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

Summary of findings

Overall summary

Rose Villa is located on one of the main roads leading into the city of Hull. There is good access to public transport plus local facilities and amenities. The service is registered to provide care for up to 36 people who need nursing care and some of whom may be living with dementia. It also provides an intermediate care service to help prevent hospital admissions and to facilitate early discharge from hospital. A team of therapists, nurses and a hospital consultant provide on-going support to people admitted to the intermediate care service.

Rose Villa has a mixture of shared bedrooms and those for single occupancy; there is a passenger lift to the three floors. There is a large sitting room divided into separate areas to facilitate seated areas, a small dining area and a quieter space in the conservatory at one end. The service has a range of bathrooms, showers and toilets on each floor. At the time of the inspection, there were 13 people living in Rose Villa and 19 people receiving an intermediate care service.

The service had 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 last full comprehensive inspection was completed in March 2015 and the service was rated as 'Good'. We carried out a focussed inspection in July 2016, as there had been some concerns raised with us. We found concerns with cleanliness in parts of the service, management of infection prevention and control and the management of medicines. We found the quality monitoring systems had not picked up these issues. We didn't change the overall rating of the service as we did not complete a full comprehensive inspection, but we did rate the service as 'Requires Improvement' in the three areas we looked at which were Safe, Responsive and Well-led and we planned to re-inspect in six months.

At this full comprehensive inspection, we found improvements had been made regarding cleanliness, infection prevention and control, the management of medicines and aspects of the monitoring system that oversaw these areas. However, when we looked at the full quality monitoring system we found some areas had not been wholly effective in highlighting areas for improvement and there lacked action planning to address issues that had been identified.

We found there was a lack of understanding about the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and how these can impact on staff practices in relation to obtaining consent and making decisions in people's best interest. There was one person whose liberty was deprived but this had not been recognised and actioned appropriately. This meant the registered provider was not acting within the law.

We had some concerns with the management of risk and not all areas of risk had been identified. For

example, some people told us their bedrooms were cold; there were portable heaters used and one in the lounge was very hot to touch. The bedroom doors upstairs were wedged open as there were no fire door stops. Some extension leads had multiple plugs in them. Disposable gloves were not always made inaccessible. Some people lacked a current risk assessment with control measures to guide staff in how to minimise risk.

You can see what action we have asked the registered provider to take, regarding the above concerns, at the back of the full version of the report.

We found there were some activities taking place but some people told us they would like to do more. There was no programme of events and we didn't see any activities during the two days of the inspection. The person designated the role of activity coordinator was new to the role, had limited information and had not completed any training. We made a recommendation about this.

We saw people had assessments of their needs prior to admission and plans of care to guide staff in how to support them. Some assessments and care plans were detailed but others had generic information which made them confusing. We made a recommendation about reviewing the generic sections of the care plans.

We saw staff were recruited safely and there was sufficient staff on duty to meet people's needs. The registered manager told us they would check out a comment about waiting times for buzzers to ensure people were not waiting excessive amounts of time for staff to attend them.

People received their medicines as prescribed and their health needs were met. Staff referred people to community health care professionals when required and in a timely way.

People liked the meals provided and their nutritional needs were met. There were choices and alternatives on the menus and action was taken to refer people to dieticians or speech and language therapists when required.

We saw staff had a kind approach and there were positive interactions between them and people who used the service. We observed staff promoting privacy and confidentiality.

There was a complaints procedure on display and people told us they felt able to complain.

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.

There were some concerns with highlighting risk and managing this in a timely way so that people's safety, health and wellbeing were promoted.

Since the last focussed inspection, there had been improvements in the management of medicines. People received their medicines as prescribed.

Since the last focussed inspection, there had been improvements in the cleanliness of the parts of the environment and management of infection prevention and control.

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

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was a lack of understanding regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which had led to the registered provider not acting within the law and to staff being unsure of how to manage a difficult health care and consent situation.

People's health and nutritional needs were met. Staff referred people to community healthcare professionals as required and in a timely way.

Staff had access to training, support and supervision. Some gaps in refresher training had been identified and arranged by the registered manager.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives told us staff had a caring approach.

