Liverpool City Council

Venmore Community Centre

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

We carried out an unannounced inspection of Venmore Community Care Centre on 06 and 07 September 2016.

The service was last inspected on 03 January 2014 and was found to be compliant with all the regulations we assessed at that time.

Venmore Community Care Centre is a purpose built building with accommodation for twenty five people over three floors. It provides short term intermediate care, reablement and rehabilitation care, to people over 18 years old, who are resident within the Liverpool borough or registered with a Liverpool GP practice. Venmore aims to provide an environment in which people can maximise their independence in all aspects of daily living.

At the time of the inspection the service 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.'

We saw the service was clean and had appropriate infection control processes in place.

All the people we spoke with told us they felt safe. The service had up to date safeguarding policies and procedures in place, with guidance on how to report any safeguarding concerns to the local authority. Staff were trained in safeguarding vulnerable adults and had a good knowledge of how to identify and report any safeguarding or whistleblowing concerns.

Both the registered manager and staff we spoke to had knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their own best interest. No one at the service was currently under the DoLS framework.

Robust recruitment checks were in place to ensure staff working at the service had met the required standards. This included everyone having a Disclosure and Barring Service (DBS) check, full documented work history and three references on file. The majority of staff working at the service had been employed by the council for a number of years, working across services.

We saw that medicines were managed and administered appropriately. We saw the service had systems in place for the safe storage, administration and recording of medicines. We saw that staff who gave out medicines had their competency assessed before being able to do so and regular medicines audits were carried out. Each floor of the service had its own medication room and mediation trolley, and the team organiser allocated to each floor was responsible for administering medication. This meant the process was

completed promptly and effectively.

Staff reported they received a good level of training to carry out their role, with refresher sessions and other training courses provided to ensure skills and knowledge were up to date. Staff were also able to request specialist training in specific areas, with bespoke sessions being created to meet this need.

Staff also told us they felt supported through completion of regular supervision meetings and team meetings both as a full staff group and also with the smaller teams on each floor.

Throughout the inspection we observed positive and appropriate interactions between the staff and people who used the service. Staff were seen to be caring and treated people with kindness, dignity and respect. The feedback we received from both people who used the service and their relatives was complimentary about the standard of care provided.

We looked at six care files, which contained detailed information about the people who used the service and what they wanted to achieve during their time at the service. Each file also contained detailed care plans and risk assessments, which helped ensure their needs were being met and their safety was maintained.

The service had positive links and displayed effective partnership working with a number of professionals. Social workers, occupational therapists, physiotherapists, speech and language therapists, GP's and district nurses all had regular input and involvement with the service and spoke highly of the professionalism displayed.

The service had a range of systems in place to monitor the quality of the service. These included audits of medication, care plans and the environment, along with overall audit of service delivery by the area manager. We saw evidence of action plans being drawn up and implemented to address any issues found.

Everyone we spoke to felt that the service was well run and managed. The registered manager and team organisers were reported to be approachable and helpful and each staff member told us they loved their jobs and enjoyed working at the service.

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.

Staffing levels were appropriate to meet people's needs.

Medicines were stored, handled and administered safely by trained staff that had their competency assessed regularly.

Staff were trained in safeguarding procedures and knew how to report concerns.

Is the service effective?

Good

The service was effective.

People had regular access to medical and other professionals to ensure their needs were being met.

Though nobody at the centre was currently subject to the Deprivation of Liberty Safeguards (DoLS). All staff spoken to had knowledge of the Mental Capacity Act (MCA 2005) and DoLS.

Staff received regular training to ensure they had the required skills and knowledge to successfully carry out their roles.

Is the service caring?

Good

The service was caring.

Both people living at the service and their relatives were positive about the care and support provided.

Throughout the inspection we observed positive staff interactions. Staff members were friendly, kind and respectful and provided encouragement and validation to the people they were supporting.

Is the service responsive?

Good

The service was responsive.

Care plans provided staff with the necessary information to deliver support to people in a person centred way.

Care plans were devised with involvement from each person and reviewed on a weekly basis via a multi-disciplinary team.

The service was responsive to people's needs, ensuring that necessary monitoring and support was in place to maintain people's safety and well-being.

Is the service well-led?

Good

The service was well-led.

Audits and monitoring tools were in place and used regularly to assess the quality of the service, with action points generated and details of progress clearly documented.

Team meetings were held regularly to ensure that all the staff had input into the running of the home and were made aware of all necessary information.

The service had strong links with a number of professionals which ensured people received effective support and were able to achieve their goals

Venmore Community Centre

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 06 and 07 October 2016 and was unannounced.

The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC).

Before commencing the inspection we looked at any information we held about the service. This included any notifications that had been received, any complaints, whistleblowing or safeguarding information sent to CQC and the local authority.

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.

During the course of the inspection we spoke to the registered manager, five staff members, a cook, a social worker and a physiotherapist. We also spoke to seven people who used the service and two visiting relatives.

