Black Swan International Limited

Valentine 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

Summary of findings

Overall summary

The inspection took place on 22 April and was unannounced. Valentine House is a residential home which provides accommodation and personal care for up to 50 people who have a range of impairments, including people living with dementia. On the day of the inspection there were 43 people living in the service, nine of whom were receiving respite care.

The home is spread across three floors. The ground floor had communal dinning and lounge areas and there was a secure private garden area.

A new manager had recently been appointed. They had submitted an application to the Care Quality Commission (CQC) to become a registered manager; at the time of the inspection their application was being processed. 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.

People and their relatives told us that they felt safe living at Valentine House. People were cared for by staff who knew how to keep them safe and managed individual risks well. We spent time with people in all areas of the home. We saw that the staff offered people assistance and took the time to speak to people and take up the opportunities they had to interact with them and offer reassurance if needed.

Staff knew how to Safeguard people and were clear about their responsibilities to report safety concerns to the manager and, if required, how to inform outside agencies.

Risk assessments were robust and detailed and included control measures to minimise and manage risk effectively. There were enough staff available to meet people's needs and keep them safe. All necessary checks had been completed before new staff started work at the home to make sure that they were safe to work with the people that lived there.

New and existing staff received training which ensured that they had the skills and knowledge needed to carry out their duties and to support people. Staff received a regular programme of supervision and annual appraisals from management.

People were supported in line with the principles of the Mental Capacity Act (2005) (MCA) and the Deprivation of Liberty Safeguards (DoLS). Where people could not make decisions for themselves, people's rights were protected because important decisions were made in their 'best interests' in consultation with appropriate people. The provider had made applications to the Local Authority in accordance with DoLS and the MCA and at the time of the inspection was awaiting the outcome of those applications.

People's healthcare needs were identified and the service worked with other healthcare professionals to

support people's health and well-being. Medicines were appropriately administered by staff who had completed the relevant training.

People's dietary needs were identified and the service offered them a choice of food and drink.

Care plans were personalised and detailed people's needs, choices and preferences. These were subject to regular review and created with the involvement of the person and their relatives. Where people's needs changed, these were reflected in their care plans. There was an activities co-ordinator in the service who arranged a variety of activities and events in the home. People understood how to make complaints, and their grievances were handled and resolved effectively.

We saw that the staff approached people in a friendly and respectful way. Staff consistently demonstrated a kind and caring attitude to people. It was clear that staff knew about the people living in the home and consequently the care that they delivered was individualised and person-centred. People living there told us that care staff were mindful of their privacy and treated them with respect.

People, their relatives and staff were positive about the management of the service and felt supported and listen to. Robust procedures were in place to check the quality and safety of the care people received, and to identify where areas needed to be improved. Where concerns were identified, action plans were put in place to rectify these.

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.

There were sufficient staff to keep people safe and provide people with the support they required.

Staff knew how to safeguard people from abuse.

People's medicines were handled safely and appropriately.

Is the service effective?

Good

The service was effective.

Staff had received sufficient training to enable them to carry out their roles effectively.

People provided consent to their care and support and the service met the requirements of the Mental Capacity Act 2005.

People were supported to eat and drink sufficiently to maintain their health.

Is the service caring?

Good

The service was caring.

Staff provided kind and compassionate care to people.

People were encouraged to maintain their independence and make everyday choices which were respected by staff.

Staff treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Care plans were reflective of their people's individual needs and choices and ensured that their care was provided in the way they preferred.

People were supported to enjoy a range of activities both in the home and in the local community.

There was a system in place to receive and handle complaints or concerns raised.

Is the service well-led?

Good

The service was well led.

People, their relatives and staff were positive about the management of the home.

Systems were in place to monitor and improve the quality and safety of the service.

Valentine 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 April 2016 and was unannounced. The inspection team consisted of two inspectors.

A provider information return form (PIR) was sent to the provider and completed and returned within the required timescale. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The information contained in the PIR reflected our inspection findings.

Prior to the inspection we reviewed the information we held about the service including information from previous inspection reports and statutory notifications the provider sent to inform us of events which affected the service. A statutory notification is information about important events which the provider is required to send to us by law.