We observed staff supporting people in a kind and patient way and they respected people's privacy.

Confidentiality was maintained. Conversations were held in private and personal records held securely.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff knew people's needs well and how to support them. However, there was an inconsistency regarding the information and detail in care plans which in part was due to the generic nature of them. We have made a recommendation about this.

There were some activities provided for people but there was no structure, no assessments of people's ability to participate and limited information and training for the person designated to carry out activities. We have made a recommendation about this.

There was a complaints process and people felt able to complain to the registered manager or general manager. The complaints process identified timescales for resolving complaints and how to escalate them.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a quality monitoring system but this had not been wholly effective when action plans were needed to check out areas to improve, to assist learning and to improve practice.

There was an open culture and staff told us management was supportive and they felt able to raise issues.

Rose Villa Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 and 5 January 2017 and was unannounced. The inspection team consisted of two adult social care inspector and an Expert by Experience [ExE] on the first day and one adult social care inspector on the second day. An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

The registered provider had not yet been asked to complete a Provider Information Return (PIR) this year. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. However, 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 spoke with local authority safeguarding, contracts and commissioning teams about their views of the service. We also spoke with staff from the intermediate care service and continuing health teams.

During the inspection, we observed how staff interacted with people who used the service throughout the days and at mealtimes. We spoke with 10 people who used the service and eleven people who were visiting their relatives. We spoke with the registered manager, one nurse, one nursing assistant, three care workers, the activity co-ordinator/carer, a cook and two domestic staff, one of whom worked in the laundry.

We looked at seven 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 16 medication administration records (MARs) and monitoring charts for food, fluid, weights, pressure relief and bathing. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their

behalf.

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

Requires Improvement

Is the service safe?

Our findings

At the last focussed inspection in July 2016 we had concerns about people not receiving their medicines as prescribed. At this inspection, we found improvements had been made and people received their medicines as prescribed. Medicines were ordered, stored appropriately and disposed of safely when no longer required. We observed part of a medication round and saw that medicines were administered safely. One person told us, "They stand with you while you take your tablets." We noted some minor recording issues which were addressed with the registered manager during the inspection.

Also at the last focussed inspection, we had concerns about infection prevention and control (IPC). At this inspection we found improvements had been made. The registered manager provided us with a copy of an infection control audit and subsequent action plan that had been created following an audit completed by an IPC specialist nurse. The audit showed the service had achieved a total rating of 95% and confirmed appropriate action had been taken to rectify all of the issues that were identified in a timely way. We completed a tour of the premises and found the service to be clean and free from unpleasant odours. Staff wore personal protective equipment when required and were observed to follow safe hand hygiene techniques. There were some minor infection control issues found during the inspection, which were addressed on the day with the registered manager. During the writing of this report, we received a complaint about hand hygiene practices and have asked the registered manager to address this with staff.

We found some concerns with risk management in the environment which had the potential to impact on the safety and wellbeing of people who used the service. For example, during the inspection, we found some of the bedrooms upstairs were cold and some people confirmed this in discussions with them. Some comments from people about bedrooms being cold at times included, "I share a bedroom, its freezing cold", "My bedroom is cold sometimes" and "It's always cold in here and my diabetes affects me." We checked and the radiators were working but the heat they gave off may not be sufficient for some people. We saw some people had portable electric heaters and were offered blankets for their legs. There was one portable heater in the lounge which was very hot to touch. Following the inspection, we received two complaints regarding specific bedrooms being cold and also two concerns about overloaded extension leads and one concern about a portable heater; we addressed these concerns with the general manager and they reported the heater had been checked and was safe to use. Following the inspection, we were told a new heating system had been agreed and was due to be installed in April 2017 when warmer weather arrived. In the meantime, the registered manager has purchased thermometers for each bedroom so the temperature can be monitored closely. They also contacted a heating engineer who confirmed there was no issue with heating in a specific bedroom.

The bedroom doors on the ground floor were held open by a magnetic system linked to the fire alarm so they would automatically close if the fire alarm sounded. The registered manager confirmed that the doors upstairs were not linked to the fire alarm and we saw that a number of doors were propped open with items such as waste bins and side tables. This posed a fire risk as the doors would not close if the fire alarm sounded and if the fire started upstairs the amount of time it would take the fire to spread would be significantly reduced. The registered manager said, "I know we need to get the upstairs linked to the fire

system but I am restricted by the budget I have."

