Isle of Wight Council

Venner Avenue

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

Summary of findings

Overall summary

Venner Avenue is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Venner Avenue is a is a local authority residential care home which provides accommodation for up to four people with learning disabilities and Autism who need support with their personal care. At the time of our inspection there were four people living in the home.

The home was a single floor building with the bedroom accommodation located around the main living areas. There was one main bathroom available to people. There were two communal areas in the home, which were a kitchen/dining room and a lounge.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

At our last inspection, we rated the service good. At inspection, we continued to rate the service as good

The principles of the Mental Capacity Act 2005 were not being followed as required; best interest decisions were not in place for all people that required them. However, the provider was in the process of implementing such a process.

There were sufficient staff to meet the needs of people and to support them to access the community.

Families told us they felt their relatives were safe at the home. Staff understood their roles and responsibilities to safeguard people from the risk of harm. Staff knew how to identify, prevent and report abuse.

There were robust arrangements in place for the safe recording, storage and administration of medications, as well as risk assessments and practices to safeguard people's health and wellbeing.

Risks to people and the environment were assessed and reviewed regularly.

The registered manager understood their responsibilities for end of life care and knew how to access relevant support if needed.

The provider had an effective recruitment process in place. Staff had undertaken all other appropriate training to be able to support people according to their needs, choices and preferences. Care plans and risk assessments were regularly updated and contained personalised information to support people's needs.

Staff had developed respectful, caring relationships with the people they supported. People received care and support which reflected their preferences, capabilities and needs. People were involved in making decisions about their care and had care plans that were compiled using pictures and photographs so that they were accessible to them.

Staff worked in partnership with health and social care professionals to promote people's health and wellbeing.

The registered manager promoted a person centred, caring philosophy, which was shared by all staff.

The home had a warm and friendly feel and people appeared happy and relaxed with staff.

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 remains Good.

Staffing levels met the needs of the people using the service. Staff had been recruited safely.

Appropriate systems and processes were in place to protect people at risk of abuse. Staff understood their safeguarding responsibilities and had received safeguarding training.

People received their medicines as required.

There were appropriate systems in place to protect people by the prevention and control of infection.

Is the service effective?

Good

The service remains Good

The principles of The Mental Capacity Act were not being followed as records of best interest decisions had not been made for all people. However, the provider was in the process of ensuring this occurred for all people at the time of the inspection.

People's nutrition and hydration needs were met. They were supported to access healthcare services when needed.

Staff had received appropriate training to enable them to meet the needs of the people. Staff were supported through regular supervision and appraisal to develop their day to day practice.

People had access to health professionals and other specialists if they needed them.

The premises had been designed and adapted to meet the needs of the people.

Is the service caring?

Good

The service remains Good

The staff showed kindness and were caring in their interactions with people.

Positive communication methods were being used, which enabled people to be actively involved in making choices about their lives.

People's privacy and dignity was maintained.

Is the service responsive?

Good

The service remains Good

Care planning was robust and person centred. Pictorial care plans were accessible and people were actively involved in decision-making.

Staff involved people in daily activities and promoted choice and individuality.

People were supported to participate in activities in their community.

Is the service well-led?

Good

The service remains Good.

The provider had a system in place to monitor the quality of the service provided.

Environmental risks and risks to people were monitored effectively.

The registered manager and staff had developed a positive culture where people were involved in decisions and supported to do as much for themselves as possible.

Community links had been developed and new opportunities were actively sought.

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a comprehensive inspection. The inspection took place on 17 and 18 April 2018 and was unannounced. One inspector undertook the inspection.

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 reviewed the PIR, previous inspection reports and notifications we had been sent by the provider. A notification is information about important events, which the service is required to send us by law.

