Vision Homes Association

Vision Homes Association - 2 Ouzel Drive

Inspection report

Westwood Park
Clayton Heights
Bradford
West Yorkshire
BD6 3YN

Tel: 01274815532
Website: www.visionhomes.org.uk

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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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 28 April 2016 and was announced. The provider was given 48 hours' notice because the location provides an extra care service for adults who are often out during the day; we needed to be sure that someone would be in.

The service had been inspected previously in November 2013 and found compliant in all the legal requirements inspected at that time.

Vision Homes Association offers personal care and support to people who have one or more of a variety of conditions. These can include but are not limited to, sensory impairment, learning disability and acquired brain injury. Number 2 Ouzel Drive is staffed by a permanent team of support workers who provide 24 hour care and support to four people. The service is housed in a large bungalow divided into four self-contained one bedroom flats, a communal area with kitchenette and a staff office. People have separate access from their flats to a garden area.

There is a requirement for a registered manager to be in place at the service. 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 the time of the inspection there was no registered manager due to the resignation of the previous registered manager in March 2016. However, the Commission had been notified about this and we were satisfied appropriate interim measures were in place and actions had been taken to appoint a new registered manager within a timely manner.

People told us they felt safe in the service. Staff told us they felt people were safe and they had not seen anything of concern whilst working at the service. Safeguarding procedures were in place which were understood by the staff we spoke with.

Records and procedures for the safe administration of medicines were in place and being followed.

Care files were comprehensive and person centred, containing detailed information which demonstrated the service had fully assessed people's needs and provided the required care and support. People's health, safety and wellbeing were regularly assessed and robust risk assessments put in place to minimise any identified risks. Staff understood how to provide appropriate care that met people's needs.

There were sufficient staff deployed to ensure people were supported to be as safe and independent as possible, with opportunities to partake in a variety of activities both during the day and in the evenings. People were encouraged to go out into the community as much as possible to engage in meaningful

activities.

Safe recruitment procedures were in place to ensure staff employed by the service were of suitable character to support vulnerable people.

Staff had access to a wide range of appropriate training which was up to date. Annual staff appraisals were in place. However staff supervisions and spot checks had not been carried out since early 2016. This demonstrated a lack of clear governance, although the deputy manager had an action plan in place to reintroduce these.
Staff told us although morale had improved and they received good support from the deputy manager, they would benefit from more contact and support from the provider.

People were appropriately supported to eat and drink and maintain a healthy lifestyle wherever possible. People had access to a wide range of services to ensure their healthcare needs were met.

Systems were in place to assess and monitor the quality of the service with a range of regular audits undertaken. However, although staff told us the service had not received any complaints, there was no information displayed about making a complaint or whistleblowing information.

The provider held annual review meetings with people that used the service and their relatives to discuss any concerns or changes required to their care and support.

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 told us they felt safe in the home. Robust risk assessments were in place which helped staff manage risks associated with care and support.

Medicines were managed safely. People received their medicines as prescribed and appropriate records were kept.

At the time of our inspection we concluded there were enough staff to support people safely and provide consistent care.

Is the service effective?

Good

The service was effective.

Staff supported people to maintain good health and encouraged them to have an appropriate and varied diet.

Staff received a range of appropriate training at regular intervals. Staff we spoke with demonstrated good knowledge of the people and subjects we asked them about.

The service was meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards(DoLS).

Is the service caring?

Good

The service was caring.

People told us staff were kind, caring and supportive.

We saw staff showed a high level of regard for people's privacy and dignity and respected their choices. It was clear staff were committed to developing strong relationships with people.

Is the service responsive?

Good

The service was responsive.

People received personalised, responsive care which met their individual needs. We saw evidence of staff putting people's care plans into practice.

People and their relatives were involved in decisions relating to their care and support. People had access to a range of activities and social activities according to their individual preferences.

A system to manage and respond to complaints was in place.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Staff supervisions were not carried out on a regular basis.

Staff told us they needed more support from the provider.

People's views on the service were sought and mechanisms were in place to involve them in the running of the service.

A range of audits and checks were undertaken to assess and monitor the quality of the service.

Vision Homes Association - 2 Ouzel Drive

Detailed findings

Background to this inspection

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

The inspection took place on 28 April 2016 and was announced.

The provider was given 48 hours' notice because the location provides an extra care service for adults who are often out during the day; we needed to be sure that someone would be in.

