Mrs L Huntley

Venville House

Inspection report

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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

Overall summary

We undertook an unannounced visit to the home on 27 October 2014.

Venville House provides accommodation and support to older people who may be living with dementia. Any nursing needs are met through community nursing services because it is not a nursing home. The service can accommodate up to eight people. At the time of our inspection seven people were using the service.

At our last inspection in July 2013 the service met the regulations we inspected.

The service is run by an individual registered by the Care Quality Commission under the Health and Social Care Act 2008. They have the legal responsibility for meeting the requirements of the law.

There was some outdated practice in assisting people to move from their chairs.

People were at the heart of the service, treated as individuals and as part of a family. People were supported by staff that were kind and treated them with dignity and respect. It was normal practice for staff to spend time engaging with people.

Summary of findings

People led busy and fulfilled lives and were supported to follow interests outside of the home. Much effort was made to maintain contacts with family and friends. People's anxieties were understood and staff were able to promote feelings of wellbeing.

Staff felt valued for their work. There was a positive culture within the service which was demonstrated by the attitudes of staff and management. Many of the staff had worked in the service for a long time, knew people very well and had developed meaningful relationships with people they supported. Staff understood people's vulnerability and how to protect them from abuse and harm.

The registered person set the standards staff were expected to meet and regularly provided support, advice and mentoring so people's welfare was promoted. Staff were quick to recognise changes in people's health and wellbeing and ensured health care advice was sought promptly when needed.

The service worked to the principles which underpin the codes of practice of the Mental Capacity Act 2005. Staff knew how to make sure people, who did not have the mental capacity to make decisions for themselves, had their legal rights protected and worked with others in their best interest. People's safety and liberty were promoted.

Quality monitoring was based on people's views, close monitoring of people's health, social and emotional needs and audits. Changes were made which improved people's lives where this was possible.

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?

Good

The service was safe.

People were protected from abuse, discrimination and their legal rights were upheld by a well-informed staff who understood their responsibilities.

Sufficient staff were available to ensure people were cared for in a safe way. There were robust recruitment arrangements in place so staff recruited were suitable to care for vulnerable people.

Medicines were managed in a safe way.

Is the service effective?

Good

The service was generally effective.

A care worker helped two people out of their chairs using outdated practice.

People received care from staff who had substantial experience. Physical and psychological health care needs were well met in line with people's care plans. Professional advice was sought promptly when necessary.

People received an adequate and nutritious diet which took into account their specific health needs and preferences.

At the time of our inspection no one was subject to the Deprivation of Liberty Safeguards. The service was meeting the requirements of the Mental Capacity Act 2005 code of practice although they were not documenting how decisions about people's capacity had been made.

Is the service caring?

Good

The service was caring.

People who used the service were supported by staff who had built positive caring relationships with them. People were valued and respected in a home from home environment.

All care delivered was based on person centred care planning. People were involved in decisions about their care. Their care needs were fully understood and always taken into account.

Is the service responsive?

Good

The service was responsive to each person's individual needs at all times.

People's needs were assessed and care plans were produced identifying how to support people with their care needs. These plans were tailored to the individual and reviewed as people's needs changed. The service had developed creative and innovative ways of ensuring people led fulfilling lives within the limitations of their health.

The service was centred on each individual at the home. Their past, present, likes, dislikes, anxieties and personalities were taken into account and the care they received was based on meeting those needs.

Summary of findings

Is the service well-led?

Good

The service was well led.

The culture was one of openness, caring and respect. This was led by the registered person who provided day to day support for people using the service and frequent support and mentoring of staff.

The service was monitored through listening to people, their family and staff, observation and regular audits of the service provided.

Venville House

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, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection was carried out on 27 October by one inspector.

Before the inspection, the provider completed 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. We also reviewed the information we held about the home and any notifications we had received. A notification is information about important events which the service is required to tell us about by law.

Before this inspection we spoke with three health and social care professionals about Venville House. During the visit we looked around the premises. We spoke with two people who used the service, one person's family and two members of staff and the registered provider. Not everyone was able to verbally share with us their experiences of life at the home. This was because of their dementia/complex needs. We therefore spend time observing people and staff as they supported them.

We looked at records which related to three people's individual care, recruitment files for two staff, the staff training plan, three risk assessments and three policies which related to the running of the home.

Good

Is the service safe?

