their likes and dislikes and what was important to them. This could be completed with the person and their relatives during the first days of admission when staff were getting to know people. One visitor of a person who used the ICS told us staff had not asked them any information about their relative. They went on to say the person had recently lost their pet dog and this would have a huge impact on them; this information could have been gathered at the initial stages of admission. The registered manager told us they would address this shortfall in information gathering.

During observations in the main sitting room, we saw some people's personalised care could be improved. For example, one person did not receive appropriate pressure relief. Although the person had not developed any pressure ulcers, they were at risk and timeliness of pressure relief was important. We saw staff supported the person to eat their lunch but there was little encouragement and engagement from staff during the meal. They had information in their care file from a recent health professional which stated they were able to feed themselves if sat up in a chair. We observed the person was sat up but was fully assisted by staff at lunchtime and not offered the opportunity to feed themselves.

We observed people were not asked if they wanted to use the dining tables at lunchtime. A visitor told us they had to ask staff to support their relative to the dining table so mealtimes could be a social occasion for them, however as other people were not asked or encouraged to use the dining table, the meal was an isolated occasion for them. One person who used the service said, "The food is good but no, we are not asked to use the dining tables." There had also been an occasion when a person had been dressed in clothes and spectacles which were not their own; this was addressed with the registered manager by the person's relative.

We also noted that in the ICS sitting room, there was only one system for people to call for assistance. This was reliant on one person who used the service noticing someone needed assistance and ringing the bell. There were no call bells within reach at the other end of the room; we saw people in these seats often required assistance. During the inspection, there were occasions when people asked the inspectors to call for help for them and there was one occasion when a person rang for assistance and it was 10 minutes before staff noticed, despite a number of staff passing the person seated in the dining area.

The above points were mentioned to the registered manager to address with staff.

Requires Improvement

Is the service well-led?

Our findings

People who used the service said they felt able to raise concerns with the registered manager.

During the preparation for the inspection, we checked our system for notifications of incidents which affected the safety and welfare of people who used the service. We found we had received outcomes from five investigations completed by the registered manager at the request of the local safeguarding team; the outcomes had been sent to us from the local authority but notifications of the incidents had not been sent in by the registered provider and registered manager. The registered manager told us this had been an error and in future the Care Quality Commission (CQC) will be notified all safeguarding incidents when they occur. It is important we receive notifications for these incidents so we can monitor the amount of them and check with the registered manager how they are addressing them. We found the registered manager had sent in appropriate notifications when people who used the service had died.

Lack of notifications of incidents which affect the safety and welfare of people who use the service is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. On this occasion we have written to the registered provider reminding them of their responsibility regarding notifications to CQC.

We found there was a quality monitoring system in place which included audits on the environment, medicines management and documentation. There were cleaning schedules and maintenance checks. However, in light of the findings during the inspection, the audits had not been sufficiently robust to highlight shortfalls so that action could be taken to address them.

Not ensuring a system was in place to routinely check the environment, medicines management and care files in a more robust way was a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the registered provider to take at the back of this report.

We looked at the care files and other documentation for four people and found gaps in recording. People had monitoring charts for food and fluid intake, pressure relief and weight recording. We found inconsistencies in some of the monitoring charts. For example, checks of the continence records for one person between 8 and 25 July 2016 showed large gaps in recording and an absence of any record on two of the days; recording varied from between once a day to six times a day. The person's assessment completed on 9 July 2016 stated their continence aids were to be checked hourly and the person was to be kept clean and dry. We found an instance when there was no recorded check for seven and a half hours. It was difficult to check if the person had received attention and it had just not been recorded. There were similar gaps in recording of nutritional and fluid intake, balancing fluid intake and output and the application of creams.

There were recording gaps in medication administration records (MARs) so it was difficult to audit if people had consistently had their medicines as prescribed. There were also times when records indicated three people had been administered specific medicines twice. The registered manager assured us the discrepancy

was a recording issue due to duplication on the MARs.

For people who used the intermediate care service (ICS), there was very little information recorded about their likes, dislikes and preferences for care. This meant staff may not have a full and up to date picture of people's individual needs and how they preferred to be cared for.

We saw a 'do not attempt cardiopulmonary resuscitation' (DNACPR) form for one person had not been reviewed at the date requested, which meant the form was out of date and not valid. This meant that should the person have a medical emergency, their current wishes may not be respected.

One person had a catheter insitu but there was no plan to guide staff in how to support the person with catheter care.

People had risk assessments for areas such as falls, nutrition, skin integrity and moving and handling. However, these did not consistently record the control measures staff would need to be aware of. For example, one person had sustained numerous falls and a risk assessment was in place which indicated they were at high risk but did not highlight the measures taken and put in place to minimise risk. Also personal emergency evacuation plans did not include full information about how people need to be supported when exiting the building in an emergency.

Not having accurate and up to date records is a breach of regulation 17 (2) (c) of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 and could mean important care may be overlooked. You can see what action we have asked the registered provider to take at the back of this report.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured safe care and treatment by the proper and safe management of medicines. Some people had not received their medicines as prescribed. Also assessing the risk of, and preventing, detecting and controlling the spread of infections was not sufficiently robust. Sluice rooms, linen rooms and store cupboards required cleaning and tidying and systems put in place to ensure stock rotation of shelf limited items. Regulation 12 (2) (g) and (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not developed robust systems that monitored the quality of the service including the environment, medication and care documentation. Accurate, complete and contemporaneous records of the care and treatment provided to service users was not consistently in place. Regulation 17 (1) (2) (a) (b) (c)