We engaged with three people, who communicated with us verbally in a limited way. We were unable to have coherent conversations with all people living at the home due to their learning disabilities. We observed care and support being delivered in communal areas of the home. 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 spoke with three staff, the provider's group manager, the provider's service manager and the registered manager. We spoke with one family member and two external professionals. We looked at care plans and associated records for four people, staff duty records, staffing records of three staff, records of accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in December 2015 when it was rated as Good.

Good

Is the service safe?

Our findings

People appeared safe and were relaxed around staff. However, they were unable to tell us if they felt safe or have coherent conversations with us because of their learning difficulties. We observed staff supporting people to move around the home safely and they gave clear explanations to people of what they were doing. For example, one staff member said, "I'm just going to lift your legs up and take the foot stool away, are you comfortable?" A family member told us, "I feel [person's name] is safe at the home and staff are careful and know how to look after them."

There were sufficient staff numbers to meet people's needs. The registered manager reviewed the staff rota daily to ensure safe staffing levels. They told us that short-term staff absences were usually covered by the existing staff team, and they used the provider's own bank staff when they needed to. We looked at the staff rota and saw that sometimes they were unable to get cover for all the staff absences. We discussed this with the registered manager who told us that they tried to have three staff on duty so that there was more opportunity for people to go out individually with a staff member and do things in the community. However, we observed that despite there only being two staff on duty, people still went out individually and had regular access to activities in their community. A staff member told us, "It is much better with three staff on duty, but we manage with two when we need to." We discussed staffing levels with the registered manager who then completed a risk assessment, which considered the impact on people when they had one less staff member on duty. The impact was identified as people having fewer opportunities to individually access the community but did not find people's safety was being compromised.

The provider had appropriate policies in place to protect people from abuse. Staff had received training in safeguarding adults and they were able to identify different types of abuse and describe the actions they would take if they suspected or observed abuse. Staff said they would have no hesitation in reporting abuse and were confident the registered manager would act on their concerns. One staff member said, "I am confident that I would do the right thing and know who to contact, if I was not happy with the response I would contact the local authority or CQC if I needed to." There was written information in the office, which gave staff the details of who to contact. This included the registered manager's number, the provider and the local social services safeguarding team. The registered manager was aware of the action they should take if they had any concerns or concerns were passed to them. They followed local safeguarding processes and had responded appropriately to allegations or concerns of abuse. Records confirmed that the registered manager had reported incidents appropriately and promptly to the local safeguarding authority.

People had robust risk assessments, which were stored in their care files. We looked at four care files and all risk assessments had been reviewed regularly and kept up to date. Risk assessments included the use of safety equipment to help people to move, risks about accessing the community and risks around eating and drinking. We saw one care file had identified risks around the use of a fluid thickener. This can be prescribed when people have difficulties in swallowing fluids. The registered manager was aware of the risks posed by a fluid thickening powder if ingested without it being mixed with fluids. However, there was no risk assessment to identify the risks and consider where fluid thickener was stored in the home. This was discussed with the registered manager at the time, who promptly wrote a risk assessment to consider the

storage and use of fluid thickener and the risks to people in the home. In addition to the risk assessment, there was also a guidance sheet, which described exactly how the person would need their drinks preparing and the support they would need when drinking. Staff confirmed they had read them and understood how to support people to keep them safe. This meant that staff were able to use information in people's care plans to support people safely, whilst enabling them to be as independent as possible.

Environmental risks had been assessed robustly and were monitored to make sure people were protected from avoidable harm. Checks on the building and equipment in use, including a bath hoist and sensor mats to alert staff if a person had a seizure, were being carried out. Tests to check that the equipment was working were carried out daily. This meant that people could be assured the equipment in use was safe and that sensor mats would alert staff when needed. Gas and electrical appliances were serviced routinely. Staff also checked the temperature of all hot water outlets on a weekly basis.

The provider had an accident and incident reporting system. We reviewed incident and accident records for four people. The records showed that themes and patterns were analysed and action taken when required. For example, one person had recently had a fall. The registered manager identified the cause and consequently the carpet in one room was replaced. The provider had a policy in place to prevent and control the spread of infection which included the reporting of infectious diseases. Staff used protective equipment such as disposable gloves and aprons when delivering personal care. Cleanliness was maintained throughout the home.

