The Villas Care Homes Ltd

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Inspection report

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Date of inspection visit:
15 June 2016
16 June 2016

Date of publication:
27 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 15 and 16 June 2016 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 13 people using the service. Accommodation is provided over two floors with access via two stairwells or a passenger lift.

The Villas Care Homes Limited did not have a registered manager in post at the time of our inspection. 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 providers understanding and response to promoting people's safety through the mitigation of risk was not fully understood. Potential risk to people had been identified where they required support with personal care; these risks were managed through the provision of staff training and the use of equipment, and guidance for staff being included within people's records. We found the provider's understanding as to their responsibilities in promoting people's safety did not sufficiently consider and balance their freedom, choice and control. We found instances where decisions had been made, that placed restrictions on people, with no evidence as to how the risk had been determined, or the involvement of the person in the decision.

The environment had undergone some improvement; however we found further improvements were needed to ensure people's safety and welfare. We found a strong offensive odour in two areas of the service and a kitchenette that had an unpleasant odour and damp. The provider was aware that improvements were needed; however they were unable to provide a timescale as to when the necessary improvements would be made.

We found there were sufficient staff on duty to keep people safe, and people told us they felt safe at The Villas Care Homes and were confident to speak with staff if they had any concerns. Staff had received training which enabled them to promote people's safety and were knowledgeable as to whom they should report information to should they believe someone was at risk or experiencing abuse.

People's safety and health were supported by the safe storage and administration of medicine. We found improvements were needed to ensure medicine audits carried out by nursing staff were effective and robust in order that shortfalls were identified and addressed.

People's understanding of their rights and choice, along with their experiences and views of the service and the provider and staffs ability to provide care and support was mixed. This was influenced by the level of support people required. Where people required support, their lifestyle choices were sometimes restricted as there was not always sufficient staff available to enable them to lead a fulfilling and active life, both within

the service and the wider community. Whilst people who were independent were able to access the wider community as they chose.

People were encouraged to have a healthy and balanced diet with a choice of menu being provided. The dining experience was not managed in a way that promoted a pleasant dining experience for people, whilst maximising choice and control. People's perception and understanding as to their access to food and drink were mixed, this was influenced by people's level of independence in making their views known and their ability to access drink and food independent of staff.

People had access to a range of health care professionals. Discussions with people showed that some made and attended appointments independent of staff, whilst others required the full assistance of staff. We identified that staff did not always ensure effective monitoring of people's health as staff did not always recognise changes in people's behaviour as being potentially indicative that a person's health needs had changed. Therefore referrals to external health care professionals were not always made.

Staff were responsible for the assessment, development and reviewing of people's care plans, however, the records we looked at evidenced that staff did not always have the necessary knowledge, skills or training to enable these to be completed effectively. The training available to staff had been limited, with training recently being re-introduced following the appointment of a manager. The manager had recently reintroduced the supervision of all staff and was using this as an opportunity to develop staff skills and knowledge, through constructive guidance and support.

People spoke positively about staff and their role in providing support and care. Staff who had worked at the service for many years had a good understanding of people's needs and knew their personal preferences, likes and dislikes.

The leadership, management and governance of the service were not robust, which meant the provider did not have a clear direction and plan for the development of the service, based on an assessment of the service that was currently being provided. Therefore the quality of care people received was not fully supportive of individual needs and did not recognise and support people's choices and freedom and the promotion of their independence.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and The Care Quality Commission (Registration) Regulations 2009.

You can see what action we told the provider to take at the back of the full version of the report.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Assessments to mitigate risk were not completed and to minimise risk the provider had placed restrictions on some people's freedom, choice and control over aspects of their daily lives.

Improvements to aspects of the environment were required, which had been identified by the provider; however timescales for improvement had not been determined.

There was sufficient staff to keep people safe and meet their personal care needs.

Medicine was administered and stored safely by nursing staff.

People felt safe at the service and were confident they could speak with staff. Staff were aware of their role and responsibilities in safeguarding people and protecting them from avoidable harm.

Is the service effective?

Requires Improvement

The service was not consistently effectively.

People's care plans and records were not fully supportive of the principles of the Mental Capacity Act.

People's understanding as to their accessibility to food and drink were mixed and reflective of people's independence and understanding of their rights and choices.

People had access to healthcare services, however staff in some instances did not identify changes in people's well-being and therefore referrals to relevant professionals were not always made.