As part of the inspection we looked at three people's records relating to the use of medicines and assessed medicine management, storage, administration and disposal. We spoke with ten people who lived at the home, five care workers, two domestic staff, the manager and the regional manager. We toured the building looking at the environmental standards within the home.

We observed the interactions between members of staff and people who used the service. We reviewed the care records and risk assessments for four people who used the service. We also looked at three staff files to see whether staff had been recruited safely and at staff training records to ensure that staff were trained to deliver the care and support people required. We looked at complaints and compliments received by the service and reviewed information on how the quality of the service was monitored and managed.

To help us understand people's experiences of the service we used the Short Observational Framework for

Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

Good

Is the service safe?

Our findings

We spoke to people who lived in Valentine House and asked them if they felt safe and comfortable in their surroundings. We saw that all the people who lived in the home were relaxed with the staff that were supporting them.

Staff had completed training in safeguarding and understood the procedure they would need to follow if they needed to safeguard people from risk of harm. Staff told us that they would document any unexplained injuries on body maps and we saw that these were used by staff in people's care plans to record accidents and injuries. Our discussions with staff showed evidence they had a good knowledge of the different forms of abuse. There was a whistle blowing policy in place. All the staff we spoke to were aware of the policy and told us that they would be confident reporting any concerns about the safety of people or the behaviour of other staff members.

Risk assessments were in place to guide staff in actions they should take to help keep people safe. These assessments covered a variety of possible risks including scalding, falls, leaving the home, choking and malnutrition. We saw that staff put risk assessments into practice and that the assessments were regularly reviewed. For example, we saw that people were protected from the risk of choking by suitable risk assessments and that people were provided with foods which did not place them at risk. We noted that one person's dentures were very loose fitting which could have presented a choke risk. We brought this to the attention of the manager who, following a discussion with the person, put steps in place to reduce any potential risk.

The environment was regularly audited and risk assessed to ensure that it was safe for people to use. Fire safety equipment was checked and personal electrical appliance (PAT) testing had been carried out to ensure that electronic equipment was in safe working order.

All the staff that we spoke with said that they felt that staffing levels were sufficient to meet the needs of the people who were living in the home. One member of staff said, "There are enough staff. Mornings are busy but there's enough. Sometimes, if people are happy, we give them their breakfast before they get dressed and they're fine with it." People living in the home told us that there were enough staff to meet their needs. One person who was nursed in bed said, "They come in a minute or two if I need them". Another said, "If you do press the button in the night or in the day they come. In the night that's good because you really need them". On the day of the inspection no agency staff were on duty.

Although there was not a particular dependency tool in place to calculate staffing levels the manager was responsive to the needs of the people living in the service and responded to feedback from staff. For example an additional care worker had been included in the rota to ensure that enough support was available during the busy times of the evening when the night shift began and people started to go to bed. We checked 6 weeks of staff rosters that confirmed staffing levels.

There was a recruitment policy in place which was followed by the service to employ staff safely. This

included making sure that new staff had all the required employment background checks, security checks and references taken up before they were offered a position in the organisation. We looked at three staff files. Each file contained at least two references from previous employers and DBS (Disclosure and Barring Service) checks had been completed. DBS is a way of checking whether staff have any previous convictions which allows employers to make safer recruitment decisions.

Medicines, including controlled drugs, were organised and well managed. We checked medicines administration records for three people (MAR) and saw that these had been completed properly with no unexplained gaps. Medicines were stored appropriately and stock levels were regularly taken and labels applied to all medicines that had been opened. There were robust procedures in place for booking in, storage, administration and disposal of medicines. Staff told us that they did not administer medicines until they had completed the required training. Staff who did administer medication were well trained and their competency was checked every six months. We saw that medication audits were carried out by an external company.

We observed staff giving people their medicines and saw that they explained what they were giving people and enabled people to be as independent as they could be when taking their medicines. For example, we saw that before staff gave medication to one person they established which their strongest hand was before putting a tablet into their hand for them to take. Staff were patient and made sure people had received their medicines before moving on and made sure to check that people were not in pain. One person said, "I'm not in pain – I take eight paracetamol!"