We saw one person who used the service had exited the building via one of the fire doors. This had occurred a few weeks before the inspection but when we checked their records, there was no risk assessment in place to guide staff in how to minimise the risk of this reoccurring. We saw the registered manager had completed other risk assessments for people in areas such as falls, moving and handling, nutrition and hydration, constipation and skin integrity. However, we saw these did not always provide sufficient guidance to staff in how to minimise risk and there had been times when they had not been completed in a timely way. For example, in one care file we looked at, the risk assessment indicated the person was at risk of dehydration and staff were to encourage fluids and balance fluid input and urine output. We saw there was no optimum level identified for staff to aim for on the risk assessment, care plan and fluid monitoring charts, and fluid input and urine output was not balanced properly. The same person was admitted with complex needs but the risk assessments were not completed until two weeks after admission. There were also a number of people who required updated information in their personal emergency evacuation plans.

At the last inspection, the registered manager agreed to store disposable gloves in the lockable nursing cupboard to ensure the people who used the service did not have access to them. However, we noted that a box of disposable gloves was left in a communal shower room on the ground floor; this posed a risk to people who may be living with dementia.

During visiting time, which is organised in the afternoon as people using the intermediate care service have therapy in the mornings, there is an influx of visitors. We saw this had the potential to affect the safety of people at one end of the lounge; there was insufficient space for people sitting in the chairs to get up and walk safely with their frames. This needs to be managed more effectively.

Not ensuring risk was assessed and managed effectively was a breach of regulation 12 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 the report.

People who used the service told us they felt safe living there. Comments included, "The staff look after me; safe, yes, I agree with you there", "Yes, it is a safe environment", "I'm diabetic; I get my blood sugars monitored and the staff do my medications. The staff know what they're doing, yeah. I couldn't feel happier here" and "I self-medicate and the staff just keep an eye on me."

Relatives stated, "Mums perfectly alright here; the nurse came yesterday",

A health professional said, "The service is safe although it appears a bit chaotic at times." Three other health professionals said they thought the service was safe.

Equipment used in the service was maintained to ensure it was safe to use.

We found staff were recruited safely and employment checks were carried out prior to them starting work in the service. These included the completion of application forms so gaps in employment could be explored, an interview, references and a disclosure and barring (DBS) check. The general manager responsible for recruitment records told us, "We always try and get two references; sometimes other companies don't want to give them or this is the person's first job but we always do our best" and "When we do only get one we monitor the staff closely just to be sure." The registered manager told us, "New staff get an induction and shadow other staff; they are not part of the numbers until I think they have developed the skills they need." We saw there were agency staff employed to cover any short notice absences. The general manager told us,

"We only use one agency and the contact we have has assured me that they do all the relevant checks and make sure people are fully trained before they send them to us."

The general manager received a profile of agency staff and their skills and experience. They told us they would ensure they obtained copies of training records along with the profile of agency staff to evidence this has been carried out. This would ensure people who used the service were not exposed to the risk of being supported by staff who were not trained to the correct standards.

Staff had received safeguarding training; they knew the different types of abuse, the signs and symptoms which may alert them to specific issues and who to report concerns to. The registered manager contacted the safeguarding team for advice when required and completed appropriate documentation when asked to do so.

Staff rotas showed there were one nurse and five care staff from 7am to 7pm and one nurse and three care staff at night, 7pm until 7am; there was handover time built into the shift patterns. The registered manager told us there was an additional nurse two days a week to support during multi-disciplinary meetings. There was a range of ancillary staff such as a cook, a maintenance person, two domestics and a laundry worker each day. This helped to ensure care staff were not occupied with other duties and could focus on delivering the care and support people required. People who used the service said, "There seems to be enough day staff. If I use my buzzer they come as quick as they can; it depends what's happening" and "If I press my buzzer they come and make sure I'm alright." We observed one person had to wait just over 20 minutes before staff were able to take them to the toilet. This was mentioned to the registered manager to check out. The registered manager told us there was an additional member of staff deployed to ensure a presence was maintained in the main lounge from 8am to 6pm and to support people to take part in various activities. However, there were times when this member of staff was absent from the lounge as they supported people to go to the toilet or to their bedrooms.