We looked around the centre and viewed a variety of documentation and records. This included five staff files, six care plans, seven Medication Administration Record (MAR) charts, policies and procedures and audit documentation.

Good

Is the service safe?

Our findings

We asked people who used the service if they felt safe living at Venmore Community Care Centre. All seven people confirmed they did with one telling us, "Yes, it's good here, I can't fault them." Another said, "Yes, I do, I am well looked after."

We looked at the services safeguarding systems and procedures. The service followed the local authorities' protocols for reporting safeguarding alerts or concerns. Services are also required to notify the CQC of any incidences of suspected abuse. The last notification received from the service was dated 2014. We checked the service records during the inspection and verified that no incidents had occurred since that time that required a notification.

The five staff we spoke with all confirmed they had received training in safeguarding adults and this was refreshed annually. They displayed a good knowledge of what to look out for and how they would report concerns. One staff member told us, "Yes, I have done safeguarding training, it gets refreshed each year." Another said, "I would take any concerns to the team organiser, there is always a senior staff member here to report to." Whilst a third told us, "I would assess the situation, makes sure people are safe and then report to my line manager or [registered manager] directly."

We looked at five staff files to check if safe recruitment procedures were in place. All the staff in question had worked for the council for a number of years; either in other residential homes or providing domiciliary care, before working at Venmore. As a result some of the staff files did not contain application forms or references, however did contain confirmation letters from the local authority confirming these had been checked and were stored centrally. We saw evidence that Disclosure and Baring Service (DBS) check information had been sought for all staff, with the certificate number and expiry date listed in each file. We noted that two people's certificates had expired, however the registered manager provided evidence that new certificates had been applied for.

Upon arrival at the centre, we completed a walk round of the building to look at the systems in place to ensure safe infection control practices were maintained. The premises were clean throughout and free from any offensive odours. Alcohol gel dispensers along with hand hygiene guidance were in place on each floor. We saw bathrooms and toilets had liquid soap and paper towels available. The bathrooms were well kept and surfaces were clean and clutter free. Cleaning products were stored safely and Control of Substances Hazardous to Health (COSHH) forms were in place for all the cleaning products in use. We saw a copy of the infection control audit that had been carried out by Liverpool Community Health NHS Trust in September 2016. The service was found to be compliant with an overall rating of 91%.

We looked at how falls, accidents and incidents were managed. The service had an electronic system in place, which they called the 'bump book' onto which any accident or injury was documented. As the service provides a 'step down' facility from hospital, accidents were also reported via the National Patient Safety Alerting System. The service also ran a falls clinic twice a week, which was attended by NHS occupational therapists and physiotherapists. During the clinic any people using the service at risk of falls were reviewed

and action plans generated.

We asked staff for their views on staffing levels at the service and whether they felt they could meet people's needs safely. One told us, "We have five on our shift, but only really need three to cover and meet people's needs, so we definitely have enough." Another said, "Yes, we have enough staff, always have cover for sickness and other absences." A third staff member said, "They are quite good to be honest, people only wait seconds for assistance."

Staffing on each floor of the centre is overseen by a team organiser; we asked one how the service coped with sickness and holidays. They told us, "The staffing team is very flexible and will cover additional shifts. We have a number of people on part time hours, who are very happy to increase their hours to cover any shortfall."

We asked the registered manager about staffing levels. They told us that between 8am and 10pm there were usually 14 staff on shift, which consisted of 11 care staff and three team organisers. Four staff were allocated to the ground floor and five allocated to both the first and second floors. A maximum of three people per shift could be off at any one time, which would then bring the staffing levels down to 11 per shift to cover a maximum of 25 people. At night the service ran with six staff consisting of a night team organiser and five night carers. On both days we inspected, the service had a full staff compliment with only 17 occupants.

Within the six care plans we looked at, we noted that a body map was completed upon admission to check for any current or potential pressure sores. As standard each person was automatically put on pressure relief charts for the first 72 hours, with walking or standing relief provided two hourly. The charts were discontinued if no issues were identified. At the time of the inspection, nobody using the service had a pressure sore.

We looked at the centres safety documentation to ensure the property was appropriately maintained and safe for people who used the service. Gas and electricity safety certificates were in place and up to date. We saw all lifts, hoists and slings were serviced as per guidelines with records evidencing this. We also saw that call points, emergency lighting, fire doors and fire extinguishers are all checked regularly to ensure they were in working order. The service had also received two visits from the local fire service this year to check compliancy.

During the inspection we assessed medicines management. We asked people who used the service if they received their medicines when they should. One told us, "Yes, I get these in the morning, at dinnertime and in the evening every day." Another said, "Oh yes, there's no problem with this."

Each person had a Medicine Administration Record (MAR) chart in place, which included their name, date of birth, medical history, temporary and own GP details, list of allergies and their photograph. The service had a medicine room on each floor, with the team organiser for each floor being responsible for administering medication. The service used the bio-dose system, with any additional medication being stored in sealed plastic boxes with the person's name, room number and photograph attached. This ensured safe storage and administration practices were adhered to.

