Precious Homes Limited

Vermont House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 13 October 2015. After that inspection we received concerns in relation to the safety of the service. As a result we undertook an unannounced focussed inspection of this service on 25 April 2016 to look into those concerns. This report only covers our findings in relation to this focussed inspection which looked at whether the service was safe. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Vermont House on our website at www.cqc.org.uk.

Vermont House provides accommodation for up to nine people who require support with personal care and who are living with learning disabilities and/ or autism spectrum disorder. At the time of the focussed inspection the home had five people living there.

There was a registered manager at the service who was present throughout the inspection. 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.

We found that systems in place to monitor the safety of the premises were not always robust and timely action had not been taken to resolve an issue identified with some of the safety equipment in the home.

Whilst people received their daily medicines safely we found that the management of medicines given on an 'as required' basis needed improving. Staff did not always have access to the information needed to administer 'as required' medicines consistently and safely.

Safe recruitment practices had been followed. We found that there was a lack of consideration of the competencies of staff when planning staffing levels.

Staff had information about how to support people in emergency situations. However, we found that information had not been updated when a person's needs changed which may lead to an inconsistent approach from staff when supporting the person in emergency situations.

You can see what action we told the provider to take at the back of the full version of this report.

Following the inspection we received assurance from the registered manager that the issues identified would be addressed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The service did not have robust systems in place to take timely action in respect of the safety of the premises.

The management of medication given on an as required basis was not robust.

Safe staff recruitment processes ensured that people were supported by staff of good character. The competencies of staff had not been considered when planning staffing levels.

Vermont 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.

We undertook an unannounced focussed inspection of Vermont House on 25 April 2016. This inspection was carried out due to information of concern we had received about the safety of the service. We inspected the service against one of the five questions we ask about services: is the service safe.

The inspection was undertaken by two inspectors.

As part of our inspection we reviewed information we held about the home, including notifications that had been sent to us.

At the inspection visit we talked to the registered manager, the deputy manager, two people who lived at the home and two staff members. We sampled records including one medication administration chart, staff rotas, the providers recruitment processes, quality audits and maintenance records.

Requires Improvement

Is the service safe?

Our findings

During the inspection we met and spoke with three of the people using the service. Two of the people said that they were supported by staff when they needed. One person advised that they felt safe living the home. Another person told us that they had some concerns about aspects of the support they received from staff. However, they advised us that they discussed their concerns regularly with staff and received support on a one to one basis from staff at all times.

Prior to our inspection we received information of concern about the suitability and safety of the premises. At this inspection we found the service had systems in place to monitor the safety of the premises although these were not always effective. These systems included checking the equipment in the building and testing fire safety equipment to make sure they were safe to use. We noted that where issues had been found with these systems, appropriate action had not been taken in a timely manner to ensure that the systems kept people safe. For example during a fire drill that had taken place two weeks prior to the inspection issues with the fire safety equipment were identified as faulty. There had been no action taken to ensure this equipment was made safe or that the concerns about the equipment had been shared with the full staff team. This meant that people could not be assured of a safe exit should a fire start. The service had not ensured that electrical items had been tested for safety and had not followed up recommendations from an electrical installation report. The service did not have robust systems in place to ensure the safety of the premises was maintained in order to keep people living at the service safe.

There was information available about the individual support people living at the service would require in the event of a fire. We found however that where a person's support needs had changed, this had not been communicated to staff and records had not been updated. This meant there was a risk that staff could have an inconsistent approach in supporting a person in the event of an emergency evacuation.

The failure to act on risks to health and safety from the equipment not been in working order is a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service managed medicines. Staff who administered medicines had received training and the service had carried out checks to make sure the staff member was competent to give medicines. We viewed one medication record which contained information about the different medicines the person was taking and the frequency they needed to take them. We saw that daily medicines had been given as prescribed.

We found that where a person had refused a medicine there was no record to state why they had refused or action taken to monitor the person. We found that the provider's procedure which required two staff to sign to confirm that people had received their medication had not always been followed. Although people's records identified medicines that were to be taken on an 'as required' basis, there was no clear information for staff detailing when they should be given. In one instance there were no details for staff about when or how they should support a person to take their medication if they suddenly became unwell. This meant that appropriate action may not be taken to support this person in an emergency. We brought this to the

attention of the registered manager who assured us that they would rectify this to ensure staff had the necessary information to support the person consistently. The management of medicines to be given on an as required basis was not consistently robust and had failed to ensure people received consistent, safe support with medicines that were given in this manner.

The premises had been adapted to allow people to access all areas safely with the exception of the kitchen on the ground floor. We found that the kitchen had not been adapted to meet people's individual needs which meant that not all people living at the service had the opportunity to safely prepare and cook food independently.

We saw that the service carried out safe recruitment practices which included obtaining a Disclosure and Barring Service (DBS) check and obtaining references to ensure staff employed were suitable to support people.

At our last inspection in October 2015 we found that staff were knowledgeable about how to safeguard people who lived at the service. At this inspection we found that most staff continued to know their responsibilities to safeguard people living at the service and knew appropriate action to take should they have concerns.

We found that there were sufficient staff available to support people safely. However, we found that the skill mix of staff on each shift had not been considered. For example, one newly employed staff member who had no prior experience in social care had not received training in key topics important to their job role including safeguarding. This staff member was included as part of the staffing compliment. When we spoke to the staff member they were able to inform us of some of their responsibilities but were not clear of the full responsibilities of their role.

Following the inspection the registered manager provided us with assurance that the issues identified would be addressed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that equipment relating to the health and safety of people living at the service was in working order. Regulation 12(1).