When we asked staff about the staffing levels in the service, we received a mixed response. One member of staff said, "Sometimes we are short staffed, if someone rings in sick we don't always get cover." A second member of staff told us, "I think we do have enough staff, we have busy periods but we always manage. We have enough staff to meet everyone's needs." Other staff commented, "The staffing levels are pretty good", "Yes, we have enough" and "Sometimes we do and sometimes we don't. Some staff always look busy but don't do a lot."

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found there were three people where the registered manager had made applications to the local authority for DoLS to be authorised. However, we also found that one other person met the criteria for DoLS, and their liberty was being deprived, but this had not been recognised as such. An application for DoLS had not been made which meant the registered provider and registered manager were not acting within MCA legal framework.

We found there was a lack of understanding amongst some staff about MCA, DoLS and gaining consent prior to carrying out treatment. One person, who had been assessed as having capacity to make their own decisions, told us they had declined specific treatment but this had been carried out against their wishes. Despite the person needing the treatment, they had the right to refuse it; staff had not recognised the implications of this action and that they had not acted within the law. We reported this to the local safeguarding team for investigation. Other staff described the alternative ways consent could be taken if people lacked the capacity to make specific decisions themselves. A member of staff commented, "The first thing I do is ask, if the person doesn't have capacity or can't give their consent then we include their families and speak to professionals."

We found there was inconsistency regarding the application of MCA with regards to assessing people's capacity and best interest decision-making. For example, we saw some people had assessments to determine capacity and best interest meetings to make important decisions when they lacked capacity such as the need for nursing care. The registered manager had also completed assessments of capacity and best interest decisions regarding staff carrying out personal care such as bathing and hair washing. However, some people had restrictions such as lap straps, bedrails and sensor mats but these had not been included in decisions about whether they were in place in people's best interest and whether these were the least restrictive option for their safety. This meant some people may be restricted unlawfully.

We saw two people had a capacity assessment but the documents had been completed inaccurately with reference to other people's name recorded on them.

Not ensuring best practice regarding gaining consent and acting in line with MCA principles is a breach of Regulation 11 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 the report.

Following the inspection, the registered manager told us they had adjusted the training plan to include MCA and DoLS refresher training for all staff; this was to be completed in April and May 2017 and the topic to be included in a staff meeting. The registered manager also told us they had developed a much more detailed care plan to give staff clear guidance of what to do if the situation reoccurred.

People were provided with a balanced diet and were supported to eat their meals when required. Each person had a risk assessment and care plan to guide staff in how to support them to maintain their nutrition and hydration needs. We saw staff had made referrals to dieticians and speech and language therapists when required regarding concerns about people's nutritional intake or swallowing difficulties. The cook told us some people who used the service had been put on 'nutrition mission' and described this as them requiring a fortified diet; the cook was clear about what constituted a fortified diet. They also described how they blended foods separately when people required a pureed diet so they had the opportunity to taste individual food items. People's weight was monitored in line with their risk assessment. We did note that one person declined to be weighed and staff had not considered other ways of monitoring their weight such as measuring their arm circumference to check for weight loss. This was mentioned to the registered manager to address.

The menus included two choices at lunch; there was also a vegetarian option at lunchtime. The evening meal consisted of a hot choice, sandwiches or soup. We saw that daily options were written on a chalk board but saw no pictorial menu's that would help people living with dementia to make choices. We saw staff informed people what was on the menu for lunch and the evening meal and recorded their choice; this information was given to the cook. We overheard staff offering alternatives to people who had not eaten their meals and encouraged people to eat, as well as asking them if there was anything specific they wanted to ensure they ate sufficiently. We saw that some people used specialised equipment such as beakers and plate guards to enable them to eat independently and staff offered support when required. People told us they liked the meals prepared for them. Comments included, "Yes, the food is good and there are choices", "The food is always good; it's hot and you get a choice. I had two slices of toast and two cups of tea for breakfast" and "The food is usually very good here; at Christmas we had a three course meal."