The inspection was conducted by an Adult Social Care Inspector.

Prior to the inspection, we contacted the local contracts and safeguarding teams. Information was also reviewed about this service from notifications received from the provider. 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. This was returned to us within the agreed time scales.

During our inspection we reviewed two people's care records, as well as other information regarding the running of the service including policies, procedures, audits and staff files. We spoke with the deputy manager, two care workers, as well as two people who used the service.

Good

Is the service safe?

Our findings

People we spoke with felt they were safe in the service. One person told us, "I feel safe." Staff told us they felt people were supported to be safe in the service whilst maintaining a good level of independence. The deputy manager told us, "We support, advise and guide. We can't force anyone to do anything."

We looked at how people's medicines were managed. Medicines were kept in locked safes in a cupboard within people's flats. Staff that supported people to take their medicines were trained in the safe management of medicines and their competency had been assessed. We saw that medicines were administered according to what was stated on the Medicines Administration Record (MAR). For instance, some medicines had special instructions about how they should be taken in relation to food, for example 30 to 60 minutes before food. We saw that these had been given in accordance with the instructions. MAR charts were consistently completed which indicated people had received their medicines correctly each day.

We saw the MAR chart contained written information about what each tablet looked like, for instance 'small white oval tablet'. This helped people identify the medicines they were supporting people with. People's medicines were supplied in dossette boxes, which are boxes that contain medicines organised into compartments by date and time, to simplify their administration. Medicines on the MAR charts were highlighted in the same colour as the dossette cover for each period of the day they should be given. The deputy manager told us they had introduced these measures to help reduce medicine errors. Systems were in place to order and dispose of medicines.

The deputy manager carried out weekly medicines checks to ensure medicines were being stored and administered correctly. We saw there were clear processes in place for dealing with any medicine errors and saw evidence that any errors had been dealt with appropriately. We carried out a random audit of medicines stocks and found no discrepancies. This indicated people had received their medicines consistently as prescribed and records were correct.

We saw there was clear information about the medicines at the back of the medicines file, indicating what each medicine was for and possible side effects. However, we saw no clear guidance for 'as required' (PRN) medication, such as indicating under what circumstances the medicine should be given. One person's MAR chart contained two sheets with similar PRN medication, one dated 28 January 2016 and the other 22 January 2016. We drew this to the attention of the deputy manager who explained the January chart was an old one which was still in the file as it contained staff signatures on the rear indicating they understood the person's medicines. However, they accepted this was confusing and would remove the outdated information. They also agreed to add PRN protocols to the medicines information sheet.

MAR folders contained emergency hospital admission 'grab files' with a recent photograph of the person and relevant information such as the person's GP, next of kin, medicines prescribed, allergies, likes and dislikes and key worker.

Risk assessments were in place according to the individual needs of people. For instance, we saw one person had a risk assessment for fire due to being a heavy smoker and the risk they would not put cigarettes out properly or falling asleep whilst smoking. We saw a matrix had recently been introduced throughout people's risk assessments which showed the likelihood and impact of the identified risk. This provided clear guidance to staff about the severity of each risk. Risk assessments were signed by staff to provide a declaration they understood the risk and support required.

The service had an up to date safeguarding policy. Staff we spoke with had a reasonable understanding of safeguarding and were able to give examples of what they would do if concerns were identified. We saw evidence safeguarding procedures had been followed to keep people safe from abuse and preventative measures put in place by the home. The service had a whistleblowing policy which was kept in a file in the office. However this was not clearly displayed within the service.

There were sufficient staff to support the people living at the service and staffing levels were reviewed according to people's needs. For instance, the deputy manager told us an extra member of staff had been added to the staff numbers one evening during the week when two people went out to the pub, since they recognised this led to a heightened risk of an incident between them. We saw risk assessments in the people's care plans that confirmed the need for an extra staff member at this time. The service had recently reduced the cover at night time from one waking staff member and one sleeping staff member to one waking staff member and an 'on call' emergency system. This was put in place following a meeting between the provider and the local commissioners and discussions about night time dependencies. A lone worker risk assessment had been completed for the waking night carer shift. However, the deputy manager told us there had been no negative impact on the service since they had rearranged shifts so that evening shifts finished later at 11.30pm to allow staff to continue to meet people's needs. Staff we spoke with confirmed this and told us there were enough staff to respond to people's needs and provide the support for people to enjoy activities away from the service.