The training, supervision and appraisal of staff had recently been introduced by the manager, along with staff meetings which were being used to share information and bring about improvement to the service.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's involvement in making decisions about their care was not fully explored with them, in particular for those people who challenged the service or who were not confident or able to share their views.

People's privacy and dignity was not fully promoted as staff did not in all instances consider how their behaviour and interaction with people had the potential to affect the person receiving care and support.

People spoke positively about the support provided by staff and spoke of the positive relationships they had and its impact on their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's involvement in their care to enable them to receive personalised care was not fully supported as people's views as to their interests, aspirations, choice and control were not explored or assessed.

Is the service well-led?

Inadequate

The service was not consistently well-led.

The provider was not proactive in providing opportunities for people using the service or other interested parties to influence the service provided to drive improvement.

The service did not have a registered manager in place. The provider did not demonstrate good leadership and management of the service.

Governance and quality assurance systems were not robust and therefore the quality of the care being provided was not understood. This limited the provider's ability to ensure the appropriate resources were in place to bring about the necessary improvements, in a considered and measured manner.

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Detailed findings

Background to this inspection

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

This inspection took place on 15 and 16 June 2016 and was unannounced.

The inspection was carried out by an inspector and 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. The expert by experience had experience within the field of learning disabilities.

We contacted commissioners for social and health care, responsible for providing funding for people that live at the service and health and social care professionals who provided support to people and asked them for their views about the service. We spoke with a commissioner who visited the service during our inspection and spoke with a further three commissioners by telephone.

We also reviewed the information that the provider had send to us which included notifications of significant events that affect the health and safety of people who used the service.

Before the inspection, we asked the provider to complete a 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. The PIR was completed and returned to us.

We spoke with five people who used the service and contacted a person's relative by telephone. We spoke with the provider and manager, three members of care staff, a nurse, two ancillary staff and a chef.

We looked at the records of three people, which included their plans of care, risk assessments and medicine records. We looked at the recruitment files of five members of staff, a range of policies and procedures, maintenance records of equipment and the building, audits and the minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

We found a lack of understanding by the provider as to their responsibilities in ensuring people's safety was promoted as risk assessments to mitigate risk had not been completed. Decisions made by staff to promote people's safety meant there was potential for people's freedom, choice and control over their daily lives to be compromised. Records showed that in some instances, people did not retain responsibility for their cigarettes and/or lighter, or their day to day finances, which meant cigarettes and money, were kept in the office. Records did not record whether those using the service had been involved in the decision process, or had agreed to the restrictions. Therefore people had to ask staff for these. When we asked why these practices were followed, of the provider, manager, a nurse and a member of the care staff team. The responses were varied and showed that the provider had not given due consideration to people's rights and the balance of risk.

People's finances in some instances were managed by the provider, with people's monies being paid into a business account from organisations that commissioned their care. People's records did not include a risk assessment or assessment to identify the level of support they required with managing their money. We looked at the parts of people's financial records, which reflected people's day to day expenditure, for two people who used the service. We found financial records were not always clear or easy to follow in order that an audit could be undertaken, which meant there was a potential for people to experience financial abuse. The provider did not have a policy reflective of the procedure for the management of people's finances and the involvement of staff.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Commissioners shared with us, the outcome of their quality monitoring process following a visit to the service in April 2016; they had advised the provider that action needed to be taken to bring about improvements, which included ensuring people's finances were clearly documented to show how their money was kept. The management of people's finances needed to be supported by best interest decisions and supported through risk assessments to protect them from potential abuse. Their findings also identified that options to encourage people to manage and control some or all aspects of their finances were to be explored. We found no evidence in the records we viewed that these issues had been addressed. The provider advised us they would take action.

A person's record showed that potential risks had been identified. A plan written by an external health care professional provided clear guidance for staff to follow, which enabled them to assess the person's wellbeing and detailed the approach staff should take in delivering personal care. When we spoke with staff about this approach, staff referred to the guidance provided within the plan, which showed staff followed plans that were in place to promote people's safety.

We identified areas of concern in relation to the maintenance aspects of the service, which compromised the safety and well-being of people. The small domestic size kitchen, referred to as the 'rehabilitation

kitchen', which people who used the service had access to make themselves drinks had a strong odour of damp and we found that the plinth of the cupboards and the cupboards themselves were damp and had mould, making the rehabilitation kitchen an unpleasant and unwelcoming environment for people to use. The provider showed us a plan for the refurbishment of the kitchen; however this had yet to be ordered. Commissioners we spoke with confirmed they had had assurances from the provider over an extended period of time that the kitchen would be refurbished; however the kitchen had not been refurbished.