There were clear procedures for supporting people who needed to take Warfarin, a blood thinning medicine, and to take medicines which were only required occasionally (PRN), such as those for pain relief. There was information about people's PRN medicines but it was brief and did not clearly identify how long to give a particular medicine before the GP should be called to review the person.

The service was clean and odour free. People told us, "It's always very clean. They come around every day, sometimes twice a day to clean." A deep clean was carried out on all rooms once a month and members of the domestic staff told us how they ensure that all areas of the service, including those not frequently accessed, are kept clean. They told us that covers are regularly removed from radiators in order to clean them as sometimes people drop food and rubbish behind the covers. We observed staff using different cleaning equipment for different areas of the service and all had undertaken COSHH training and were able to tell us about the principles of infection control.

Good

Is the service effective?

Our findings

During our inspection we saw that people were given choices throughout the day. Some people chose to spend their day in their rooms, only coming to the dining room for their meals or remaining in their rooms for their meals. Others stayed in the communal areas of the home chatting with other people, their visitors and the staff. We heard staff asking people where they wanted to sit, if they wanted a drink and if they were comfortable.

All the staff we spoke to said they had completed appropriate training to ensure they had the skills and knowledge to carry out their roles. One new staff member described starting to work at the service saying, "It was like I'd been here for years. Everyone was so helpful and you had all the training you could want for." Staff had completed training including dementia awareness, diet and nutrition and manual handling. Staff told us that they were able to request additional training to further their knowledge and we saw that staff had completed additional training in areas such as diabetes and advanced care. One staff member said "Any courses you want they'll get for you". The manager kept a monitoring system which listed the dates that staff had completed training and when it was due to be refreshed.

A twelve week induction programme was in place for new members of staff. This consisted of training modules, observation and shadow shifts. New starters were also required to pass a probation period, which included completion of the Care Certificate. One member of staff described how, "I had a mentor. I did not do meds to start with. I have had loads of support and really felt part of the team"

Staff told us they received formal and informal support and supervision from management. The manager had a system in place for monitoring the progress of supervisions and performance reviews and determining when these were due. We saw that supervisions were carried out regularly and included observation of care and medication administration and that performance reviews were held annually.

Some people who lived in the home were not able to make important decisions about their care and how they lived their daily lives. The manager understood her responsibilities under the Mental Capacity Act 2005, (MCA) and around protecting people's rights. 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 made on their behalf must be in their best interests and as least restrictive as possible. 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff training had been completed in respect of the MCA and DoLS. The staff we spoke to understood their responsibilities to ensure people were given choices about how they wished to live their lives and staff demonstrated that they respected all the choices people made. Where people did not have the capacity to consent themselves we saw that the service had operated in line with the requirements of the MCA. We saw that people had appropriate DoLS in place and we did not see any restrictive practices for those who did

not.

If people had appointed someone as their Lasting Power of Attorney (LPA), who this was and in what capacity was clearly documented in their care plan. An LPA is a legal document that allows someone to appoint one or more people to help them make decisions or to make decisions on their behalf.

We saw staff routinely asked people for their consent before care and treatment was provided and observed staff taking time to establish if people were happy to receive a particular form of support before providing it. We observed staff supporting and caring for people in a skilful way. When one person became distressed we saw staff working in accordance with agreed protocols to reassure them.

People told us that they had enough to eat and drink and were very positive about the food. One person said, "The food is great! My family bring supplies but I don't need them!" Another person said "If you want a cup of tea or something they will make you one." We saw that people had access to food and drink throughout the day. People told us that they were given a choice at every meal time and we saw that people had a copy of the menu for the week in their bedrooms. Several people told us they liked to eat in their rooms and this was respected and their meals arrived promptly and were still hot.

At lunch time we observed staff supporting and encouraging people in a patient and appropriate manner. We observed staff providing people with condiments and ensuring they had everything they needed before they were left to enjoy their meal. A senior member of staff told us that care staff are organised so that they could provide support for people who struggle to eat without assistance. We saw that staff gave people the time to eat at their own pace and that people with specific dietary requirements, such as pureed meals, had their needs met appropriately.