Safe recruitment procedures were in place. We reviewed two staff files and saw these included an application form, interview information, references and disclosure and baring (DBS) checks. These demonstrated appropriate checks on new staff were undertaken prior to commencement of employment.

Good

Is the service effective?

Our findings

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.

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. In the case of Domiciliary Care applications must be made to the Court of Protection. The service had not needed to make any applications to the Court of Protection. We found the service was working within the principles of the MCA and that staff had an understanding of how these principals applied to their role and the care they provided.

We saw some people's relatives had 'lasting power of attorney' for finance, health and well-being, and saw evidence of regular consultation meetings being held.

We saw evidence people's choices were respected and people told us this was the case. For instance, one person would tell staff what they wanted on their shopping list and specify what supermarket they preferred the staff to use. When the person was not feeling able to do this, staff waited until they were happy to continue at a later time. Another person had chosen to stay in bed for the morning. Staff told us, "Sometimes [person's name] just wants to stay in bed. It's [person's name] choice."

We saw people's needs were assessed and reviewed regularly, with care files and activities reflecting these needs. Some people exhibited behaviours that challenged and we saw staff using effective strategies to help manage these, for instance explaining calmly to a person where their behaviour or language was not appropriate. We saw strategies clearly documented in the care files and risk assessments in place where appropriate.

People were supported to be as independent as possible with their food and drink. People had their own weekly menus which they agreed with their care worker, who supported them to make healthy choices wherever possible. Some people prepared their own food and drinks, whereas others were encouraged to assist as much as possible with food preparation. We saw people were given choice with menu planning as well as encouraged to go out for meals of their choice. For instance, one person told us they enjoyed going out for a curry and we saw this identified on their weekly plan of activities.

New staff were required to complete the Care Certificate. This is a recognised training qualification for new care workers to ensure they have achieved a standardised set of skills and knowledge. Induction training also included working through an induction file, reading the company's policies and procedures and completing a period of shadowing in order to become familiar with the people they were supporting. New staff responsible for supporting and administering medicines were required to undertake training in the 'safe management of medicines', as well as undergo observations and competencies, which included a

mock medicines administration using a MAR chart containing mistakes.

We spoke with a care worker who said, "We get a lot of training." The provider had their own training manager who delivered training at service locations on a regular basis. For instance, we saw they were delivering training on the day after the inspection, covering hygiene, hydration and nutrition. We reviewed the training matrix and found this to be comprehensive and appropriate to the needs of the service. For instance, in addition to mandatory training, staff had attended training on subjects such as head injuries, autism and challenging behaviour. We saw staff training was up to date or booked. For example, we saw that all staff had been booked to undertake updated safeguarding training between February and June 2016.

Staff received support with annual appraisals and regular supervisions. However, staff told us and we saw in the staff files that supervisions had not been carried out since early 2016. We spoke with the deputy manager who told us they had an action plan to reintroduce these.

We saw people had access to a wide range of healthcare professionals including GPs, psychiatrists, district nurses, opticians, chiropodists, and dentists. For instance, we saw one person had a medication review and health check booked with their GP on the following week. People had individual medical files in a cupboard in their flats containing information such as health care contact details and outpatient appointments.

Good

Is the service caring?

Our findings

We saw good interactions between staff and people. The staff we spoke with had good knowledge and understanding of people living at the service and their individual needs, likes and dislikes. For instance, staff told us about how one person had had a dog when they lived at home and talking about this helped calm them when they were feeling anxious. One person told us, "I get on with the staff. They're all right." Another person said, "I feel happy here. There's nothing to complain about. I feel very settled here. It's perfect."

We saw staff using effective communication techniques, talking to people calmly and clearly. Communication strategies were clearly identified in people's care records. For instance, one person's care records told us they would raise their voice and express their anger and opinions verbally. We saw clear strategies in place for these situations, where staff would withdraw and explain to the person why they were doing so, leave the person to calm down for a short while and then re-engage. We observed this strategy used effectively during our inspection.

People told us they felt able to express their opinions and were involved in making decisions about their care, treatment and support. For instance, one person usually went to help at a charity shop three days a week, but decided they needed to go somewhere else on one of these volunteer days. We heard the deputy manager supporting the person with their decision through conversations with the person and the staff at the charity shop, telling them, "It's [person's name] choice."