We found there to be a strong odour of urine in the corridor on the ground floor to the right of the building, the odour permeated into people's bedrooms. On the first day of our inspection a person remained in their bed with their bedroom door open, which meant the odour was noticeable to them, thus affecting their quality of life. In addition we identified a strong odour of urine in an individual's bedroom and the corridor that linked their bedroom to their en-suite. The provider said they were aware of these issues and were looking to make improvements; however no fixed timescales had been made.

These were breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment since our previous inspection had undergone some improvements, which included new flooring in the reception corridor and dining area and new dining tables, armchairs and flooring in the lounge. Commissioners we spoke with and information they shared, found improvements made by the provider were as a result of them having raised their concerns about safety and maintenance of the service, including trip hazards due to ill-fitting carpet tiles in the hallway, reception area and worn flooring in the lounge.

People we spoke with told us they felt safe at The Villas Care Homes, one person saying, "I feel more safe here than the other place, an old people's home." When we asked people if they knew who to speak with if they were worried about something, one person told us, "I would tell staff. They are good here. You can tell them anything. I haven't had to say about anything."

The training of staff in safeguarding people (protecting people from abuse) was on-going; we found training had been scheduled, with planned dates for staff to attend, facilitated by Derby City Council. Staff we spoke with knew that any concerns about people's welfare were to be raised with the senior staff or manager. Staff were aware that they could contact The Care Quality Commission (CQC); ensuring people's rights were supported and protected from potential abuse.

People using the service told us about fire drills, evidencing that some were aware of what action they should take, "Every Tuesday, fire drill. The handyman does the alarm." When we asked people if they knew what to do when the fire alarm went off, some people were unclear, whilst one person told us, "Just over there in the car park." Indicating where they were to assemble. One person told us, "You are not allowed in the lift then. I would have to come down the stairs."

We asked staff what they would do if there were a fire. A member of staff told us they would check the fire panel to ascertain where the fire was located and undertake an initial check of the area and contact the emergency services. The manager had undertaken a risk assessment for each person identifying the level of risk should there be a fire. The outcome of these assessments was displayed on people's door by the use of colour, red, amber or green. This was designed to assist the emergency services to identify those people who were most vulnerable and would need assistance to evacuate the building.

We found there were sufficient staff to keep people safe; however we found staffing levels did not support

people in accessing the wider community, where they required the assistance and support of staff. During our visit staff supported people who required support, to attend appointments with health care professionals, however there was limited availability to provide support for people to access social activities within the wider community or within the service. A person told us, "I like going to town but have to wait, I can't go on my own." Staff told us, "We were short of staff this morning, someone cancelled. Residents could go out if there were more staff." We asked a member of staff about activities, they told us, "One resident goes to the day centre every Wednesday and one goes to knitting at the library every Thursday. They are all generally here. Some coming and going."

We noted a person following lunch was taken in their wheelchair to the lounge and placed facing the patio doors onto the car park area. We asked staff what activities they did during the week. They told us, "Oh his mum comes at the weekend to take him out, so we don't really, sometimes, but it needs two staff."

We spoke with commissioners who told us through discussions with staff, they had identified that people were not being supported with social activities outside of the service, as there were insufficient staff, as some people required the support of more than one member of staff. Commissioners advised us that their assessments had identified some people required one to one care for specific areas of their care. However their discussions with staff had identified that in some instances people were not receiving the one to one care they required.

We observed a nurse responding to someone's query regarding their medicine, offering them reassurance. The nurse was seen supporting a person to take their medicine, and we saw the person questioned them. The person questioned their medicine stating they were not theirs as a tablet was a different colour. The nurse spoke to the person, "Let's go to my room together and check." This they did and after checking the person said, "Ok, thanks. I didn't think it was mine."

We found people's medicine was managed safely and that people received their medicine on time. A person told us that when they were in pain staff offered them medicine to relieve their pain and that their medicines were given to them on time.

We found there had been improvements to the management of PRN (medicine which is taken as and when required) medicine since our last inspection. Clear written protocols were now in place which provided information as to when individuals PRN medicine was to be given, thus promoting consistency in its use and promoting people's safety, health and well-being.

Commissioners shared with us the outcome of their quality monitoring visit and action plan, which reflected concerns about medicine management and the recording of accurate information about people's medicine within their care plans, they had advised the provider that action needed to be taken, which included medicine audits. Medicine audits were being conducted by nursing staff. We spoke with a nurse about these. We found whilst medicine audits were being carried out further clarity was needed to evidence what specifically had been considered within the audit and the outcome of the audit. The manager and nurse said that would make improvements.