In care plans we saw that everyone had a nutritional assessment in place. Weights were checked monthly and where people had been identified as being at risk of eating and drinking too little we saw that they were monitored by being placed on a food chart. The staff monitored people using the MUST (Malnutrition Universal Screening Tool) tool. We saw that one person had lost weight since their admission to the service, which can sometimes occur due to the upheaval in a person's life. The service had placed them on a food chart for one month and staff were reviewing them on a regular basis. We also saw that people who needed to gain or maintain their weight were provided with high calorie snacks in addition to their meals.

People's healthcare needs were met through good working relationships with external health care professionals. The registered manager confirmed they received very good support from the local GP surgery and the district nursing team. Records showed that people had recent dentist, chiropodist and optician appointments. People were also able to access specialist advice if necessary. This included the dietician and speech and language therapist. Records of people's visits to these professionals were kept in their care plans and updated following actions taken as required. For example one person had been advised by the District Nurse to elevate their legs to reduce swelling and staff had assisted them to elevate their legs on a foot stool.

The service managed people's skin integrity well and we saw that one person had been quickly referred to the district nursing services when they began to develop the start of a pressure sore. The same person's records also showed that the GP had been called on the same day that the person's urine output had been poor and staff recorded the GP's advice and the issue had resolved.

We saw that some people were not having access to support with regular baths and instead having washes. It was not clear from the records if this was people's choice as it did not always correspond with information

in people's care plans. We raised this issue with the manager who assured us they would look into this.

Good

Is the service caring?

Our findings

We observed the interaction between the staff and the people who lived in this home. Staff treated people with respect and as individuals. We saw that staff supported people discretely and encouraged them to be as independent as possible. For example, we saw that one person, who told us they had a poor short term memory, had a small notice by them which said, 'Now it's Friday morning'. On another occasion at lunch time one person was struggling to get food onto their spoon. Staff discreetly assisted them to move the food nearer to them so that they were able to independently continue with their meal.

People were very positive about the caring nature of the staff. One person said, "I haven't got a short term memory but I know I am very well looked after". Another said, "I like it here. I think that they are very kind." We observed that staff treated people individually and respected their particular choices and preferences, whether this was to have their lunch in their room or to have a sherry before their lunch. One person told us "The whole atmosphere is lovely. Everyone is very kind and helpful. It's really good."

Staff demonstrated a caring and compassionate attitude towards the people using the service. One staff member said "We're here for the residents. If they are happy we are happy." It was clear that staff knew the people that they were supporting and caring for and had developed close relationships with them. All of the staff we spoke with told us they would be happy to place a relative of theirs at the service.

On the day of the inspection a new person was admitted to the home for respite care. Staff greeted them and their relatives in a warm and welcoming manner and they were given a 'welcome' box of chocolates by the manager. One member of staff said, "Let's show you around and introduce you to everyone." The person and their relative were shown around the home and introduced to people and staff by the member of staff who had completed their pre-admission assessment.

We looked at the care plans for four people and saw each care plan was centred on the assessed needs and included information of what was important to the person and how they wanted their care and support to be delivered. Preferred routines were documented and personal histories were included to give guidance to staff about what people liked or disliked. Staff repeatedly told us that there was time for them to sit and chat to people and establish their preferences. One staff member said, "There's time to sit and have a chat with people – especially on the middle floor. They don't get left out." This was confirmed by the people we spoke with, who told us they were able to make choices about the way their care was provided and what kind of support they wanted and this was respected by staff. One person said, "I've been downstairs but I like to stay in my room. They let me. They never rush me. They don't fawn over you. I like it here. They are very good". We saw that another person had made the decision to spend most of their time in their room. They told us, "I like to chat to the staff. …I like to read and watch TV."

People's privacy and dignity was maintained and promoted. People were supported discretely with their personal care needs and staff were seen to be very respectful. We noticed that doors were shut to protect people's dignity and staff knocked and waited respectfully on people's doors. People with a Do Not Attempt Resuscitation order in place had discrete and small red stickers on their doors to alert staff of this important

information.

Good

Is the service responsive?