Our findings

People said that if they had any concerns they could take them to the registered provider. We asked one person if they felt safe and they told us, "100%". They said they wanted staff at the home to make sure they were always safe as safety worried them. A person's family said they had seen nothing to be concerned about at the home.

Staff demonstrated a good understanding of what might constitute abuse and knew where they should go to report any concerns they might have. For example, staff knew to report concerns to the registered person and externally such as the local authority, police and the Care Quality Commission (CQC). Staff told us they had received safeguarding training. Records of training confirmed that five of the seven staff had received safeguarding training in line with the renewal date decided by the service. However, posters and recently reviewed safeguarding and whistle blowing policies were available for staff reference.

The registered provider demonstrated a clear understanding of their safeguarding role and responsibilities. They explained the importance of working closely with commissioners, the local authority and relevant health and social care professionals on an ongoing basis. The safeguarding policy set out types of abuse, how to recognise abuse and the steps which should be followed to safeguard vulnerable adults, such as working in partnership with the local authority. Staff confirmed that they knew about the safeguarding adults' policy and procedure and where to locate it if needed. There have been no concerns, complaints or safeguarding alerts raised about Venville House since the last inspection.

The registered person had a detailed understanding of protection from discrimination. Staff confirmed this was successfully put into practice on occasions when a person using the service wished to raise attention to what they perceived to be a staff difference and discriminate against them. The registered person addressed this with the person, and supported the staff member, each time this occurred. This showed that discrimination was addressed at Venville House.

Risks to individual people were identified and the necessary risk assessment reviews were carried out to keep people safe. For example, we saw risk assessments for managing behaviours which challenged, medicines management and going into the local community. Risk management considered people's physical and mental health needs and showed that measures to manage risk were as least restrictive as possible, such as the use of distraction techniques when a person was becoming distressed. We observed staff using these techniques. The registered person was able to describe why the person was distressed that particular day and how the cause was being addressed. They told us, "You need to get to the route of the behaviour".

The number of staff on duty was sufficient to meet people's needs and a person told us their needs were always met. Staff felt that there were sufficient staffing numbers, which was always a minimum of two staff. The registered person lived on the premises and was part of the staffing team. Staffing numbers were adjusted to enable people to access the community with staff support. For example, for health care appointments or social events.

There were robust recruitment and selection processes in place. Two staff files for the most recently recruited staff included completed application forms and interviews had been undertaken. In addition, pre-employment checks were done, which included references from previous employers, health screening and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work with people using the service.

People received medicines in a way which promoted their independence. For example, where a person had wanted to look after their own medicines they had been supported to do this, with assessed risk being managed. Appropriate arrangements were in place when obtaining medicine which was from two GP surgeries on a monthly basis. These were supplied, where appropriate, in blister packs so that staff could administer people's medicines in a safe way. Records were kept of medicines requested, delivered and returned to the pharmacies so medicine use could be monitored.

Medicines were kept safely in a locked medicine cupboard. The cupboard was kept in an orderly way to prevent mistakes from happening. There were no medicines known as controlled drugs which require specialist storage arrangements at the time of the visit.

Good

Is the service safe?

Medicines were administered in a safe way, usually by the registered person. The medicines recording records were appropriately signed when administering a person's medicines. Certain additional checks had been put in place by the home to ensure that people received the correct type and dose of medicines. For example, codes were used to indicate where medicines had been refused.

Good

Is the service effective?

Our findings

The home's training schedule showed that staff received a variety of training, such as fire safety, diversity, dignity, continence and pressure ulcer prevention. The training review dates also showed that some training, for some staff had not been completed within the timescale which was stated. For example, six of the seven staff had not received a medicines training update. The registered manager said only staff who had undertaken medicines training administered medicines. Only two of the seven staff had received training in dementia care in the last six years, whilst most people using the service lived with dementia. The registered manager said she attended conferences and kept up to date with the latest developments in dementia care. This included Masters level training in therapeutic practice. We saw the registered provider frequently instructing, supporting and mentoring staff. She told us they also work regular night shifts to ensure staff practice was as they required it to be.

People using the service, their family and health and social care professionals did not voice any concerns about the staff's ability to meet people's needs and the training they received. A community psychiatric nurse described the staff as "very thorough". A social worker said, "They have a lot of understanding of people's behaviours."

Staff knew how to respond to specific health and social care needs. For example, changes in a person's behaviour indicating they had an infection. Staff understood how they contributed to people's health and wellbeing. For example, the type of support a person responded to when they became anxious.