We observed people were spoken to and treated with respect and dignity. For instance, staff knocked on people's flat doors and waited to be invited to enter. One person told us, "Staff treat me with respect." We observed a staff member visiting a person in their flat with permission, discretely placing their dressing gown on the bed for them to put on before coming out of their bedroom and telling them they had done so. This showed us staff respected people's dignity.

Staff were able to tell us about people in detail and how they liked to be treated. For instance, staff told us and we observed how they approached people in different ways according to their personality and the person's mood state. We saw where one person's mood state fluctuated rapidly, staff understood this and responded accordingly.

We saw the service placed a high emphasis on independence and choice. One person told us, "I'm a big boy. They give me independence." The deputy manager told us, "We work in a support and guidance capacity." We heard the deputy manager discussing with staff how they had to allow people to make their own decisions and informed choices, even if staff considered these to be incorrect. We saw people chose what activities they wanted to do, for instance what nights they went out, with some people choosing to go out nightly and others less frequently. We observed staff encouraging people to assist writing shopping lists and choosing what meals they wanted to eat. One person told us, "Staff are pretty good at giving me choices for meals."

We observed staff responded positively to people's preferences. For instance, we heard staff discussing what

activities they could do with a person they wanted to build a better relationship with. This involved looking at what the person enjoyed doing such as attending air shows since they were interested in aircraft. This showed us the service was actively developing positive caring relationships with the people using the service.

We saw evidence of advocacy involvement where people were not able to make key decisions.

People told us their relatives and friends were freely encouraged to visit or take them out and we saw information in people's daily notes to confirm this was happening.

Good

Is the service responsive?

Our findings

Care records were highly person centred, and entitled, 'My Life Book' with subsections such as 'About Me', 'Things I Do', 'Looking After Myself and Support I Need', and 'My Health Action Plan'. This showed us people were receiving personalised care. Files contained information such as detailed life histories, relevant photographs, likes and dislikes and individualised risk assessments which were cross referenced to people's care plans. However, some risk assessments were not signed by all members of staff which meant there was no evidence these staff had read and understood the plans of care. We found the information in care records such as life histories, likes and dislikes corresponded with what people and staff told us when we spoke with them. We looked at two people's care files which we found comprehensive and easy to understand, with care plans relating to the individual person's risk assessment.

Each person had their own medical file stored in a cupboard in their flat, containing up to date information regarding their health needs. This cupboard also contained other information such as a personal memories file, meal planning information, and a money file containing personal bills and statements.

We saw details in one person's care file that staff had organised a medicines review with the community psychiatric nurse (CPN) and GP after noticing the person had become lethargic and not engaging in their usual activities. As a result of the review the person's medicines were altered and staff noticed an improvement in the person's mood and engagement. This showed us staff were being proactive in reviewing people's care.

We saw evidence people were actively involved in their care. One person told us, "I've got two key workers. If something's going to change or happen they'll sit down and talk to me about it. They'll talk to my wife as well."

Key workers were usually allocated to people according to personality matches and shared interests. However, where this wasn't possible, the key worker was encouraged by the deputy manager to find common ground with the person to build a good relationship. For instance, we saw one staff member search on the internet for relevant activities where they could spend time with a person away from the service in order to build their relationship. This showed us the service was actively seeking ways to build trust and positive relationships between staff and people using the service.

We saw the provider held individual yearly review meetings at the service involving the people, their family members, key workers, and the provider's Operations Manager. This was to discuss all aspects of care and support and any concerns raised by people and their relatives.

People who used the service had a good degree of independence and were supported by staff to retain their independence. For instance, we heard one person ask the deputy manager to use their cash machine card to get money out of a local cash machine for them. The deputy manager told them, "I can't get money out for you. It's important you do this for yourself." We spoke with the deputy manager who told us people who had their own cash machine cards were responsible for using these themselves with appropriate levels of

support. From speaking with staff we were reassured this was happening.

Activities were individualised in accordance with people's wishes and needs. For instance, one person worked in a charity shop three days per week and went to a day centre two days per week. Another person was encouraged to assist with light household tasks in their flat, including choosing and assisting with preparation of their meals. Weekly activity plans for each person were displayed in their flat and we saw these contained activities for daytime and evenings, such as shopping, going out for a meal, going to a day centre and watching football or rugby. We saw records of people's daily logs were very person specific, detailing the person's daily routine and including information such as, 'Support [person's name] to make a beef sandwich,' and showed activities such as attending the Snooker Championship, going out for meals and going out for a drink with staff.

