Rose Villa Care Limited

Rose Villa

Inspection report

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Date of inspection visit: 26 and 28 May 2015
Date of publication: 17/07/2015

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?	Good
Is the service well-led?	Requires improvement

Overall summary

We carried out this unannounced inspection on 26 and 28 May 2015.

Rose Villa is a small family owned care home located in a residential area. The home is arranged over two floors and can accommodate up to 20 people. At the time of our inspection there were 18 people living at the home. The home supports people with a range of needs. A small number of people were quite independent and only needed minimal assistance. Others needed assistance with most daily living requirements including support with managing their personal care, medication and mobility needs. Some of the people being cared in the home were living with dementia and a small number could display behaviour which challenged.

The home had two registered managers who shared the responsibilities of this role. 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 and

Summary of findings

associated Regulations about how the service is run. The registered provider lived in the grounds of the care home in their motor home and also took an active role in overseeing aspects of the service.

Some areas required improvement.

The service was not effectively managing risks associated with hot water, legionnaires disease and fire safety. Suitable checks were not taking place to ensure that all aspects of the facilities and amenities within the home were fit for purpose and kept people safe.

The provider had not ensured that there was a fully effective system in place to assess and monitor all aspects of the safety and quality of the service. We identified some concerns in relation to the safety of the service. These had not been identified by the provider before our visit.

The provider was not following relevant guidance when assessing whether people had capacity to consent to key decisions about their care. Where a person lacked capacity to make decisions about their care and support we were not always able to see that appropriate best interests consultations had been undertaken.

Improvements were needed to some aspects of how people's medicines were managed. Staff were not following best practice guidance which increased the risk of medicines related problems occurring.

Some aspects of the design and decoration of the building could be enhanced to meet the needs of people living with dementia or those with sight loss. Some areas of the home, particularly the corridors on the first floor did not have appropriate light levels. We were concerned that this could increase the risk of falls for people with sight loss.

New staff shadowed experienced staff when they began their employment at the home and had an opportunity to familiarise themselves with people's care plans and key polices. They did not receive any formal assessed induction in line with recognised standards within the sector. Staff had not been receiving regular supervision and appraisals. A range of essential training was provided for all staff which was mostly up to date. Some staff had undertaken additional training relevant to the needs of people using the service.

People told us they felt safe and staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns to their management team. Safe recruitment practices were followed and appropriate checks had been undertaken which made sure only suitable staff were employed to care for people in the home.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations had been applied for.

Care plans included a number of risk assessments in relation to people's individual risks such as falls, moving and handling and skin care. This helped to ensure that people's care and support was delivered safely.

People told us that the food was tasty and provided in sufficient quantities. People's care plans included information about their dietary needs and risks in relation to nutrition and hydration and staff were aware of these.

Where necessary a range of healthcare professionals had been involved in planning and monitoring peoples support to ensure this was delivered effectively. A health care professional told us, "The systems work here, they monitor pressure areas well, and are familiar with people, we get called in quickly and appropriately".

People told us they were happy with the care provided and told us that they were supported by staff that were kind and caring. People's comments included, "I love the nurses" and "Everybody is so kind and its very free and easy, no-body has ever been horrid". Staff showed they had a good knowledge and understanding of the people they were supporting and were able to give us examples of their likes and dislikes and daily routines which demonstrated that they knew them well.

People told us they usually received care and support when they needed it. They felt that staff were responsive to their needs and took action to ensure they saw their doctor if they were unwell.

People and their relatives told us they were confident that they could raise concerns or complaints and that these would be dealt with.

Summary of findings

People were positive about the management and leadership of the home. Staff told us they felt fully supported by the registered managers who they said maintained a strong presence within the home. The registered managers promoted an open and supportive culture in the service which helped to ensure that people were supported by a motivated and caring staff team.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we have told the provider to take at the back of the full version of this report.

Summary of findings

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 always safe.

The provider was not effectively managing risks associated with hot water, legionnaires disease and fire safety. Suitable checks were not taking place to ensure that all aspects of the facilities and amenities within the home were fit for purpose and kept people safe.

Improvements were needed to some aspects of how people's medicines were managed. Staff were not following best practice guidance which could increase the risk of medicines related problems occurring.