Staff had completed an induction when they started work at the service, which included training. The induction required new members of staff to be supervised by more experienced staff to ensure they were safe and competent to carry out their roles before working alone. Staff received a range of training, which enabled them to feel confident. Staff had received training in moving people safely however, on two occasions we saw staff assisting people to stand using a technique which was outdated and had the potential to cause injury.

People were consulted about their daily lives and their consent was sought routinely. There were frequent examples of how people were enabled to make choices, spend their time and make decisions, such as whether to speak with the inspector in private.

Staff demonstrated an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. For example, what actions they would take if they felt people were being deprived of their freedom to keep them safe. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. One person's family confirmed that, where the person was unable to decide what medical care they would accept, family knowledge about them had been sought so the decision was made in the person's best interest.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst no-one living at the home was currently subject to a DoLS, we found the registered person understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

Where people did not have the capacity to make particular decisions about their care and support, due to their health condition, there was evidence of a good understanding by staff of mental capacity and promoting people's decision making. However, records did not show how people's capacity to make a decision had been assessed. For example, recording whether the individual could understand the decision to be made. There was supporting evidence of best interest discussions or meetings which had taken place, such as contact with appropriate health care professionals, such as a GP.

Individual dietary needs were understood and met. For example, the registered person had taken considerable time to identify foods which were causing one person health problems. Individual diets were catered for in accordance with people's preferences. One person told us the food they chose was "wonderful". People were offered regular drinks and served an attractive and balanced lunch

Good

Is the service effective?

during our visit. Where people were at risk of weight loss, their weight was monitored on a regular basis. Staff described how they recognised changes in a person's eating habits and when they needed to consult with health care professionals involved in people's care.

People were supported to see appropriate health care professionals when needed, to meet their healthcare needs. People's care plans provided staff with information about people's physical and mental health needs. Records showed the involvement of health and social care professionals in people's individual care on an on-going and timely basis. For example, GP, care manager and community psychiatric nurse. These records demonstrated how staff recognised changes in people's needs and ensured other health and social care professionals were involved to encourage health promotion. Health and social care professionals spoke positively about the care provided at Venville House. Comments included "thorough" and "very proactive".

Good

Is the service caring?

Our findings

Staff were caring, unrushed and considerate when supporting people. For example, one person lacked the speech to tell the staff what they wanted to do but the staff gave them time and provided options until the decision was made. Another person was anxious and staff gave them the time they needed to reduce that anxiety. Staff told us, “We always have time to talk however long it takes. (The registered person) would expect that.” The registered person said, “I make sure staff know how to keep (a person) calm”.

People using the service were assessed and a questionnaire was completed on admission. The registered person said this provided a starting point to develop activities and outings in line with people’s preferences. People’s comments included: “It’s very nice. (The registered person) is as good as good. They think along my lines.”

Staff involved people in their care and allowed them time to make their wishes known. People’s individual wishes were acted upon, such as how they wanted to spend their time. For example, one person preferred their own company and remained in their room. Two chose to complete a puzzle and two watched the television. Staff consulted people and kept them informed, such as when lunch would be ready. Staff were people, not task oriented. Staff adopted a strong and visible personalised approach in how they worked with people. There was evidence of commitment to working with people to meet their individual needs, which meant that people felt cared for and valued.

People’s views were sought when making decisions about their care and treatment. For example, how they preferred personal care to be delivered, how they preferred to dress and whether to have an influenza injection. People’s views were respected.

Staff treated people with dignity and respect when helping them with daily living tasks. Staff told us how they maintained people’s privacy and dignity when assisting them, for example by knocking on bedroom doors before entering and gaining consent before providing care and support. We were able to observe this. Staff were adept in the way they involved people and respected their independence. One person told us how pleased they were they had been “given access to friends they had not seen for a long time”. The registered provider told us they made all activities meaningful. For example, people made cards that could be sent to relatives.

Staff relationships with people were friendly, caring and supportive. Staff spoke confidently about people’s specific needs and how they liked to be supported. Through our observations and discussions, we found that staff were motivated and inspired to offer care that was kind and compassionate. For example, staff told us that each person at Venville House was not a resident but an individual. They said, “We know people’s backgrounds”.

Good

Is the service responsive?