Requires Improvement

Is the service effective?

Our findings

People said that the meals were of a good quality and that the choice and quality of meals had improved since the employment of a new cook. However we found people's views as to the accessibility of food and drink were mixed, with some saying that food and drink was only available at set times. This was dependent upon people's perception and understanding as to their access to food and drink and whether they needed the assistance of staff. One person told us, "Lunch at 12…..Chicken and vegetable pie. The menu is up in the dining room. Alternatives were available if requested. Half an hour for breakfast, eight till half past, unless staff haven't helped them [people who required the support of staff] as they can't walk, then they can have it." They went onto say, "Five O'clock, sandwiches. …Never choose, it's made for you, tuna, corned beef or something, cake or pudding and a drink." When asked if they had supper, they replied, "Cakes and sandwiches, what was left over at tea. It's put on the coffee table and you help yourself."

We asked people if they had access to snacks and drinks in addition to mealtimes. People's responses were reflective of their level of independence and expectations. People's comments included, "No, no snacks unless it's your own food and "You can get juice at night. Not a hot drink." (when asked if staff would provide refreshments if asked). Whilst speaking with someone they told us they looked forward to having a cup of tea at three O'clock. We asked them what they would do if they fancied a cup of tea and two O'clock. They replied, "I would have to wait."

People (those who had the necessary skills) told us that they made their own drinks in the rehab kitchen; one person did say they sometimes were unable to do this as there was no milk available, so they had to ask for drinks. The manager told us it may have been due to staff not restocking. We saw people who used the service help staff making hot drinks, which were served by staff using a trolley to take drinks to people. A member of staff told us, "Drinks we do for ten and three O'clock. One of the residents helps sometimes." Whilst a person told us, "Staff make a drink if you ask." We asked someone what they would do if they wanted a drink at night, they shrugged and told us, "I don't get one, just have to wait."

We spent time with people during breakfast. We saw people go to the hatch (link between the kitchen and dining area) to collect their meal. We found different cereals had been placed into individual bowls and toast had been cut and had butter and other toppings added. The cook told us that they knew what people liked so they got it ready for them, which meant people were not asked. People then took their breakfast to sit at the dining table. The dining tables were not set and there were no condiments available, for people to customise their meal. We spoke with the provider and manager and asked why people were not given the opportunity to prepare their own breakfast, by making cereal and milk available to them, along with butter and toppings for toast. They told us they would speak with people using the service and seek their views.

We observed during the lunchtime meal that there was very little interaction between people using the service and staff. People were advised that lunch was ready by the cook at quarter to twelve. The meal was served from the serving hatch and meals were already plated, there was a potential that meals had cooled by the time people or staff collected the plated meal. The menu had stated sweet potato, however this was not served and there was no gravy or sauce provided.

People did say that the cook did provide alternative meal options if requested. One person said, "Staff do cooking. If we don't like it, they do something else." Another person said, "Staff ask in the morning, with a choice of two, what's for lunch. I didn't want the pie. I fancied egg and chips. That's what I like and that's what she is doing me." Later on the person told us, "I liked my egg and chips."

Diets specific to people's needs, which included people with diabetes were understood by the cook. A person's records stated that good nutrition would assist in their physical recovery following a period in hospital. This had not been formally assessed and a care plan had not been put into place. The person's dietary intake was recorded, however specific foods to aid the person's recovery, such as a high protein or high calorific diet had not been considered. We spoke with the manager and nurse who gave a conflicting opinion as to the volume of food the person regularly ate and differed in their view as to the whether the person had a 'healthy' appetite. This showed a lack of assessment and care planning meant people's needs were not consistently understood and met, Discussions identified it was unclear as to who had responsibility amongst the staff team for assessing people's needs and the writing of care plans.

We identified through discussion with the manager that a person's recent behaviour had changed, however no action had been taken to identify why, from either a mental health or physical health perspective. This meant that the provider was not ensuring that the person received the appropriate care and necessary treatment if required. The person's social worker had not been informed and no action had been taken to refer the person to health care professionals. We spoke with the person's social worker following our inspection and found that the manager following our visit had contacted them, The person's records did not detail the changes in the person's behaviour and no assessments or care plan had been put into place. Records detailing the person's behaviour had not been kept. The nurse following our comments to the manager made a referral to a health care professional on the person's behalf.