People's medicines were recorded, stored and administered safely. Staff had received appropriate training and medicines administration records (MAR) were completed accurately. Regular audits of medicines were carried out and there were secure systems in place for staff to transport, administer and return people's medications if they went out for the day. People's care plans contained relevant information about what their medicines were needed for and how any medical conditions might affect them. When people required 'as and when' (PRN) medicines such as for pain relief, staff had clear guidance to follow. This meant that they could assess the person and only administer any medicine when needed.

There were policies and procedures for staff to follow in the event of a fire and each person had a personal emergency evacuation plan (PEEP). This was to ensure that staff knew each person's needs in the event of a fire or an emergency. The PEEP's detailed the support people would need if the building needed to be evacuated. Fire drills had taken place, which enabled staff to be clear about what to do in the event of a fire. Arrangements were in place to accommodate people at another home owned by the provider, should this be required in the event of an emergency evacuation. The provider's policy was that fire detection and management equipment would be tested weekly, and this was being done.

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. This was managed by the provider's business support team in conjunction with the registered manager. This required applicants to provide a full employment history and to undergo reference checks and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruiting decisions and helps prevent unsuitable people being employed. We looked at three staff recruitment files, which all contained the relevant documentation. This meant that the provider could be assured that the people they employed were suitable to work with people who used care and support services.

Good

Is the service effective?

Our findings

Many people living at Venner Avenue had a cognitive impairment and were not able to give valid consent for certain decisions. This included the delivery of personal care, the administration of medicines, and the use of bedrails. During the care planning process, staff had made these decisions on their behalf. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We saw new records that had been completed for one person and were being completed for other people. We discussed this with the registered manager who told us that best interest decisions would be recorded for all people, and would take family members and other relevant people's views into consideration.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (2005). The procedures for this in care homes are called the Deprivation of Liberty Safeguards. The registered manager had applied for authorisations under the safeguards for people where necessary and these were reviewed when required.

People's needs and choices were fully assessed and recorded in their care plans, which were regularly reviewed and updated. Updates on people's needs were also shared in staff handover meetings. People's care plans contained detailed information how they liked to be supported and things they liked to do. An external professional told us, "The staff are very knowledgeable about the people at Venner Avenue and they always have the support that they need."

Staff described how they asked people what they wanted and explained what they were doing each time they provided care and support. One staff member said, "We ask people to decide things or help them to understand what we are doing. We always ask them and encourage them to show us if they agree. They show us by smiling or by pushing us away if they do not want something and we always respect their decision. If it is important, like for medicines, we just ask again a few minutes later and explain why we are supporting them."

Staff told us that they had received an induction into their role and also worked alongside more experienced staff when they first started employment. We saw that they had relevant qualifications such as vocational qualifications in health and care or 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 registered manager told us that all new staff completed the provider's induction and if they had not already achieved it, would undertake the Care Certificate. Staff we spoke with said they had felt well supported when they started employment and were able to raise any questions they had with the senior staff member or the registered manager.

The provider had a mandatory training programme, which staff had completed. This included safeguarding, fire safety, first aid, and moving and handling training and infection control. Staff had also received some more specialist training. For example, epilepsy awareness and training for administering a specific medicine for when people had seizures. This meant that staff were well trained to meet the assessed needs of the people who lived at the home. We saw the training records for staff, which showed the training that staff had completed and when further training was needed and this was kept up to date. Some training was due to be refreshed for a few staff members and the registered manager told us that this had been raised with the provider and was being arranged. However, staff had not received end of life training. We discussed this with the registered manager who told us that this had been requested and was being arranged. Further information about end of life care can be seen in the responsive section of this report.