People who used the service had their health needs monitored. Records indicated people had access to a range of community health professionals for advice and treatment such as GPs and outpatient consultants, dieticians, specialist nurses, emergency care practitioners, speech and language therapists, opticians, dentists and chiropodists. Staff recorded when health professionals visited and what treatment had been prescribed.

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

Comments from people who used the service about how their health and nutritional needs were met included, "The night staff bring me a cup of tea and sandwiches. My blood sugars get monitored", "I've seen the physio twice since I've been here. I don't see how you couldn't be happy here", "Yes, the staff know what they're doing; I've not got a bad word to say about these nurses, they're great" and "Very well run, very nice. They take notice of what you're saying. If you're in the room and you ask for something, they're here and they pay attention. My buzzer works."

In discussions with staff, they were clear about how they would recognise the signs of people's health

deteriorating and the action they would take, for example if people were developing a chest infection. They accurately described how to prevent pressure ulcers from occurring and how to treat reddened or sore areas. They told us they knew people well and recognised when there was a change in their behaviour. Health professionals said, "The home appears to have a very good relationship with the GP next door and most of the residents are registered there making access to health support rapid", "The home seems competent in managing health issues such as urinary tract infections and referring to the dietician, and following the nutrition mission", "They always contact us if there are any problems" and "Yes, they seem to be effective."

We saw staff had access to induction, training, supervision and appraisal. The training records indicated when courses had been completed. Staff told us they had completed a range of training that equipped them with the skills and abilities to support people effectively but confirmed they had not completed refresher training for extended periods. One member of staff said, "I did all my training years ago; we do updates every now and then but it's been a while since I've had any." Another member of staff commented, "Most of us have an NVQ one or two [a nationally recognised qualification in Health and Social care] and we do have training, but I think I need to do refresher courses in most things." The registered manager said, "Finding the time to do staff training is extremely difficult; we should do mandatory training every year but we are behind." We saw the registered manager had planned and booked refresher training between January and May 2017. The courses included safeguarding, health and safety, dementia care, food hygiene and MCA/DoLS. We saw staff had completed first aid, fire safety and moving and handling training in 2016; some staff had also completed a dementia awareness course, dignity in care, communication and infection prevention and control training.

The registered manager confirmed that the nursing staff were working towards their revalidation and said, "We all use the revalidation tool on the Nursing and Midwifery Council website. No one is due until April but I will check all of their work before then."

Staff told us they felt supported in their roles but confirmed they had not had a supervision meeting recently. One member of staff said, "I can speak to either of the managers anytime and they really listen if we raise anything." Another member of staff told us, "We do have supervisions but I haven't had one for ages, I think it was about August [2016] when I had my last one." Other staff said, "The manager is great, he listens and encourages us to speak to him if we have any problems" and "I get lots of support but we don't have the meetings like we used to do; the person who did them has left and they have stopped." During the inspection, the registered manager showed us a supervision plan which was to start in January 2017 and would ensure care staff had specific meetings so that their roles, responsibilities, training and development needs could be discussed. We saw staff had received an appraisal in 2016.

Good

Is the service caring?

Our findings

People who used the service told us that staff cared for them well and treated them with respect. There was one negative comment from a person who used the service but this has been dealt with in Effective. Comments included, "The staff are nice; they take good care of me. I had a meeting when I came in here and they listened and I was fully involved", "Two staff help me in the bath and one in the shower; they're great. They come up and check on me often", "If I say can I have some toast they get me it. Sometimes they put bacon in it for me but I have to keep it quiet. They always ask how I'm feeling and bring me plenty of drinks," and "Relatives can visit anytime. I can talk to [name of physiotherapist] about anything. Touch wood everything's been perfect. I can have a good banter with staff. I don't mind male carers; they always cover me and respect my privacy."

A relative said, "Yes, the staff seem very good."

Some people who used the intermediate care service told us they did not have a choice about using a shared bedroom. There were currently 19 places for use by the intermediate care service, to facilitate an early discharge from hospital, and it was not always possible for people to access a single bedroom. We saw shared bedrooms had a privacy screen between the beds.