People told us they felt safe and staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns to their management team.

Is the service effective?

Requires improvement 

The service was not always effective.

The provider was not following relevant guidance when assessing whether people had capacity to consent to key decisions about their care. Where a person lacked capacity to make decisions about their care and support we were not always able to see that appropriate best interests consultations had been undertaken.

Some aspects of the design and decoration of the building could be enhanced to meet the needs of people living with dementia or with sight loss.

People told us that the food was tasty and provided in sufficient quantities. People's care plans included information about their dietary needs and risks in relation to nutrition and hydration and staff were aware of these.

Is the service caring?

Good 

The service was caring.

People told us they were happy with the care provided and told us that they were supported by staff that were kind and caring.

Staff showed they had a good knowledge and understanding of the people they were supporting and were able to give us examples of their likes and dislikes and daily routines which demonstrated that they knew them well.

Is the service responsive?

Good 

The service was responsive.

People told us they usually received care and support when they needed it. They felt that staff were responsive to their needs and took action to ensure they saw their doctor if they were unwell.

Summary of findings

People and their relatives told us they were confident that they could raise concerns or complaints and that these would be dealt with.

Is the service well-led?

Requires improvement 

The service was not always well led.

The provider had not ensured that there was a fully effective system in place to assess and monitor all aspects of the safety and quality of the service. We identified some concerns in relation to the safety of the service. These had not been identified by the provider before our visit.

People were positive about the management and leadership of the home. Staff told us they felt fully supported by the registered managers who they said maintained a strong presence within the home. There was an open and supportive culture in the service which helped to ensure that people were supported by a motivated and caring staff team.

Rose Villa

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.

The inspection took place over two days on 26 and 28 May 2015. The inspection was unannounced.

The inspection team consisted of two inspectors 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 service.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is used by registered managers to tell us about important issues and events which have happened within the service. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with 13 people who used the service and four relatives. We also spoke with the two registered managers, the registered provider and five other staff members. We spoke with a visiting healthcare professional. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed the care records of four people in detail and the training and recruitment records for two staff. We also reviewed the Medicines Administration Record (MAR) for nine people. Other records relating the management of the service such as audits and policies and procedures were also viewed.

Following the inspection we contacted three community health and social care professionals to obtain their views on the home and the quality of care people received.

The last inspection of this service was in June 2014 when no concerns were found in the areas looked at.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at Rose Villa. One person said, "Oh yes, everyone is safe here". Another person told us, "I'm safe, yes; they always want to come with me when I walk". Whilst people told us they felt safe, through our observations and discussions with staff, we found some aspects of the care were not always safe and needed to improve.

The health and safety executive publication; Health and Safety in Care Homes, states that where bathing facilities are accessible by vulnerable people then the temperature of water being discharged from the taps should not exceed 44 °C. This is to avoid the risk of scalding. This document also states that staff involved in bathing service users should check the temperature before the person gets into the bath and also periodically (e.g. weekly) monitor the outlet temperature of the bath/shower water using a bath thermometer. These checks were not taking place. We were concerned that this meant there was a potential risk of people being scalded by water which was too hot. Since the inspection, the provider has taken action to ensure these checks are now taking place.

The health and safety executive also publish, 'legionnaires disease; the control of legionella bacteria in water systems, Approved Code of Practice and Guidance on Regulation published 2013. This Code describes the safe operating temperatures for hot and cold water systems and states that for precautions against the growth of legionella to remain effective, the condition and performance of the system need to be monitored. The provider had commissioned an external contractor to undertake an annual risk assessment for legionella, but they had not made arrangements to ensure regular monitoring and checks of the water system were undertaken. We could not be assured therefore that the temperatures of the water system remained within the parameters necessary for effective legionella control.

The provider showed us risk assessments which indicated a number of risk management measures were in place to reduce the risks associated with scalding from hot water and legionnaire's disease. These measures were not taking place. This meant the provider was not following their own risk assessments and risk management protocols.

Following the inspection, we were sent a copy of a fire inspection repot undertaken by Hampshire Fire Service in September 2014. This had identified a number of areas where improvements were required. One requirement was that the provider's fire risk assessment be updated as the current assessment was inadequate. It required this to be updated by January 2015. This had not been done. This meant people could be at risk as potential fire safety deficiencies had not been adequately addressed. The provider told us they had not previously received this report from the fire service but agreed to commence an immediate programme of fire safety improvements and seek further guidance and support with this from Hampshire Fire Service.