Staff had received regular supervisions and anyone who had been at the service for longer than 12 months had also received an annual appraisal. Supervisions provide an opportunity for management team to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff said they felt supported by the management team. The registered manager was available to staff and they had their phone number if they needed to speak to them when they were not in the building.

People were supported to eat independently and where necessary, specialist cups, crockery and cutlery were provided. People's nutritional needs had been assessed and guidance from speech and language therapists (SALT) was being followed. Staff were aware of which people needed soft or pureed food or a thickener for drinks and supported people in a relaxed and unhurried way.

The home was designed to meet people's needs, clean and decorated according to the tastes of the people who lived there. For example, the bathroom was large and accessible to people with mobility needs. In addition, people's bedrooms had been decorated in a style that they had chosen and there were personal objects and photos in each person's room. We were told that the staff had used pictures, spoken to family members and taken people to shops to choose the décor they wanted.

Staff told us they worked in partnership with professionals such as social workers, SALT's and the NHS community learning disability service to support people's needs. This was confirmed in records that we reviewed. Staff told us people were supported to access appointments with healthcare professionals in a timely way when needed. Records confirmed that healthcare professionals visited the home to support people's healthcare needs. We saw a chiropodist supporting people in the home on the first day of the inspection and staff remained with people to support them through the treatment. People had information about their health needs and any medicines they took in a quick access file that could be taken with them should they need to be admitted urgently to hospital or another service.

Technology was being used to alert staff to when people required assistance at night, such as sensor mats. Some people had sensory lights in their rooms, which we were told helped them to feel relaxed.

Good

Is the service caring?

Our findings

We saw positive and caring interactions between staff and people living at the home throughout the inspection. Staff treated people kindly and spoke to them in a respectful and friendly manner whilst laughing and joking with them. People were encouraged to be involved in what was happening in the home and were given choices in everything they did. One staff member was sat next to a person, who was laughing and trying to give them their sock. They said, "Do you want me to have that [person's name], oops you've dropped it on the floor, here it is. Do you want to give it to me again?" The person then laughed and dropped it again in fun. In another example, a staff member noticed that a person was trying to indicate they wanted something. The staff member said, "What is it [person's name]; did you want something? The person then pointed to what they wanted and the staff member said, "Here we go then, is this what you wanted?" Family members of people told us that they thought the staff were caring. One said, "The staff are very caring, I have no worries about that at all." An external professional also told us staff were supportive of people living in the home. They said, "The staff are very good and kind with people, they are always pleased to see the residents when they arrive at work, which shows they care."

We saw positive methods of communication, which had been adapted to the needs of each person. There was a keyworker system in place. Keyworkers helped people to communicate their needs and preferences, using aids such as pictures and symbols. Staff told us that they felt the system worked well and their roles included helping the person to decide what trips they wanted to do, where they wanted to go on holiday and to make sure they were supported to stay in touch with their families and friends. One staff member supported a person to look at their pictorial care plan and asked them to show them what they wanted to do. The person was able to look at the pictures and pointed to something, which the staff member then responded to by saying, "Oh you want to watch a DVD, which one would you like to choose?"

Staff delivered personal care sensitively and maintained people's dignity and privacy. We saw staff knocking on doors before entering people's rooms and discreetly helping people to change clothes when needed. Staff spoke confidently about applying the principles of privacy and dignity when caring for people, such as gaining consent before giving personal care. One staff member said, "We need to make sure we do our job well by looking after people and respecting their privacy." Care plans and confidential documents were kept securely in the office and only staff could access these.

Most people using the service were unable to have coherent conversations due to their learning disability and required a high level of support to be able to engage in activities and tasks of daily living. People were actively encouraged to be involved in choosing food and drink or what they wanted to do, and we saw one person being supported to make a drink and showing staff what they wanted. This demonstrated that staff worked with people to engage them in making choices and being involved in day-to-day decisions. Although we were told that there were plans to introduce pictures and symbols of food and drinks, to assist people to understand information and to make choices, these were not actively being used at the time of the inspection.