Upon our arrival on the second day, we sat with two people whilst they ate breakfast. One person told us they had made an appointment that morning with their GP, whilst the second said they had a dental appointment. Both people told us they would be attending their respective appointments independently as they did not require staff support. A third person we spoke with told us that staff made appointments on their behalf and went onto say that if they were unwell during the night, "I pull the buzzer, staff come and ask, check blood pressure, ring doctor sometimes, I don't wait too long." People's records recorded the involvement with health care professionals, which included chiropody services, opticians and dentists and appointments at hospital clinics for specialist services, such as eye screening for people with diabetes and reviews as to people's mental health.

The provider could not evidence that the care people received was provided by staff that had the knowledge and skills to carry out their role and responsibilities. People's assessments and care plans identifying their needs and providing information as to the support people required had not been robustly completed by staff. Discussions with staff identified that some staff did not have the appropriate skills to accurately assess, plan and review people's care as the appropriate guidance and training had not been provided. A person's care plan said that staff were to provide support to a person should their behaviour change, by distracting them. The care plan did not say what the person's usual behaviour was and therefore it was unclear as to how staff were to identify changes or interpret the significance and no information was provided as to what distraction techniques were effective. Which meant staff could not be confident in their approach to people in providing appropriate support and care.

Records revealed that since the previous inspection there had been limited training and supervision of staff, until the recent appointment of a manager. The provider had identified this as an area of improvement within the PIR. The provider at the previous inspection had stated their intention to implement, 'The Care

Certificate', which is a set of standards for care workers that upon completion should provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support. This had not been introduced; the manager advised this was something that would be implemented.

Staff we spoke with told us since the appointment of the new manager they had undertaken a range of training in a variety of topics, with future training having been scheduled. Training provided and scheduled was in topics related to the health, safety and welfare of people. People who used the service required support with their mental health however records showed staff had not undergone training informing them about mental health, its effect on people's well-being and how they as staff should provide support. On the second day of our inspection staff received refresher training on emergency first aid and resuscitation. A member of staff told us, "It's good to receive training; if you don't keep up to date it's easy to forget." They spoke to us about the training they had undertaken that day, stating that they had been assessed in resuscitation techniques by the trainer.

Staff received training specific to an individual needs, whose records we viewed. A member of staff told us they, along with other staff had received training from a psychologist as to how they were to support a person. It required staff to undertake an assessment of the person prior to each intervention of care to determine the person's well-being using set criteria. Staff approach to the person was then tailored to meet the person's need, reflective of their well-being and receptiveness in receiving personal care. Staff we spoke with were aware of this approach and information was available in the person's plans of care and within their bedroom, which ensured the person received the support appropriate to them as staff had the necessary skills and knowledge.

Since the appointment of the manager staff had received supervision and records showed staff as part of their supervision were being encouraged to develop their skills. Senior care staff, who had worked at the service for many years, were being asked to mentor new staff, to share their knowledge as to the needs of people to help promote consistency of care. The manager spoke to us of their intention to extend supervision to include observation of staff in the carrying out of their role, to enable them to assure themselves of staff's competence. For example identify that staff use the appropriate equipment and implement the appropriate techniques when supporting people with their personal care.

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.

Nursing staff at the time of our inspection were involved in completing MCA assessments for people. Completed assessments we viewed did not answer the questions posed by the assessment and evidenced that staff did not have the necessary skills required. For example a question, asking whether the person is able to manage aspects of their medicine had been answered by recording the person's health needs and disabilities. We brought our findings to the attention of the provider and manager who acknowledged that improvements were required. Training for staff on the MCA and DoLS had been scheduled for the week following our inspection.

The manager had a clear understanding as to their responsibilities under the MCA. A member of staff we spoke with had a clear understanding of the MCA and was able to speak with us at length about the DoLS which had been authorised and the conditions attached to these, which helped to ensure that these authorisations were adhered to.

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. 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 three people had a DoLS authorisation in place with two having conditions attached. We found where conditions had been set these had been met by the service, which included ensuring one person accessed the wider community no less than two days a week and for another person to move to a ground floor bedroom.

Records showed that those people who had a DoLS in place had regularly meetings with a 'paid person's representative'. They monitored the implementation of the DoLS and as part of their role spoke with staff and viewed the person's records which recorded how staff implemented the DoLS. This showed that the provider worked with outside agencies to ensure people's care, where a DoLS had been authorised, was in line with legislation.

Requires Improvement

Is the service caring?