Some areas of the home, particularly the corridors on the first floor did not have appropriate light levels. The corridors were dark and including areas where there were steps. The only lighting was two small night lights. We were concerned that this could increase the risk of falls for people with sight loss.

There were failings in how the service was managing risks associated with the environment such as the hot water, legionnaires disease and fire safety. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

The provider had not been undertaking suitable checks to help ensure all aspects of the facilities and amenities within the home were fit for purpose and allowed care and support to be delivered in such a way as not to compromise people's dignity. For example, we found that in four people's room, there was no hot water available which meant staff had to bring bowls of hot water from a nearby bathroom in order to assist people with personal care.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment.

Improvements were needed to some aspects of how people's medicines were managed. A number of people were prescribed topical creams; however, records were not being maintained to show when these had been administered. Some people needed PRN or "if required" medicines. However there was not always a detailed and personalised protocol in place which gave staff guidance

Requires improvement

Is the service safe?

about when these medicines should be given. We found a number of hand-written medicines administration records (MAR's). NICE Guidelines for Managing Medicines in Care Homes SC1, states that hand written MAR's should only be produced in exceptional circumstances and that where this is required, the new records should be checked for accuracy and signed by a second trained member of staff before it is used. The home was not following this guidance and this increased the risk of medicines related problems occurring.

We recommend the provider follow NICE guidance SC1 to ensure all relevant processes are in place for safe and effective use of medicines in the care home.

Staff who administered medication had completed training and the manager had recently begun to carry out competency assessments to ensure staff remained safe to administer people's medicines. People told us they received their medicines when they needed them. One person said, "I always get my tablets on time". Another person told us, "I get my tablets regularly which means I don't get any aches or pains". Medicines were kept safely in a locked trolley in a treatment room and arrangements were in place to ensure medicines were being stored within the recommended temperature ranges.

People were mostly positive about the staffing levels. For example, one person said, "There's always enough of them". One person told us that sometimes at night, they might have to wait for support to use the bathroom. They said, "They [the staff] can't be everywhere….so we have to wait". The staff team was led by the two registered managers who oversaw a team of senior care workers and care workers. The home also employed a maintenance person, a cook and a housekeeper. The target staffing levels for morning shifts were four care workers. In the afternoon, this reduced to three care workers and then from 5pm – 10pm there were two care workers on duty. At night there were two waking care workers on duty. We reviewed the staffing rotas and found that these staffing levels had been met. The registered managers did not use a dependency tool which looked at each person's level of dependency (care needs) and calculated the required staffing numbers needed to meet these needs. However they told us they were confident they had a good understanding of the number of staff required to deliver a safe service. They had recently conducted a number of spot checks which they felt helped them to have a good understanding of the staffing needs and requirements of particular shifts. They had identified there was sometimes a need for a third member of staff on the evening shift and so had recently recruited another member of staff to this role. They told us that in the interim, they were able to provide any additional support that was needed to ensure people were safe and their needs met in a timely manner. They felt this was preferable to using agency staff as this helped to ensure people received care from consistent staff that were familiar with their needs. Throughout our inspection, we observed that staff responded quickly and people's needs were met in a timely manner. People told us they were able to choose when to go to bed and when to get up and that the staffing levels supported this. This was confirmed by the staff we spoke with. Some staff did report that the 5-10pm shift could be challenging at times and therefore welcomed the commitment by the provider to deploy an additional member of staff on this shift.

Accidents and incidents were recorded, but we noted these were not reviewed by the registered managers. This is important as it helps to ensure that the nature and cause of incidents and accidents is reflected upon and appropriate actions taken to reduce the risk of similar events occurring. The registered managers told us staff always informed them about accidents which helped to ensure they were aware of potential risks to people using the service.