Our findings

The needs and wishes of each person using the service were responded to promptly. For example, the registered provider said staff would look at the weather and plan a trip to the park or across the moor for an ice cream at a moment's notice. The small staff team had detailed knowledge of the people in their care. They looked for innovative opportunities for activities "at any time of the day". These included activities of daily living, such as baking, laundry or table games, which we observed people involved in. A community psychiatric nurse told us, "A very family orientated small, integral setting".

Care planning was personalised and arrangements were in place to acquire any information about a person's history which could help staff support them in the present. This frequently involved involving people who knew them well or learning about people through providing care and support and noting how they responded. One example was a person's bedroom décor which matched that of their family bedroom, which they told us they missed. Staff understood people's anxieties, needs and wishes and responded to them. For example, people could bring their pets when they moved to the home. Staff supported people to care for their pets, including with dog walking and animal health care appointments.

Service improvements were specific to each individual. For example, one person had to move to the home very quickly to meet their needs. Staff had sought information of what was most important to them to help them manage the change. This led to an immediate transfer of the person's furniture and a large quantity of personal items to Venville House. Another person was assisted to visit their family home to collect pictures which were important to them. They were also enabled to meet with a builder there to sort out maintenance work which was worrying them. People who found going to the shops difficult were able to use mail order purchases. We were told if there were problems with a size the staff would take the item back to get them changed. Another person moved to Venville House with very little clothing and so the issue was dealt with by taking them shopping for shoes, slippers and other clothing necessities.

People had a wide range of activities available to them. These included a regular tea dance, shopping trips, magazines ordered for people's special interests and walks to see donkeys in a nearby field. They also knew people who preferred to be "left alone" and they respected this. However, people were not isolated in the family environment of Venville House.

Staff understood people's verbal and nonverbal communication, such as changes in mood. This included end of life care, for example, deciding the best time for a person to move to a nursing home when terminally ill. The registered person told us, "Positive engagement is not a one size fits all activity".

The complaints procedure was available on admission and seen displayed at the home. The registered person was regularly available to people living at and visiting the home, to discuss any issues or concerns and provide information. We were told there had been no complaints made about the service and the CQC has received no complaints about the service. A person using the service told us, "I would have a word with (the provider) if I had any concerns". A person's family told us, "(The provider) keeps me in the picture."

Detailed discussion and planning, which was over a considerable period of time, were involved where a person moved between services. This involved the person, their family representative and health and social care professionals. The registered provider was fully engaged in supporting one person as decisions were made to move them in their best interests. Detailed records accompanied the change of service so the transfer was well planned.

Good

Is the service well-led?

Our findings

We observed a culture at the home of respect for people using the service and the staff supporting them. A social worker told us, "(The registered person) goes the extra mile" and "Staff at Venville seem to love what they do".

The registered provider was able to provide, through familiarity and kindness, the security people needed within a family environment. For example, they supported one person to make the decision about staying at the home, spending hours with them discussing their wishes and fears and visiting the family home they had left.

The registered provider led by example and provided support and advice for staff. A staff member said, "I am very supported by (the registered provider). We are asked how things are going, about training and how we think things could be improved". They talked of taking time to talk to people, saying this was expected of them as normal practice. The registered provider described a "robust management structure with all senior staff at the home trained to NVQ 4".

The quality of the service was under regular review based on people's views and assessment of their wellbeing. Information toward service review was also sought from observing staff providing support. The registered provider worked regularly alongside staff, including regular night duties, to ensure "full understanding of the needs of service users across the full 24 hour period". People's opinions had led to changes. For example, the need of a new front door, purchased to keep the home warmer. Records confirmed audits of the service provided information to ensure safety at the home, such as whether there were trip or fire safety hazards. Those audits included keeping pets within the small home environment. To meet this challenge staff members supported people to walk their dogs regularly, or walked the dogs on their behalf.

A new recording arrangement had been introduced for reviewing the effectiveness of people's care. The new records were being reviewed on a monthly basis. They took into account changes to risk, mobility, mood and wellbeing, appetite and nutrition and had been designed to improve the monitoring of how people were progressing. We saw these had been completed. We asked about the monitoring of accidents or incidents to look for trends. We were told there had been none for a considerable time. We had not received notification of any adverse events or injuries at Venville House, which supported what we were told. Health and social care professionals were unaware of any incidents or accidents.

Health and social care professionals praised the leadership at the home and the service delivered. They described the staff as seeking prompt advice as necessary to promote people's wellbeing. They said the home was very proactive in ensuring people had links with the community; there was much evidence for this, including maintaining family relationships by taking people using the service to visit their family.