Isle of Wight Council

Venner Avenue

Inspection report

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14 December 2015

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Say when the inspection took place and whether the inspection was announced or unannounced. Where relevant, describe any breaches of legal requirements at your last inspection, and if so whether improvements have been made to meet the relevant requirement(s).

Provide a brief overview of the service (e.g. Type of care provided, size, facilities, number of people using it, whether there is or should be a registered manager etc).

N.B. If there is or should be a registered manager include this statement to describe what a registered manager is:

'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.'

Give a summary of your findings for the service, highlighting what the service does well and drawing attention to areas where improvements could be made. Where a breach of regulation has been identified, summarise, in plain English, how the provider was not meeting the requirements of the law and state 'You can see what action we told the provider to take at the back of the full version of the report.' Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work at there.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The manager had assessed individual risks to people. They had taken action to minimise the likelihood of harm in the least restrictive way.

People received their medicines at the right time and in the right way to meet their needs.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

Is the service effective?

Good

The service was effective.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Staff received an appropriate induction and on-going training to enable them to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

People were encouraged to maintain friendships and important

relationships.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

Care plans and activities were personalised and focused on individual needs and preferences.

People were allocated a keyworker who provided a focal point for their care and support.

The manager sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Good

The service was well-led.

The provider's values were clear and understood by staff. The manager adopted an open and inclusive style of leadership.

People, their families, health professionals and staff had the opportunity to become involved in developing the service.

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment.

Venner Avenue

Detailed findings

Background to this inspection

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

The inspection was unannounced and was carried out by one inspector on 14 December 2015.

Before this inspection, we reviewed the information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the provider is required to send to us by law.

We met with the four people staying at the home, who were unable to communicate with us verbally but were able to demonstrate their understanding of what they were being asked. We observed how they interacted with staff and how care and support was being delivered in communal areas of the home. We also spoke with the relatives of three of the people staying at the home. We spoke with three members of care staff, a senior care staff member, the manager and with the group manager on behalf of the provider.

We looked at care plans and associated records for the all of the people using the service, staff duty records, four staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

Good

Is the service safe?

Our findings

The relatives of three of the people using the service told us they did not have any concerns regarding their relatives' safety. One family member said, "I have no qualms at about [my relative's] safety. I can sleep easy knowing they are well looked after". Another family member told us their relative was "Definitely safe. The staff are excellent".

Staff had the knowledge necessary to enable them to respond appropriately to concerns about people. All of the staff and the manager had received safeguarding training and the staff knew what they would do if concerns were raised or observed in line with the providers' policy. One member of staff told us, "If I had any concerns I would tell [the manager] and if they didn't take action I would take it further". Records detailed the action that was taken when a safeguarding concern had been identified; including reporting the information to the appropriate authority in a timely manner.

The manager had assessed the risks associated with providing care to each individual; these were recorded along with actions identified to reduce those risks. They were personalised and written in enough detail to protect people from harm, whilst promoting their independence. For example, the management of risks related to the activities, such as ice skating. All of the people were subject to epileptic seizures and the risk assessments relating to their seizures were different for each person. Staff were able to explain the risks relating to people and the action they would take to help reduce the risks from occurring. Where an incident or accident had occurred, there was a clear record of this and an analysis of how the event had occurred and what action could be taken to prevent a recurrence. For example, one person had recently had a fall in their bedroom. The manager reviewed the circumstances of the fall and arranged for a pressure mat to be obtained to inform staff when the person was getting out of their bed. Each person's care plan contained a 'Vulnerable Adult Form', which provided the information necessary for health professionals to support that person should they be taken to hospital in an emergency.

At our previous inspection in October 2013 we identified that the provider had failed to ensure there were sufficient numbers of suitably qualified, skilled and experienced staff. During this inspection we found there were enough staff available to meet people's needs. The manager told us that staffing levels were based on the needs of the people using the service. The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner. Staff responded to people promptly and additional staff members were available to support people attending activities away from the home, for example, visiting a local day centre, going shopping and trips out in the car. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime, staff employed by the provider at other homes, the provider's bank staff and agency staff. The manager was also available to provide support when appropriate. One family member told us, "There is always plenty of staff there when I arrive. They are always nearby or sitting talking to people". Another family member said "There seems to be more staff there than before as they are able to go out more and do things".

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited

were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks, were completed for all of the staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

People received their medicines safely. Staff had received appropriate training and their competency to administer medicines had been assessed to ensure their practice was safe. Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given. There were suitable systems in place to ensure the safe storage and disposal of medicines. A refrigerator was available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturer's instructions. There was a medicine stock management system in place to ensure medicines were stored according to the manufacturer's instructions and a process for the ordering of repeat prescriptions and disposal of unwanted medicines. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them.