People's care plans included a number of risk assessments in relation to how their individual risks such as falls, moving and handling and skin care should be managed. Staff were using nationally recognised tools to help predict the risk of people developing pressure ulcers or of becoming malnourished. A post falls protocol was in use alongside a falls risk register which helped staff to identify trends or causes for falls. We did note that in one person's case, not all of the falls they experienced had been recorded on the falls register. This would limit its effectiveness as a monitoring tool. Each person had a personal emergency evacuation plan (PEEP) which identified the help they would need to safely evacuate the home in the event of an emergency such as a fire.

We saw people were supported to continue to follow their interests and maintain their independence, even if this presented some risks. We saw people enjoyed going out for walks alone or with friends. Measures to limit any risks had been put in place, such as ensuring the person's mobile phone was programmed with the homes number.

Requires improvement

Is the service safe?

People told us they felt safe and staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns to their management team. We did note that the provider's safeguarding and whistle-blowing policies needed to be updated to ensure they contained relevant links to the local multi-agency safeguarding policy including information about how and to which organisations, staff should report safeguarding alerts or concerns about poor practice or abuse.

Records showed staff completed an application form and had a formal interview as part of their recruitment. The provider had obtained references from previous employers and checked with the Disclosure and Barring Service (DBS) before employing any new member of staff. These measures helped to ensure that only suitable staff were employed within the home.

Requires improvement

Is the service effective?

Our findings

People were positive about the skills of the care staff and felt they received effective care. One person said, "I wouldn't want to go anywhere else…I couldn't find fault with anything". Another person told us "Everything is good here for me". A relative told us, "I think they are all well looked after including me! Things are very good here". Another relative said, "It's nice for me to be able to leave [their relative] here and not worry".

Whilst people told us they received effective care, we found some areas required improvement.

Staff had received training in the Mental Capacity Act and we saw staff had considered as part of their care planning processes whether people had capacity to consent to key decisions about their care. It was not however clear that staff were correctly applying the two stage test of capacity, as set out in the Mental Capacity Act (MCA) 2005 Code of Practice. This test should be used when undertaking assessments of people's capacity to make decisions about their care and support. It was not clear to us how their decision about the person's capacity had been reached. Three of the care plans we viewed recorded that staff were to make certain decisions in the person's best interests, however there was no evidence that wider consultation with relevant people such as relatives and professionals had taken place to agree that these actions would be in the best interests of the person lacking capacity. We found a number of examples where people's next of kin had been asked to sign documents, such as those giving permission to share information, on behalf of their relative without the relevant legal authority being in place to support this.

We could not therefore be assured that staff fully understood the legal requirements of the MCA 2005 and its associated Code of Practice and how these should be used to protect and support people who do not have the ability to make decisions for themselves. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The need for Consent.

Staff asked people before they assisted them with a task such as helping them to stand or with eating their meal. People were encouraged to make choices in relation to what they wanted to do or what they wanted to eat and drink. Staff told us they made sure people made decisions for themselves wherever possible and that these choices were respected.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). These safeguards are part of the MCA 2005 and aim to protect the rights of people using services by ensuring that if there are restrictions to their freedom or liberty, these have been agreed by the local authority as being required to protect the person from harm. Applications had been submitted for each person living at the home and they were waiting for the local authority to assess these.

Some aspects of the design and decoration of the building could be enhanced to meet the needs of people living with dementia. There was a lack of signage and visual cues to help people locate toilets. People living with dementia can find that familiar symbols or photographs help them to locate particular rooms and objects more easily. For example, a picture of a toilet on the bathroom door acts as a prompt as to the room's purpose. This helps people to retain their independence. There were no calendars in the home. We heard people asking staff what day it was. Providing suitable clocks and calendars can assist people living with dementia to remain orientated to time and place..

We recommend that the provider consider best practice guidance on developing dementia friendly environments.

New staff received an induction which involved shadowing more experienced staff, reading people's care plans and key policies and procedures. However, they had not received any formal assessed induction in line with recognised standards within the sector. This is important as it helps to ensure that staff are competent and can put their learning into practice within the care home setting. The registered managers told us they had now made arrangements to introduce training for staff which if successfully passed, would result in the staff member achieving The Care Certificate. The Care Certificate was introduced in April 2015 and sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate.