We spoke to staff about involving people in choices about what to wear, what to eat and where to go out.

Staff were all very positive and told us that they always asked people what they wanted and talked to them about what they were doing and where they might like to go. One staff member said, "We ask people to decide things and help them if they can't decide, we always encourage them and don't just do it all for them." This helped promote independence.

Family and friends were welcomed into the home and had recently been invited to a party the staff had organised for Easter. People were also supported to keep in touch with family and to see them when possible. Staff arranged visits to families who struggled to visit the home and one staff member told us, "We visit [person's name] family regularly and I promised them we would visit today so we did. [Person's name] is always so happy to see them, it's important."

Good

Is the service responsive?

Our findings

We observed staff being responsive to people's needs. A family member of a person who lived at the home told us, "Staff are very good and always seem to know what [person's name] wants, they will keep trying things until they can work out what they want and don't give up." On the first day of the inspection, a person was observed looking unsettled and screwing their eyes up. A staff member noticed quickly and said, "Oh are you ok [person's name]?" The sun was coming in through the window and the staff member checked to see if this was affecting the person. They then sat with the person and gently held their hand massaging it. The person then closed their eyes, smiled, and seemed much more relaxed.

Initial assessments of people's needs had been completed when people moved into the home and care plans were developed which met their needs. As part of the initial assessment process, relatives were involved to ensure staff had an insight into people's personal history, their individual preferences and interests. Information of this type helps to ensure people receive consistent support and maintain their skills and independence levels. Care plans were accessible to staff and contained detailed information about each person's needs, including guidance for specific health needs, their communication needs and things people liked to do and things they did not. This meant that staff were able to find out the information they needed in order to support each person. Care plans were regularly updated to reflect when anything changed. For example, one person had recently required additional monitoring as part of an assessment of their needs. This information was clearly recorded and was used to update information about the person in their care plan.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way that they could understand. It is now the law for the NHS and adult social care services to comply with the AIS. The home was working with a person centred focus. People's care plans had a section that was made up of photographs with short descriptions. These explained the support each person needed and the things they liked to do. For example, one person's care plan had photographs of them swimming and other activities they enjoyed and also one of the home's cars. This enabled improved communication so that the person could point to the photo of what they wanted to do. A copy of each photograph care plan was also kept in their bedroom, so it was accessible to them at all times. On the first day of the inspection, we saw one person using their care plan with a staff member. The staff member was able to easily respond and help the person to get what they wanted. This showed that the home had adapted the communication tools they used so that people could understand information about their needs and make choices.

No one living at the service was receiving end of life care, but the registered manager had recently received training in this and knew how to access relevant support if needed. The registered manager told us they planned to discuss end of life with people and their families, so they could record wishes in people's care plans.

The home environment met the needs of the people living there and the lounge had a large painted tree on the wall. On the branches of the tree the staff had put photographs of the people who lived at the home,

participating in different activates or of them with their families. This showed many different activities and staff could talk to people about the things they had done and use the photographs as a visual aid to help the person remember.

People had spent time with their keyworker and made a record of the things that they had discussed. This had been done using pictures cut from leaflets, photographs and drawings. For example, one person had looked at different leaflets to decide where they would like to go on a day out. A zoo had been chosen and a picture of this was stuck onto the visual record and kept on the wall of the person's bedroom. This meant that they could see the things they had talked about and the choices they had made for what they were going to do in the next few months.

People were supported by staff to go out into their community and we viewed records of the different activities they did each week. The registered manager showed us their 'outing idea's folder' that staff had been encouraged to fill with potential day trips and holidays that people might like. We saw that people had regularly gone out into the community and participated in activities such as swimming, shopping, having picnics in the forest and delivering a local newsletter to homes in the surrounding streets. Staff offered choice using the pictorial care plans and showed people the activities folder. An external professional told us, "It's great because the home has two cars so people can go out whenever they want and they get lots of choice." We saw records from a recent staff meeting when new ideas for activities and days out had been discussed. Planned activities included people attending local music and walking festivals, and participating in a festival that was being run by people with learning difficulties.