A relative said, "There's no room; when there's lots of visitors you can't move". We asked staff about visiting times because relatives were not happy with how little room there was in the end of the lounge where most people who received intermediate care sat. We observed the congestion and it left very little room to walk about. One person in the inspection team tripped twice on the wheels of walking frames in this area. We saw staff had organised visiting times for the afternoons so that it didn't clash with therapists providing treatment which usually happened in the mornings. This meant there was an influx of visitors between 2 - 4:30pm although staff told us there was flexibility with visiting times. People did have the opportunity to talk to their relatives in their bedroom, but when this was shared it did limit the choices.

Health professionals told us, "The staff appear caring and take into account the residents individual needs, "I am always greeted warmly when I attend and the staff appear friendly. Several of the patients have stated they like it at this home. I cannot remember any family member stating they had concerns", "Staff seem to be positive with patients from my experience on visiting here" and "They give patients choice for example, meals, remaining in their rooms or sitting areas or to participate in activities."

During discussions with staff, it was clear they understood how to support people in a respectful and dignified way. They told us, "I treat everyone in here like they are part of my family; I don't think I can go wrong if I do that", "I always close doors and curtains when I deliver personal care", "I ask people questions, like if they need to go to the toilet, discreetly and never just shout from the other side of the room" and "When I'm getting someone washed and dressed, I do the bottom half and cover them up then do the top so they aren't just stood there."

We completed observations throughout the inspection and saw a member of staff laughing and dancing

with a person who used the service. The member of staff used their knowledge of the person's life history to engage them in a meaningful activity and praised and encouraged the person which clearly had a positive impact on their mood. Whilst we saw some really positive interaction between staff and the people they supported, we saw some areas which could be attended to in a more timely way. For example, one person had food debris on their face but staff hadn't noticed and didn't offer them the opportunity to clean their face. One person had food spillages on their clothes which was noticed after breakfast; they were not assisted to change their clothes until late in the afternoon. Another person had spillages of food on their sleeve following lunch but staff didn't notice. We mentioned these issues to the registered manager so they could ensure staff were more vigilant.

We never saw anybody use the dining tables for lunch or the evening meal and only one person used the tables at breakfast. Staff told us they did ask people whether they wanted to sit at the tables but they preferred to sit in their chairs with a table in front of them. The tables were not set for lunch and the evening meal which may encourage people to eat at them and socialise.

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

Requires Improvement

Is the service responsive?

Our findings

People told us staff responded to their health care needs.

We saw people who received the intermediate care service at Rose Villa had their needs assessed by health professionals prior to admission. The care plans were also produced by the health professionals and care staff within Rose Villa carried out the plan and delivered the care. Therapists wrote the treatment plans for physiotherapy and occupational therapy. We saw these people's care and treatment plans were updated when required and multidisciplinary meetings were held weekly to discuss progress and respond to people's changing needs. Since the last inspection in July 2016, the registered manager had introduced a 'getting to know you form' which was to be completed with people using the intermediate care service and their relatives. This gave staff personal information and preferences for how the person wanted to be cared for whilst they were in the service.

We saw people who lived in Rose Villa had assessments of their needs completed by the registered manager prior to admission and the information was used to formulate care plans. The care plans were held on computers and printed out for staff to read. There was also a care needs summary which gave an overall view or people's needs. We found one person's assessment could contain more information about the impact their condition could have on them. For example, the person's assessment identified they had experienced a stroke. There was no record of how this affected them, whether any limbs had been weakened or paralysed or how the stroke impacted on their mobility, ability to self-care, eat their meals and use the toilet. We saw other people's assessments did have more details included. This information in assessments needs to be consistent for everyone. This was mentioned to the registered manager to address.

The care plans and care needs summary had generic parts to them which could be more person-centred. For example, both documents recorded, 'Ensure [person's name inserted] is offered the facility to brush his teeth and rinse his mouth properly. For those clients with dentures please ensure these are cleaned properly on a daily basis and those clients given the opportunity and encouragement to have a mouth rinse when appropriate'. Neither document recorded whether the person had their own teeth or dentures and what the person's routine was and what they were able to do for themselves. Similarly, in the section on privacy and dignity for the person, the care plan stated, 'Staff must ensure that in shared rooms screening is provided to ensure that [person's name] privacy is not compromised when personal care is being given.' We saw this person did not occupy a shared bedroom. The issues with the generic templates for the care plans and care needs summaries meant that we found incorrect names of people who used the service slotted in to the text. Other assessments and care plans were detailed and the inconsistency was mentioned to the registered manager to address.