Staff told us they felt well supported by the registered managers who they said provided them with effective

Requires improvement

Is the service effective?

leadership and guidance which helped them to carry out their roles effectively. Staff comments included, "They [the managers] are hands on, always there, they observe you" and "If we feel we need to, we can go to them at any time". In a recent staff survey, all those that responded felt they had adequate support from management. However we found that neither the registered managers or staff had been receiving regular formal supervision or appraisals. Supervision and appraisals are important as they help to ensure staff understand their role and responsibilities. They also provide opportunities for staff to reflect upon their strengths and weaknesses and consider their continuing professional development.The registered managers were aware this was an area which needed to improve. They told us they were planning supervision and appraisals for all staff which would be completed within the next two months.

We recommend that the provider consider relevant guidance about how to most effectively provide a model of relevant training and continuing professional development for the registered managers.

A range of essential training was provided for all staff which was mostly up to date. This included Moving and handling, safeguarding, fire training, first aid and food hygiene. A small number of staff had undertaken additional training relevant to the needs of people using the service such as training in dementia care, pressure ulcer prevention and end of life care.

Food was freshly prepared on site by the cook. People told us the food was tasty and provided in sufficient quantities. Comments included, "The food? Oh yes – beautiful, I'm happy with the food". Another person said, The food is very good, and we get drinks whenever we like". A third person said, "The food is brilliant". People were full of praise for the cook who was relatively new the service, but had, they thought, already made improvements to the quality of the food. People could choose to eat their lunch in their room, the lounge or in the conservatory at dining tables. People appeared to be enjoying the dining experience and chatted readily with one another and with the staff supporting them. Where necessary people had been provided with plate guards to help them eat independently. Staff were observed to offer help with cutting food up and also provided gentle encouragement when they noted people were not eating so well.

People's care plans included information about their dietary needs and risks in relation to nutrition and hydration and staff were aware of these. People's weight was monitored at least monthly and plotted on graphs to give a clear visual representation of people's weight gain or loss. Nationally recognised tools were also used to monitor people's risk of becoming malnourished and when concerns were identified, we saw that staff sought medical intervention.

Where necessary a range of healthcare professionals had been involved in planning and monitoring peoples support to ensure this was delivered effectively. For example, two people had been referred to a speech and language therapist. Staff had noticed that one person was losing weight and so sought a referral to the dietician. People were promptly referred to their doctor if they were unwell. For example, staff had noted that one person was showing signs of an infection. Following consultation with the GP the person was started on treatment the same day. People living at the service also received support from the Parkinson's nurse specialist. A health care professional told us, "The systems work here, they monitor pressure areas well, and are familiar with people, we get called in quickly and appropriately". We did note that people did not have a hospital passport. These are used to share key information with medical staff about the person's needs, their communication methods and behaviours in the case of admission to hospital. We spoke with the registered managers about this who said they were looking at developing these for people using the service.

Good

Is the service caring?

Our findings

People told us they were happy with the care provided and told us they were supported by staff that were kind and caring. People's comments included, "I love the nurses" and "Everybody is so kind and its very free and easy, no-body has ever been horrid". A third person said, "They are nice people, very kind, everything is fine, I feel very well". A relative told us, "It feels like we are all family". A health care professional told us the staff were "Definitely kind and caring".

People received attention from staff who demonstrated their concern and interest in the person and it was clear they had developed good relationships with staff. We observed a care worker checking whether people were warm enough or wanted a blanket. We saw a care worker gently stroking the hand of a person who had fallen asleep to see if they wanted some lunch. We heard one person tell a care worker, "I miss you when you are not here". Another person told us how they "Trusted" each of their care workers. A care worker told us, "Everyone here genuinely does care".

People who used the service, and those who were important to them, were involved in planning their care. People's care plans contained a 'service user preference form' which gave detailed information about their preferred choices. People told us they could make choices about how their care and support was delivered including what to wear, and when to get up and go to bed. People could choose what to eat and drink. We observed one person ask for a hot chocolate drink instead of tea. This was promptly served and the staff knew how the person liked it. Staff showed they had a good knowledge and understanding of the people they were supporting and were able to give us examples of their likes and dislikes and daily routines which demonstrated they knew them well.

Most of the relatives we spoke with were satisfied they were involved in relevant decisions and were able to inform people's care plans by sharing what they knew about people's preferences and how they liked to live their lives. All of the visitors we spoke with said they were free to visit their relatives or friends at any time and were always made welcome by staff. One visitor told us they would like to be informed more promptly should their relative experience a fall or become unwell.