Our findings

People's care plans included information about the choices people made in regard to their own care and support. Care plans covered a range of care needs including moving and handling, evacuation in the event of a fire, nutrition, pressure care, continence, hygiene, skin integrity as well as their end of life care where appropriate. People's wishes and preferences were documented. One person explained to us, "Your needs are talked about in the first few weeks and you go on from there. It's very good." We saw that people's care plans were regularly reviewed by the service.

We saw that people's preferences regarding if they were happy to have personal care provided by a staff member of an opposite gender to themselves had been noted and people told this was respected.

There was a full time activities co-ordinator in post who worked Monday to Friday. People told us that they were kept informed of what organised activities were happening by a timetable on the notice board in the communal area. On the day of the inspection people were playing bingo in the communal lounge and an external singer provided entertainment in the afternoon. People told us that the staff supported them to maintain links with the local community and to go on day trips. For example, the village had recently celebrated its 90th anniversary and staff told us that some of the people had been involved in making posters for the village to celebrate the event. There was also a knitting club, during which people made squares which were sewn together to make blankets that were donated to elderly people living in their own homes in the local area.

People were encouraged to join in the various activities and hobbies the service provided but some people chose not to be involved. One person told us, "I like it here. I'm very lazy – I stay up here! They're very good. There's a great atmosphere. …There are things going on if you want them." They explained that they were aware of various activities that are provided but they preferred to spend time reading the paper in their room. Another person said, "You can do what you like. You don't have people telling you what to do." We saw that people who chose to remain in their rooms had call bells within reach and were able to call for assistance from staff if required and that staff responded quickly to call bells.

There was a robust system in place for handling complaints, and whilst no-one that we spoke to had ever made a complaint people told us they knew what to do if they were unhappy or needed to raise a concern. One person said, "Complaints? Not really". Another said. "I've got no complaints." We looked at the complaints file and saw that any complaints that had been made had been responded to in writing by the manager and, where appropriate, any issues raised had been addressed with the staff.

There was evidence that the service responded to concerns raised by people. For example the manager told us that one person living in the home had complained that their mattress was uncomfortable and that they were having trouble sleeping. The service arranged for them to try several different mattresses until they found one that they were happy with.

Good

Is the service well-led?

Our findings

All the people we spoke with knew the manager and staff were positive about the new manager. One person said that the service had improved lately and thought this may be because of a new manager. There was evidence of an effective working relationship between the new manager and the regional manager. The regional manager visited the home twice a week and clearly knew both the residents and the staff well. As a result of this staff felt well supported by the service and were able to raise issues with senior staff or the management if they needed to. One staff member said, "The management are very good." Another said "We all work as a team, we work together."

We saw copies of the monthly audits the registered manager was responsible for. These included a review of health and safety, infection control, people's personal finances, the environment, care plans, staffing requirements, staff supervisions and medicines within the service. We saw that issues that were raised during the monthly audits were responded to and resolved in a timely manner. For example on one occasion it was identified that the night staff needed to complete a fire drill. On the following months audit a date for this had been set and it had been completed.

There were systems in place for reporting incidents and accidents in the home that affected the people living there. We saw that these were being followed and if required CQC had been notified of any incidents and accidents and when safeguarding referrals had been made to the local authority.

Staff meetings took place monthly and gave staff an opportunity to meet and discuss issues around the service. The minutes of these were available and confirmed that the meetings were well-attended and held regularly.

The manager arranged coffee mornings to meet with the people living in the service. More formal residents and relatives meetings also took place every three months to give people a chance to provide their views and hear updates on the service. People were encouraged to make suggestions which we saw where promptly taken care of by the staff. For example people had requested a hot drinks machine in the communal lounge so that they did not have to ask staff to make their visitors a drink .This had been purchased by the service and we saw visitors using it on the day of the inspection.

The service had an annual development plan in place which included planned updates to the home including upgrading the patio area and replacing the carpet in communal area.

Staff were encouraged to share their ideas and staff were proud of the work they did and had a shared sense of purpose. Two domestic staff demonstrated how passionate they were about their contribution to the quality of the service. One said, "This is lovely in here."