We recommend the registered provider and registered manager reviews the use of generic templates for risk assessments and care plans to ensure a more accurate and person-centred focus is consistently applied.

However, in discussions with staff they were able to describe people's needs and knew how to look after them. We saw staff had responded and made referrals to dieticians when people lost weight. They

contacted GPs in a timely way when people became ill. Health professionals told us staff contacted them in a timely way and responded well to people's changing needs. Comments included, "Staff always listen and adapt to patient's needs", "They always contact us if there are any problems" and "Very responsive and keen to inform us of patient's change or progression."

We observed staff responded appropriately when people asked for assistance. They used the correct equipment in a safe way. One person who used the service commented to us on how safe and happy another person looked when they were being moved from their wheelchair to a comfortable chair with the hoist.

The general manager showed us activity sheets which were completed by the member of staff designated to oversee the lounge and complete activities with people. These recorded some activities such as watching television, listening to music or reading magazines but on some days there was little to stimulate people. For example, on Friday 2 December 2016 the record stated people were either in their bedroom or in the lounge; there was no record of any activity. On 6 December 2016, eight people joined in a quiz; other people either remained in their bedrooms or watched television. Some people were recorded as 'chatting'. There were some days when a few people joined in a quiz, a game of dominoes, had their nails 'done' or had 'chair dancing'. There had been carol singers in December and people wrapped Christmas presents and wrote cards. It was recorded when relatives took people out.

We observed two people who lived at Rose Villa were quite happy watching television or reading newspapers but we were unsure if people who preferred to remain in their bedroom required any social stimulation as there was no record any activity for them took place. People said, "We had Christmas carols at Christmas but no activities like bingo or that." We didn't observe any activities during the inspection. There was no structure or timetable for activities and the designated person for activities told us they had not developed one yet. They told us the role was a new one for them and they had not received any training yet but would like to complete some. They said they had completed reminiscence, quizzes and craft work with people who were able to participate.

We recommend the registered provider obtains information about meaningful activities and occupations and how to provide social stimulation to people living with dementia. Also that they source training in meaningful activities and occupations for staff designated to carry out this role.

The registered provider had a complaints policy and procedure, which was on display and included in the service user guide available to people who used the service. The procedure identified how to make a complaint and who to, timescales for resolution and how to escalate to other agencies. People told us they felt able to raise concerns with staff, the registered manager, the general manager or therapists from the intermediate care service. A relative said, "Staff seem approachable. We have not raised anything concerns yet." There was one negative comment from a relative about when an issue was raised; we mentioned this to the registered manager to address. A relative had mentioned a missing hearing aid for three to four days; we checked with the general manager who told us an appointment had been made at the audio clinic for the person to receive a replacement hearing aid.

Requires Improvement

Is the service well-led?

Our findings

At the last focussed inspection in July 2016 we had concerns about the monitoring of the environment and ensuring medication records were accurate. We found improvements in both these areas; additional weekly checks took place on the cleanliness of the environment and infection control practices.

There was a quality assurance system which involved a lot of paperwork with checks and audits, and some of these were effective. For example, there was an annual check of the exterior of the building to look for concerns. There was a monthly check on any health and safety issues, a dignity in care audit, fire safety checks and a recent infection control audit by an external source. The general manager completed a daily walk around to pick up any concerns and to talk to people who used the service. However, at this inspection, we found concerns in how some aspects of the quality of the service was monitored.