We saw the service had a complaints policy which was held in the office and people we spoke with understood how to make a complaint. One person told us, "If I need to complain I'll go and talk to [deputy manager's name]. [Deputy manager's name] sits and listens and responds if I have any concerns." The deputy manager told us they had not received any complaints since April 2014. We saw where a complaint was made the service had a robust action plan in place, including follow up action. However, there was no information displayed in the communal area about how to make a complaint. We spoke with the deputy manager and he agreed to take action to remedy this.

Requires Improvement

Is the service well-led?

Our findings

There was not a registered manager in position at the time of inspection. However, the Commission had been notified about the previous manager leaving in March 2016 and what interim measures were in place. We saw the provider was taking steps to recruit a new manager within an acceptable time frame. The deputy manager told us the closing day for applications was the day of the inspection.

Staff and people we spoke with praised the deputy manager. They told us they felt able to approach them with any concerns and confident they would address these. One person told us, "I can talk to him about things. He has kept this boat afloat." A staff member told us they felt supported by the deputy manager and another said, "I could go to [deputy manager's name]."

We saw the service had gone through a period of change over the last few weeks since the resignation of the registered manager. Staff we spoke with said morale had not been good when the previous registered manager was in post but had improved since the deputy manager had taken responsibility for the running of the service. However they felt more could be done to get the team to work together effectively and the service would benefit from improved support from the provider. We spoke with an outside agency who said they had seen improvements in the service recently.

We spoke with staff who said supervisions and guidance had not been formally carried out since early 2016. Prior to this, staff told us these were carried out every six to eight weeks and we saw evidence of this in the staff files. Additional staff supervision spot checks had not been documented since November 2015. We spoke to the deputy manager about supervisions. They told us the previous registered manager had been responsible for these, but was aware this was an area for improvement and had an action plan for these. They said they would be looking to hold supervisions in a separate building for staff privacy and confidentiality due to the open plan nature of the service building. We saw evidence in the staff files that appraisals were carried out annually.

We looked at audits carried out within the service, most of which were carried out on an annual basis. These included care records and training records. We saw the audit file was up to date. The deputy manager carried out a medicines audit on a weekly basis and the local pharmacy had carried out an independent audit in January 2016. The pharmacy had noted no discrepancies in medicine counts, but had sent an action plan to the service which we saw the service was putting into place. This included information such as using a pharmacy 'date opened' sticker on prescribed ointments and medicines. However, from our inspection we concluded 'as required' (PRN) protocols and documentation needed to be more robust.

We found the deputy manager was committed to making a difference to the people that used the service, especially through empowering them to make their own decisions. We observed them leading by example in the manner they approached people using the service and the promoting of person centred care. We spoke with the deputy manager about the service and they told us they had identified a number of areas where improvements needed to be made. For instance, they had already reviewed and improved the layout and content of the care files to make these more person centred and easy to understand. This was confirmed by

our review of two care files.

Although the service had a complaints and a whistleblowing policy in place, no information about these were displayed in the service. This meant people and their relatives did not have easy access to information of this nature.

People's relatives were involved in the service wherever possible. For instance, one person told us staff regularly met with their spouse to, "Discuss any changes or if anything was going to happen." The provider held annual review meetings which involved people who used the service and their relatives.

The provider sent out annual staff satisfaction questionnaires to all care staff employed by the company. The results from the survey in June 2015 indicated the majority were satisfied in their roles. The provider followed up the surveys with an annual consultation meeting at services which covered topics such as challenging behaviours and stress management, additional training, team morale, appraisals and supervisions. We saw the consultation event at the service had been held in September 2015.

We spoke with the deputy manager about the recent notifications received about financial discrepancies found with some people's monies and the subsequent action taken. We were reassured the service had taken appropriate steps to prevent a recurrence; the deputy manager had taken responsibility for any people's monies kept in the service which were locked in individual metal boxes in a cabinet in the office, to which only they had a key. They told us this was not an ideal long term solution and was looking at other ways to ensure secure, non-restrictive solutions. The deputy manager carried out a weekly audit of people's money and the provider had rewritten the finance policy accordingly. The provider was carrying out a full financial audit of the service over the next few days.

The local authority had carried out a contacts monitoring inspection in October 2015 and had identified a number of areas for improvement including care files, risk assessments and complaints action plans. We saw the service had created an action plan and when the service had been reviewed in March 2016 most areas had been addressed. This was confirmed when we spoke with the contracts monitoring team.