At our previous inspection in October 2013 we identified that the provider had failed to ensure the maintenance of appropriate standards of cleanliness and hygiene, and protect people, staff and visitors from the risk of infection. During this inspection we found the home was clean and well maintained. Staff had received infection control training and were able to demonstrate a good understanding of its principles.

There were appropriate plans in case of an emergency situation. Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Staff were aware of the fire safety procedures and the action they would take if an evacuation was necessary. Evacuation Ski sheets, which are an aid to assist staff to evacuate people with limited mobility in an emergency were also available for each person.

Good

Is the service effective?

Our findings

The families of people using the service told us they felt the service was effective and that staff understood their relatives' needs and had the skills to meet them. One family member said "Staff know [my relative] inside out. They know just what [my relative] needs". Another family member told us, "staff know exactly what they are doing and how to support [my relative]".

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. These included decisions about the provision of personal care, the use of bed rails and the use of wheelchair lap straps.

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 the provider was following the necessary requirements. DoLS applications had been made by the supervisory body with the relevant authority for all of the people using the service. Staff had been trained in MCA and DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence. People's families and other representatives had been consulted when decisions were made to ensure that they were made in people's best interests. For example the use of bedrails to protect people while sleeping.

Families told us that staff asked their relatives for their consent when they were supporting them. One family member said their relative "can make their feelings known if they don't want to do something". Another family member told us their relative would "push something away to show they didn't want it". Daily records of care showed that where people declined care this was respected.

Staff encouraged people to make decisions and supported their choices. For example, The home had planned a trip to the mainland to watch a pantomime. Two people did not want to go and staff arranged for those two people to undertake the activities they wanted to do instead.

There were arrangements in place to ensure staff received an effective induction into their role. Each member of staff had undertaken an induction programme based on "Skills for Care Common Induction Standards" (CIS). CIS are the standards employees working in adult social care should meet before they can safely work unsupervised. The manager told us that since April 2015 any new staff being recruited would

receive an induction and training, which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. The manager had arranged for all staff to undertake the care certificate training as a way of refreshing their knowledge and a means to encourage discussion within the team.

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as medicines training, safeguarding adults and first aid. Staff had access to other training focused on the specific needs of people using the service. For example, epilepsy awareness, autism awareness and training in respect of the new care regulations. Staff were supported to undertake a vocational qualification in care. Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example how they supported people who were living with a cognitive impairment to make choices and maintain a level of independence.

Since the home re-opened in September 2015 staff had received regular supervisions. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and learning opportunities to help them develop. The manager told us her plan to ensure that supervisions were arranged and monitored on a regular basis and annual appraisals were completed. Staff said they felt supported by the manager and the senior staff member. There was an open door policy and they could raise any concerns straight away.

People were supported to have enough to eat and drink. Family members were complimentary about the food and told us their relatives were supported to eat the food they liked. Staff who prepared people's food were aware of their likes and dislikes, allergies and preferences. Meals were appropriately spaced and flexible to meet people's needs. Mealtimes were a social event and staff engaged with people in a supportive, patient and friendly manner. Staff were aware of people's needs and offered support when appropriate. Staff encouraged people to drink throughout the day. A family member told us that their relative had their food pureed. They said, "Staff puree each thing separately so [my relative can enjoy the different flavours".

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail.

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. Family members told us they did not have any concerns over the level of care provided or how it was delivered. One family member said "staff are very caring and patient with [my relative]. I can't fault them". Another family member told us, "All of the staff are very good". A third family member said, "Staff are very nice, very kind".

People were cared for with dignity and respect. Staff spoke to people with kindness and warmth and were observed laughing and joking with them. Staff responded promptly to people who required assistance. A member of staff identified that a person appeared disinterested with the programme they were watching on the television. They checked with the person whether they wanted to watch the programme or whether they wanted to do something else. They offered to put on their sensory lights and confirmed with them that this was what they wanted.

Staff understood the importance of respecting people's choice, and privacy. They spoke with us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what the preferred to eat and whether they took part in activities. Choices were offered in line with their care plan and preferred communication style. Where people declined to take part in an activity or wanted an alternative this was respected. We also observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited before entering.

People's families were involved in discussions about developing their care plans, which were centred on the person as an individual. One family member told us "I was recently involved in the review of [my relative's] care". We saw that people's care plans contained detailed information about their life history to assist staff in understanding their background and what might be important to them. Staff used the information contained in people's care plans to ensure they were aware of people's needs and their likes and dislikes.

People were encouraged to be as independent as possible. One member of staff was supporting a person to mobilise out of a chair. They patiently provided gentle encouragement, support and guidance to the person until they were able to get out of the chair and mobilise with a frame. Once they had achieved this, the member of staff praised their efforts and we saw the person's face reflected a sense of achievement.

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. All of the families we spoke with confirmed that the manager and staff supported their relatives to maintain their relationships. People's bedrooms were individualised and reflected people's interests and preferences. The bedrooms were personalised with photographs, pictures and other possessions of the person's choosing.