Upon admission to the home people were given a service user guide which included a 'Charter of Rights' which stated people had the right to make choices, be treated with dignity and respect, to take risks and to comment or complain about how their care was delivered. Everyone we spoke with told us their dignity and privacy was respected. Staff spoke to us about how important it was to protect people's privacy and dignity and were able to give examples of how they maintained peoples dignity by, for example, using the screens in the shared rooms.

We saw that people were encouraged to be independent. Staff encouraged people to complete tasks for themselves, even if this took a long time. This was evident at lunch time, where staff ensured people felt able to take as much time as they needed to eat and enjoy their lunch without being rushed. Where appropriate people had access to adapted cutlery and crockery which enabled them to eat without assistance.

Good

Is the service responsive?

Our findings

People told us they received care and support when they needed it. They felt staff were responsive to their needs and took action to ensure they saw their doctor if they were unwell. People were supported to follow their own interests and to make choices about how they spent their time. The activities provided appeared to be enjoyed by some people and others appeared content just relaxing in the lounge. Staff chatted with people as they went about their work and these interactions helped create a homely and lively atmosphere within the home.

People's care plans were personalised and contained information about their life history, family members, jobs they had worked in and places they had travelled to. People's preferences and choices about how their care should be delivered were also detailed throughout their care plans. For example, we saw one person's care plan described in detail their morning routine, including the time they liked to be woken at and a request that staff warm their clothing as they disliked being cold. One person had a 'how I communicate' plan which described what aspects of their body language might mean. This supported staff to know and understand what was important to each person and to deliver responsive care. A member of staff said, "The support plans tell me what I need to know…the 'all about me' pages help as we can use this information to start conversations". Another staff member said the care plans helped them to "know their quirks and likes and dislikes". Staff told us how they delivered personalised care by ensuring they asked people about their choices and sought their consent before providing care.

Care plans contained relevant information about people's physical health and their care needs such as the support they needed to wash and dress, mobilise and manage their continence. People also had care plans which described the support they needed to eat and drink. We saw action had been taken promptly to update one person's eating and drinking care plan following a visit from a speech and language therapist. We did note that the updated plan could have described more clearly the level of supervision the person needed when eating certain higher risks foods. We fed this back to the registered managers so that this could be reviewed. People's care plans recorded their wishes in relation to their end of life care. This helped to ensure that staff were aware of what was important to people approaching the end of their life. We saw that care plans were reviewed on a regular basis, although it was not always clear that the person and their relatives had been involved in this review, however, people told us they felt listened to and had no concerns about sharing their view or comments with the management team. This was echoed by most of the visitors we spoke with. They felt that staff kept them well informed about all aspects of their relatives care and that there were plenty of opportunities to have regular dialogue with staff and the management team.

People were satisfied with the activities provided by the service. There was no designated activities staff, which meant the care workers needed to oversee these alongside their other duties, however, most afternoons they were able to offer activities such as dancing, hoopla, giant skittles and draughts. One person was completing a jigsaw person. Staff told us that when able they also spent one to one time with people doing hand massages and manicures or just spent time chatting. We observed that people enjoyed these interactions and also readily engaged with one another which meant there was happy and relaxed atmosphere. When the weather was fine, staff told us they tried to encourage people to spend some time in the garden. One person told us, "The garden is new, we had an open day, had a canopy up, everybody came it was nice!". We saw the provider had sought the involvement of relatives in the delivery of the activities programme with one relative running a bingo session once a week. The provider told us they were introducing an 'old style' tuck shop for people to use and three people were taking part in a tomato plant growing competition which had been organised by the provider. People told us they received regular visits from the local church which they valued.

Information about the complaints procedure was not displayed within the home, but was explained in the service user guide. People and their relatives told us they were confident they could raise concerns or complaints and that these would be dealt with. One person said, "Complaints? I don't have any so I don't need to". Another said that they had no complaints about their care either, but added, "I'd soon speak with the 'provider' he's always around". Resident and relatives meetings were not happening on a regular basis, but we saw there were plans to hold one the week following our inspection which it was hoped would be an opportunity for people to comment and give feedback about the quality of the service.