Our findings

The senior member of care staff told us that they were involved in writing people's care plans and spent time with people to ascertain their views so that these could be incorporated. The manager was actively encouraging staff to develop care plans with people's involvement. Nursing staff had been asked by the manager to write care plans for people, we found these to be in the early stages, the manager told us that they believed the nurses did not in some instances 'know' the people at The Villas, and relied on care staff for their knowledge and understanding of people needs. The manager hoped that nurses understanding and knowledge of people would be increased, if they were to spend time with them in writing and developing care plans

We sought the views of commissioners who had responsibility for reviewing the needs of some of those who used the service. They told us that people's needs were met, with one commissioner advising us that the robust approach of staff suited a person. They went onto say that they believed staff knowledge and understanding of people's mental health was not sufficiently understood by all staff. They told us they had spoken with a nurse and suggested they speak with the person who used the service about their health to find out how they felt. They said the nurse was dismissive of their suggestion, as in the view of the nurse the person wouldn't be able articulate their views as they talked 'rubbish'.

We found people's privacy and dignity was not fully respected or promoted. During the lunchtime meal we saw how staff's approach did not respect an individual who needed support with their meal, which meant their dining experience was not a positive one to one experience. The person sat in their wheelchair and was placed next to the hatch and not at a table. The member of staff assisting them had little conversation with them; and did not ask them if they were enjoying the meal. The staff member was distracted by other people and staff and poured drinks for others. The staff member did apologise once to them, after a short time away from supporting them with their meal. We observed a nurse approach someone in the lounge and applied cream to their foot. There was very little interaction with the person and the nurse did not ask the person if they wanted to go somewhere private to have their cream applied.

People we spoke with shared with us their views of the service and whether staff were caring and supportive. One person said, "I like it here. The [staff] help they give me, helping me get around since being in hospital." They went onto say that staff had visited them whilst they were in hospital, saying "No residents came to see me just staff. I was in for four and a half months."

We asked someone if they had a keyworker, they told us, "Yes, I know my keyworker" and went onto name them. They said, looking at another member of staff "She is always busy. Everyone likes her; they have both worked here for years."

We spent time with people outside whilst they had a cigarette. People told us that, "I like to be outside in the fresh air. Staff help me out and bring me back for meals." The person's care plan identified that they chose to remain outside for a majority of the day, we noted that they said hello to people as they came outside, and introduced us. We asked people about staff. One person told us, "I know the manager; they've been

here about a month. It has been better since she came; there is not so much shouting now. She sorted that out." They went onto say that "You learn how to get along with everyone. You make friends." Another person told us, "It's alright here." They went onto say they had lived at the service for a long time, "There are arguments, it's like a kindergarten with swearing sometimes."

We spoke with a relative of someone who used the service, who spoke positively about the approach of staff. They told us, "The staff have the skills to communicate and have developed good relationships. He is trusting of those relationships." They went onto say that they couldn't fault any of the staff.

A new member of staff told us. "I like coming here. I like helping people. Atmosphere is like a home." Staff supported people in their decisions, for example one person chose to stay in their room. The member of staff told us, "[Person's name] has stayed in bed today. He is 60 and gets tired sometimes he likes to stay in his room." They went onto say that someone was in hospital, saying that their relatives visited as did staff from the service.

Staff were seen supporting people to plan and maintain contact with their relatives. One person was asked by a member of staff after lunch, "Have you phoned your sister?" The member of staff encouraged them to go with them and telephone their sister. The member of staff stayed closed by so that they were able to confirm that the person's relative was going to be at home. The member of staff after they had left said, "He does like to go and visit his sister but I think it is only fair on her if we encourage him to ring first. We all like a bit of notice."

A senior member of care who had worked at the service many years had a comprehensive understanding as to the needs of people and spoke passionately about them. Their discussion with us made it clear that they had positive relationships with those using the service. They knew about people's lifestyle choices, their hobbies and interests and were able to tell us how this enabled them to support people. They told us how they had supported someone in liaising with a solicitor in order that they could write a Will as to their final wishes, which had included identifying the time of the day the person was most able to make an informed decision, as their capacity fluctuated. With regards to a second person they told us that the person was more vocal during the night, and therefore this was the best time to seek their opinion.

Requires Improvement

Is the service responsive?