Some checks showed limited analysis to enable shortfalls to be identified and at times there was a lack of action plans, for example, when a survey produced results that required investigation or when negative comments were repeatedly raised in meetings. We looked at the minutes of five 'resident and relatives' meetings. The last one being in November 2016. The administrative assistant told us, "We have meetings every six to eight weeks but sometimes no one attends so I try and speak to a few people every month and will speak to relatives when they come in." We saw people who used the service were asked about the care and support they received regularly. In four of the minutes of meetings held in 2016, it was recorded there was an issue with accessibility of buzzers or response times to buzzers. The administrative assistant told us the registered manager reviewed people's feedback and took action accordingly. There was no action plan to look into the call bell issues and address them to improve the level of service provided.

A survey carried out in February 2016 identified five people had rated the support from carers as 'fair'. We saw 'fair' was the next to bottom choice out of four possible ratings. There was no action plan or further investigation to find out why 20% of respondents felt the care was 'fair' and no additional audit a month or so later to see if the score had improved.

Computerised care records were audited to make sure they included documents such as risk assessments, reviews and care plans, however, these checks had not looked at the quality of the documents and had not identified people's incorrect names or missing information.

The registered manager told us they completed an annual nutrition and dining experience, the last one being in February 2016. More frequent dining experience audits may have highlighted the limited use of the dining tables and developed a plan to try to improve the experience and to make it a social occasion.

There was no check on what activities had been carried out, or the paperwork completed to reflect this, since the new system of designating a member of staff to the lounge to be a presence and to carry out activities. This may have highlighted shortfalls that could have been addressed.

The registered manager completed a report of accidents each month. This identified the numbers of slips,

trips and falls and whether they had been reported on. However, there was no analysis to look at trends and patterns to help minimise them.

The service had recently increased the number of intermediate care beds to assist in the winter pressure local hospitals were experiencing. We found this had impacted on the amount of work and time for the registered manager and on the space available for people who live in Rose Villa.
We spoke with the general manager about this and they agreed the increase in the numbers of intermediate care beds was to be reviewed.

Although there had been improvements in aspects of governance especially in relation to checking the environment and recording medicines administration, not having an effective quality monitoring system that assists in the learning and improving of care was a breach of Regulation 17 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 the report.

We spoke with staff about the handover system used in the service. Staff told us the nurse and staff coming on duty received a handover of information from the nurse going off duty. There was no written handover completed to show what information had been passed on to staff and to enable the registered manager to see at a glance what concerns there had been during the shift. This verbal exchange of information had the potential to lead to important care issues being missed or not handed over and meant staff did not have documentation to refer back to if required. We saw accidents were recorded in a book for that purpose but we also saw an accident for one person recorded in their daily notes and not in the accident book. The registered manager was unaware the accident had occurred; a handover document would have recorded this and enabled the registered manager to be informed and to cross-reference documentation during the monthly accident audit. There was a diary system for appointments at the hospital or with local GPs and as reminders to staff to check on prescriptions or planned home visits.

We saw people who used the service and staff were able to express their views at meetings. There was a newsletter each month which detailed when an entertainer or chiropodist was visiting and welcomed new people who had been admitted to the service. It also reminded people about meal times, the need to supply their own toiletries, to let staff know about hospital appointments and that a hairdresser visited the service.

There were positive comments from people about the registered manager's approach. Staff described the registered manager and general manager as very supportive and accessible.

There were no concerns indicated in a professional visitor's survey completed in February 2016. This was confirmed in discussions with health professionals during the inspection. Comments from them about how the service was managed included, "The manager has a good relationship and is able to banter with some of the residents appropriate for their individual ability and understanding", "He does appear to hold his staff in good regard and tries to be supportive", "Good management", "No problems with management" and "As far as I am aware both [general manager's name and registered manager's name] do a great job."

The registered manager was aware of their registration responsibilities and notified the Care Quality Commission and other agencies of incidents which affected the safety and wellbeing of people who used the service.

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 11 HSCA RA Regulations 2014 Need for consent The registered provider had not ensured staff had a thorough understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and the need for consent prior to treatment. One person was deprived of their liberty without this being recognised which meant the registered person had not acted within the law. Regulation 11 (1) (2) (3)

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 consistently assessed risk and done all that is reasonably practicable to mitigate any such risk. Regulation 12 (1) (2) (a) (b)

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 ensured there were consistent systems and processes established to monitor the quality of the service and action plan shortfalls so that improvements can be made. Regulation 17 (1) (2)