Good

Is the service responsive?

Our findings

The families of people using the service told us they felt the service was responsive to their relative's needs. One family member said their relative, "Is much happier since she has moved in there [my relative] really enjoys herself there". Another family member told us the staff, "monitor [my relative] all the time and they keep me informed about what is happening and if there are any changes".

Although people were not able to verbally communicate with staff, they were able to demonstrate their understood what they were being asked and could make their wishes known. Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. Staff used plain English and repeated messages as necessary to help people understand what was being said. Staff were patient when speaking with people and understood and respected that some people needed more time to respond.

When appropriate, people's families were involved in discussions about their care planning, which reflected their assessed needs. The support plans described people's routines and how to provide both support and personal care. Each person had an 'easy read' health action plan supported by pictorial representations suitable for the needs of the person they related to. This was used to encourage people to become involved in developing the care plan. Staff were knowledgeable about the people they supported and were able to tell us in detail about their preferences, backgrounds, medical conditions and behaviours.

People's daily records of care were up to date and showed care was being provided in accordance with people's needs. Handover meetings were held at the start of every shift and supported by a communication book, which provided the opportunity for staff to be made aware of any changes to the needs of the people they were supporting.

Each person had an allocated keyworker, whose role was to be the focal point for that person and maintain contact with the important people in the person's circle of support. They also supported them with their shopping, managing their clothes and maintaining their room. Each of the key workers carried out a monthly review with the person of the activities they had engaged with and the activities they might like to try. They discussed their health needs and asked for the person's views about their support. A family member told us their relative's keyworkers were "really on the ball. They seem to understand just what she wants".

Staff were knowledgeable about people's right to choice and the types of activities people liked to do, and knew what activities they would likely choose. People had access to activities that were important to them. These included going out for drives around the island, ice skating and trips to the theatre. One family member told us their relative "couldn't be happier there. They take [them] out shopping and [they] even go swimming now".

There were activities available for people in the home, such as helping with cleaning and washing up, watching films and listening to music. We also observed a member of staff supporting one person as they

looked through a catalogue to show the things they wanted for Christmas. The member of staff engaged with the person and provided both verbal encouragement and physical support when needed.

People and their relatives were encouraged to provide feedback and were supported to raise complaints if they were dissatisfied with the service provided at the home. People were supported by independent mental capacity advocates (IMCAs) who were available to support them if they were unhappy about the service provided. The IMCAs had been involved in supporting people with the decision regarding moving back into the home. The manager sought feedback from people's families on an informal basis when they met with them at the home or during telephone contact. The manager had a plan in place to seek formal feedback through the use of quality assurance survey questionnaires, in line with the providers policy, once the home had been re-opened for six months '.

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. The manager told us that people's keyworkers would support them to raise any concerns initially and people also had access to independent advocacy services if they needed them. All of the family members knew how to complain but told us they had never needed to. The manager told us they had not received any complaints since the home had re-opened and was able to explain the action that would be taken to investigate a complaint if one was received.

Good

Is the service well-led?

Our findings

The families of people using the service told us they felt the service was well-led. One family member said, "the manager seems to be on the same wavelength as me. [My relative] seems very happy there, [they] have got their sparkle back". Another family member told us, "I am very impressed with the manager, she is very good".

There was a clear management structure which consisted of a manager, two senior care staff and group manager. Staff understood the role each person played within this structure. The management team encouraged staff and people to raise issues of concern with them, which they acted upon.

Care staff were aware of the provider's vision and values and how they related to their work. Regular staff meetings provided the opportunity for the manager to engage with staff and reinforce the provider's values and vision. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. One member of staff told us, "If you say [to the manager] something is not working right, she will get on top of it straight away". They added that they felt included in the running of the home. Another member of staff said "[The manager] is approachable and easy to talk to. If I had a problem she would sort it out for me".

Family members told us they were given the opportunity to provide feedback about the culture and development of the home and all said they were happy with the service provided.

At our previous inspection in October 2013 we identified that the provider had failed to ensure there was an effective system in place to regularly assess and monitor the quality of the service provided. During this inspection we found there were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment. The manager carried out regular checks of medicines management, the cleanliness of the home, and care plans. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures, the medicine cupboard temperatures and fire safety. The manager told us that if a concern was identified remedial action would be taken.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission (CQC) if they felt it was necessary.

At the time of our inspection the manager was not yet registered because they had only recently been appointed following the home re-opening after a long closure period. Although not registered the manager understood the responsibilities of a registered manager and was aware of the need to notify the Care Quality Commission (CQC) of significant events regarding people using the service, in line with the requirements of

the provider's registration. They told us that support was available to them from the provider through the group manager for learning disabilities Homes. They were also able to raise concerns and discuss issues with the registered managers of the other learning disabilities services owned by the provider.