Our findings

People's experience of the provider's ability to provide care that was personalised to them was mixed. Where people were unable to or did not have the necessary skills to advocate for themselves, their experiences differed from those who were more independent of staff support. People who required a higher level of support perceived and experienced a more restrictive lifestyle. The number of staff on duty and the lack of staff awareness and training in promoting people's rights and choices and the commitment to promote people's independence meant their care was not individualised. This was further evidenced by the restrictions placed on people in relation to their finances and smoking, lack of staff training, our observations of mealtimes and people's limited access to social activities.

People's ability to take part in activities and access the wider community was linked to the level of support they required, for those people who did not require the support of staff when out and about were able to tell us about their lifestyle choices. One person told us they were visiting family later that day. When we asked them how they got there, they told us they had a bus pass and would be travelling by bus. They sent onto say that they independently organised day trips through a local company for themselves, which had included excursions to Skegness. A person told us, "I go out to town, for bits and bobs. It's not far, about five minutes." They went onto say, "I like colouring and crafts, you can see in the dining room some of my work

Staff where they had reviewed people's care plans had recorded 'no change' over a period of several months and had not recorded the information as to what records they had looked at or the involvement of the person in their review to evidence that the person's care plan was accurate. This meant people were not involved in the reviewing of their care plans, therefore the provider could not be confident that people's expectations of care were being met. Care plans for specific areas of need, such as mobility, included information that was not related to the topic, such as dietary requirements or stated that the person smoked. This meant that care plans were difficult to understand, as they were not specific to areas of people's need which had the potential to impact on the care and support people received.

We sought the views of commissioners who had responsibility for reviewing the needs of some of those who used the service; they told us that the providers approach to person centred care could be improved with staff supporting people to develop personal goals, to develop people's confidence and independence. The manager advised us they were looking to introduce a care plan approach that was recognised in the field of mental health, to encourage people's participation in care planning and to support and encourage recovery and independence.

We asked people as to whether their views were sought, people's responses were mixed. Two people told us that meetings were held, where they talked about improvements to the home, they told us of a planned extension to the office, which would be built on the area currently designated as a smoking area. They told us that the kitchenette was to be refurbished, but did not know when the works were to be carried out. They said they talked about trips and outings with one person saying they were going on a trip to the zoo. Other people we spoke with said, "We did have meetings. Not anymore, you have to ask for a meeting if you need it, we have one when we ask". And, "No, I don't have meetings." The manager had recently reintroduced

meetings and we found minutes detailing what people had spoken about.

A person told us, "I like knitting, drawing and painting. I go to knitting the library every Thursday. It's not too far and I have an electric wheelchair. I like colouring books. I buy them in town." They went onto say, "I do nothing in the evening. Staff help me to go upstairs. I go to my room after tea. I like the 'soaps'. Then the radio. Then sleep about nine to nine-forty five. Staff come about quarter past seven in the morning to help me with my personal care." They went onto say that they were going on holiday with their key worker to Nottingham for a week, but they were unclear as whether it had been booked. A member of staff told us, It's a [holiday company name] holiday. I need to sort it out. It's expensive because of having to get a taxi there and back. Probably a short break about four days." This showed that whilst holidays were being planned, people using the service were not always actively involved or informed as they were unclear as to whether their holiday had been organised.

Many of the people who used the service spent time outside, having a cigarette, talking with each other. This was a key social aspect for people. There was a designated smoking area to the rear of the service, which provided sheltered from the rain, however the garden area within the shelter was not well-maintained, with tall weeds growing. There was an outside area, which had been improved; however people did not use this area they told us they did if they had a barbeque. This showed that the provider did not ensure that the outdoor space used by people, that was of importance to them was well-maintained, providing a pleasant area for people to smoke.

People we spoke with said they were confident to raise concerns with the staff and a relative of someone using the service said that the provider was approachable and open to their views. Information about raising concerns was displayed within the service. The complaints policy and procedure was displayed in the entrance foyer of the service. The provider and manager told us that they had not received any complaints within the last 12 months.

Inadequate

Is the service well-led?

Our findings

The Villas Care Homes Ltd has not had a registered manager in post since August 2013. We wrote to the provider in May 2016, advising them that they continued to be in breach of their registration and requested they write to us as to their plans. We did not receive a response to our correspondence. The manager who was in post at the previous inspection resigned their position and until the appointment of the new manager, the provider with the support of consultancy firms managed the day to day running of the service. The recently appointed manager who had been in post for three months at the time of the inspection told us they had applied for their DBS; once this was received they would submit an application to the CQC to be registered as the manager.

This is a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009.