Requires improvement

Is the service well-led?

Our findings

Rose Villa had two registered managers who shared the responsibilities of this role. People were positive about the registered managers and their leadership of the home. One person said, "They manage things well and are approachable". A relative told us, "The managers are hands on and caring, they treat people with courtesy and don't issue orders". Staff were also positive about the leadership of the service and told us they felt fully supported by the registered managers who they said maintained a strong presence within the home.

Whilst people, their relatives and the staff team, were all positive about the leadership of the home, we found that some areas of how the home was managed required improvement. The provider did not have a robust system in place to identify where the quality or safety of the home could be being compromised. We found failings in how the service was managing risks associated with hot water, legionnaire's disease and fire safety. Suitable checks were not taking place to ensure that all aspects of the facilities and amenities within the home were fit for purpose, for example, four people's rooms did not have hot water. The provider had not identified these concerns through the completion of their own checks. Some of the provider's policies were not fully fit for purpose and needed to be updated to ensure that they contained all of the necessary information. The information provided to people moving into the home or people interested in coming to live at Rose Villa was out of date. The service user guide contained inaccurate information regarding their rating both with Care Quality Commission and environmental health agency. The provider did not have a service improvement plan. A service improvement plan details all of the areas where audits or feedback show that improvements could be made, the steps needed to deliver these and a timescale for completing these. This meant that the provider did not have effective governance systems that were being used to drive continuous improvements. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

Some arrangements were in place monitor the quality and safety of the service. For example, an infection control audit had been completed in February 2015 and had reviewed the cleanliness of the general environment, bathrooms, laundry, and hand hygiene and whether staff were using personal protective equipment (PPE). One of the registered managers had recently undertaken a series of spot checks. These spot checks involved the registered manager visiting the home unannounced to check that care was being provided appropriately. We saw detailed records of these checks and were able to see that any issues identified were addressed through discussions with staff or in team meetings. The registered managers also sought and benefited from the guidance and support of the local authority's quality improvement team and training recourses to help them make improvements. Feedback was sought from people using the service, staff and relatives about the quality of the care and responded to as appropriate. Staff meetings were held periodically. There was evidence that these meetings were used as an opportunity to remind staff about their role and responsibilities but also of the importance of providing people's care in a dignified and person centred manner. Staff told us, they felt able to make suggestions and come up with ideas which were taken seriously. One staff member said, "They [the registered managers] ask for your ideas, they're not, this is how its going to be done…you can tell them anything".

The registered managers told us that the values of the service were to provide "Homely, person centred care" and throughout our inspection, we observed that the management team promoted a friendly and homely culture within the home. Staff demonstrated that they worked in a manner that was consistent with these values. There was a calm, friendly and homely atmosphere. People appeared relaxed and happy and were seeing visitors and joining in organised activities. Staff described the service as "Homely" and "A real family home…it's a nice place and has a happy atmosphere". A relative confirmed this, they told us, "There is a good ambience, staff go out of their way to care". We saw other positive comments in the feedback from the relatives survey where one person had written, "There is a good homely atmosphere, I have always found the staff helpful and friendly, I really appreciate being able to come and lunch with [their relative] it makes the visits a lot easier and more relaxed".

We observed that staff were comfortable and at ease with the registered managers and it was clear from our observations and discussions that there was an open and supportive culture in the service. Staff told us they enjoyed working at the home. One care worker said, "Moral is good, we all pull together". Another care worker told us, "It's an

Requires improvement

Is the service well-led?

established staff team, there is never any friction". This all helped to ensure that people were supported by a motivated and caring staff team who were committed to providing a good standard of care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. **How the regulation was not being met:** The provider had not ensured that the premises used by the service were safe for their intended purpose. The provider had not had due regard to statutory requirements and national guidance where this related to risk associated with hot water, the effective control of legionella and fire safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **How the regulation was not being met**: The provider had not ensured that the facilities and amenities were fit for purpose and did not compromise people's dignity.

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **How the regulation was not being met**: Where a person lacked capacity to make an informed decision, or give consent, the provider had not acted in accordance with the requirements of the Mental Capacity Act 2005 and its associated code of practice.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met**: The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service.