The provider had a complaints policy in place. Family members told us that they knew how to complain but had not had to in the last year. They felt that if they had any concerns they would be listened to and acted on immediately. Meetings were held with people who lived in the home, but these had not always been held regularly. We discussed this with the registered manager who said that they had recently reviewed this and now meetings were planned regularly. The registered manager had looked at how meetings should be held to meet the needs of each person and they had recently held individual meetings and made visual records.

Good

Is the service well-led?

Our findings

Quality assurance processes, such as those relating to environmental risks and risks to people were monitored effectively. Records were kept of an on-going action plan that identified areas where work was required and if the provider or the registered manager would action them. In addition, we saw records of internal audits that were completed daily, weekly and monthly and these had ensured that the environment was well maintained, medicines were administered correctly and equipment was checked and serviced regularly.

Relatives of people living at the home told us they thought the home was well led and that the registered manager "knows that they are doing."

The registered manager had a clear vision of how the home should run and worked with staff to develop a culture of supporting people to do things for themselves as much as possible. They also provided some management cover for another home, owned by the provider. This meant that their time was divided between the two homes and therefore impacted on how much time they spent at this service. A senior staff member undertook some management duties when the registered manager was not present. In addition, the staff had contact details for the registered manager, when they needed to speak to them. One staff members said, "I feel able to report any concerns or ask questions and these get listened to, and I get an answer."

Staff described the culture at the home as good and one said, "I am really happy working here, we all get along and I love it here", while another said, "People and their families trust us so we need to make sure we do our job well and work together." We observed staff speaking to each other and to the people they were supporting with respect. Staff listened to each other and agreed who would do which tasks on each shift. For example, one staff member went to collect a person who was out, whilst another prepared the evening meal.

The registered manager and staff team had worked to increase links with the local community and people were participating in local events such as local church and community fayres. They also linked in with events being held by other homes operated by the same provider such as fetes and coffee mornings. The registered manager told us that the staff team had supported people to try a range of activities in their community such as bell ringing, the women's institute and yoga but people did not enjoy these. However, they said that staff would continue to look at potential links with the community and supporting people to try new things.

Staff worked in an open and transparent way. Visitors were welcomed, the provider notified CQC of all significant events and the home's previous inspection rating was displayed prominently in the entrance hall. A family member said, "We can visit whenever we want, although we usually plan it as [person's name] is always out doing things, which is lovely."

People and their families were consulted about the décor of the home, activities or any planned changes.

The registered manager told us that the staff team spoke to people and their families on an informal basis whenever they could. In addition, questionnaires were sent to people's relatives on a yearly basis. We looked at these records and all of the feedback received was very positive. Families we spoke with told us that they felt able to raise any concerns, but had not had to do so. One family member said, "The manager and the staff are very good, they always do everything they can for [person's name] and work hard to make sure they have what they need."

Records showed that the registered manager worked in partnership with a number of health and social care professionals such as GPs, nurses and social workers, to ensure that people's health and wellbeing were maintained.

Staff told us that they felt listened to and meetings were held regularly. Staff meetings provided the registered manager with the opportunity to update staff on any changes in policies, remind staff of their responsibilities and discuss any concerns about care provision. These meetings also provided staff with the opportunity to share ideas with the registered manager and talk about any concerns they may have.

The provider had a whistle-blowing policy, which provided details of how staff could raise concerns if they felt unable to raise them internally. The staff were aware of the different external organisations they could contact if they felt their concerns were not listened to.

The registered manager told us that they had recently attended training that had been delivered through links with another provider, whose service has been rated as outstanding. This was so that positive ways of working could be shared. The registered manager told us that through this they had identified further training needs for the staff team and ways in which they could continue to develop the service and deliver person centred care.