The provider was not proactive in providing opportunities for people using the service, their relatives and staff to influence the development of the service. Whilst meetings with people using the service were held; these were used to keep people informed of decisions made and not as a consultative process. A relative told us that their views had not been formerly sought. The provider shared with us completed surveys which sought people's views, however these were not dated. A summary report dated January 2013, appeared to correspond with the completed surveys, which suggested that people's views had not been sought recently. The provider was unclear as to when the surveys had been completed. We saw no evidence that the outcome of the these surveys had been shared to enable those who had taken part to be confident that any issues they had identified would be addressed

The manager had identified that communication between staff required improvement and handover of information between staff now involved all staff including the manager. Staff meetings had been reintroduced and minutes of meetings held in April and June 2016 recorded the improvements needed, which included increased opportunities for people to take part in activities and improvements to people's care plans and records. The minutes did not record how this was to be achieved. The manager was working to improve the service by reviewing people's care plans, undertaking audits of the service to identify improvement and supporting staff through the provision of training and supervision. We shared our concerns with the provider that the resources needed to bring about the identified improvements needed to be considered, they told us they would review the support available to the manager to facilitate improvements.

The provider was unable to demonstrate robust management and leadership, which had a direct impact on the quality of the service provided. We found there to be no clear direction for the development of the service, or recognition that our findings as part of the inspection process meant that the provider was not fulfilling their obligations in ensuring that the service people received, was safe, effective, caring, responsive and well-led. Whilst the provider visited the service regularly, they had no clear oversight as to the service being provided as they did not have a system in place to assure themselves of the quality of the service. The PIR asked the provider how they assured themselves of the quality of the service, the response provided was through training, audits, monitoring and observation. The audits that had been carried out had been

undertaken by the recently appointed manager, which in part had been acted upon and had included the supervision and training of staff. The provider spoke of planned improvements for the environment; however no timescales had been identified.

Information provided within the PIR was limited in its content and lacked detail as to how they as the provider meet their legal obligations. Areas identified for improvement were reflective of what should already be in place to ensure people receive good quality care. Areas the provider had identified for improvement over the next 12 months were; to submit an application for the manager to be registered with the CQC, the supervision and appraisal of staff, introduction of monthly audits, development of person centred care, undertaking of risk assessments and the on-going training of staff.

The provider's lack of governance and oversight of the service being provided meant they were unaware of the lack of and poor quality of documentation within people's records and its accuracy. This had a direct impact on people receiving the appropriate care and support. The lack of leadership and direction resulted in instances where people were not being referred to the appropriate health or social care professional to promote their welfare.

We found the quality of records and the system for their safe keeping and accessibility hampered the inspection process and impacted on staff's ability to provide care as they did not have access to accurate and up to date information. The provider was not aware of the quality of record keeping or its storage, which demonstrated their lack of oversight as to service provided and governance.

Where audits had been carried out we found these not to be effective as they did not in all instances identify shortfalls within the service. For example medicine audits had not identified that PRN medicine could not be fully accounted for to ensure it was administered safely. Whilst environmental audits did not include timescales for improvement and plans discussed at the previous inspection of 2015 had not been acted upon

We found people's records were kept in a range of different rooms and files, in both the office and clinical room and were secure. It became apparent on the second day of our inspection that records completed by nursing staff about people's care and support were kept separate from people's other records, which meant it was difficult for staff to have a clear overview of any person's needs.

People's finances in some instances were managed by the provider, with people's monies being paid into a business account from organisations that commissioned their care. We looked at the parts of people's financial records, which reflected people's day to day expenditure, for two people who used the service. We found financial records were not always clear or easy to follow in order that an audit could be undertaken. The provider did not have a policy and procedure detailing all aspects of the management of people's finances, including staff involvement.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider had not met their legal obligations in that they had not informed the CQC of significant events within the service. At the time of the inspection three people had an authorised DoLS in place, which we should have been notified about; information about the DoLS had been included within the PIR submitted by the provider. The provider had notified us, consistent with their legal obligations regarding a serious injury.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 5 Registration Regulations 2009 (Schedule 1) Registered manager condition The provider was in breach of the conditions of registration as they did not have a registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that the restrictions placed on people were proportionate to the level of risk or harm posed to the themselves of others.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured that the premises to which people had access were clean and well-maintained. The ground floor corridor to the ground floor of the right side of the building had an unpleasant odour. A bedroom and corridor leading to a person's en-suite bathroom had a unpleasant odour. The kitchenette (rehabilitation kitchen) had an unpleasant odour, with mould on and in the kitchen units