We viewed seven MAR charts during the inspection and saw that all prescribed medication had been administered and signed off correctly, with a running balance documented for each medicine. We saw a specimen signature chart was in place and this tallied with the staff signatures on the MAR charts. We completed stock checks of seven people's medicines including two people who were prescribed a controlled drug. All medicines we checked had the correct amount remaining, indicating that all medicines

had been administered correctly.

We checked the controlled drug (CD) cupboard and saw this was locked with the key stored separately. We checked the stock levels of two people's medicines in the CD cupboard and saw that these tallied with the CD register. We also noted that all entries were supported by two staff signatures as is required.

The home had 'when required medicines' (PRN) records in place. These were used to monitor and administer any PRN medications. The record detailed the dosage that could be administered, along with actual amount given, date, time and quantity remaining. This ensured PRN medicines were being administered safely and appropriately.

We observed that all creams, drops or lotions had labels attached detailing the date of opening and were appropriately stored. Both the medicine room and medicine fridges on each floor had their temperatures checked on a daily basis and we saw that all staff who were authorised to give out medicines had their competency assessed annually.

Good

Is the service effective?

Our findings

We asked people using the service for their views on the food. One person told us, "It's very nice, I've no complaints." Another said, "The food is good here, plenty of it."

During the course of the inspection we discreetly observed three meal times, one on each floor. A daily menu was displayed in each dining area; with people having the opportunity to request alternatives should they not like the meal options provided that day. We spoke to the cook, who explained that the alternatives available consisted of things such as jacket potatoes, omelettes, soup and sandwiches. We noted that meals were prepared in the main kitchen and transported to each floor within a heated trolley. Staff members then served food to people who had chosen to eat in the individual dining areas. Prior to meal time, staff ensured the dining areas were appropriately set out, with each table containing placemats, cutlery, napkins, cup and saucer and condiments. People were able to choose where they sat, however staff did encourage people to sit with their peers, to encourage interaction and a more positive meal time experience.

A day centre had been incorporated into the building and grounds of the service although this was run as a separate entity and managed by a different team. The main kitchen which serviced Venmore also catered for people using the day centre. People residing at Venmore, were able to utilise the large dining room adjacent to the kitchen, rather than the smaller dining areas on each floor, however nobody chose to do so during the inspection.

Each dining area also served as a training kitchen, with each having a section set out like a domestic kitchen. These contained an oven, sink, hobs, microwave, toaster and kettle along with storage space and basic food items, such as tea, coffee, bread and milk. This area allowed people to be supported to re-learn and practice daily living skills, in preparation for a return home, but could also be accessed throughout the day if people wished to make a drink or snack for themselves.

We looked at how the service managed people's nutrition and hydration needs. People we spoke to told us, "I get a drink whenever I need one. There is always a jug of water available which gets changed regularly." "Food and drink is readily available." "I have my own drinks in my room, but could ask staff for one whenever and they would make me one." We observed that special diets were catered for, allergies were documented and people's nutritional needs were assessed with nutrition and hydration care plans in place where necessary. Dietary charts, documenting what and how much people had eaten, where put in place for everyone upon admission and reviewed after a week, to determine if still required.

We looked at the training matrix which detailed what sessions had been completed by all staff working at Venmore. We also saw certificates and evidence of training completion in the five staff files we looked at. As a lot of the staff working at Venmore had been employed by the council for several years and had worked elsewhere previously, we were unable to fully review induction training processes, however were able to confirm that refresher training had been completed regularly. We did speak to one newer member of staff who told us, "My induction was good. It was a two week programme which covered eleven core training modules. The knowledge I got was enough for me to carry out my role."

We asked staff for their opinions on training provided by the service. One told us, "We have a lot of onsite training as well as some off-site, such as infection control. A list gets sent which has all upcoming sessions on it." Another said, "We do lots of training here. I asked the physio's who come in, if we could have extra training about strokes. We have put forward our questions and queries and they are going to develop a training session around these." A third told us, "We have enough training here, we have to update certain sessions every year."

People using the service gave us their opinions of staff competency. One told us, "They all seem to know what they are doing." Another said, "The staff all seem very well trained." Whilst a third added, "Oh yes, the staff are all very competent."

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of providing this. We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff confirmed they had received training and had an understanding of both. One told us, "Yes, the mental capacity act, someone will assess a person's capabilities to see if they have capacity to make decisions for themselves." Another said, "Yes, I have done two training courses covering the MCA and DoLS, I also learned about the role of an IMCA." IMCA stands for Independent Mental Capacity Advocate. Mental Capacity Advocacy was introduced as part of the Mental Capacity Act 2005 and gives people who have an impairment, injury or a disability which results in them being unable to make a specific decision for themselves, the right to receive independent support and representation.

At the time of inspection nobody using the service was subject to a DoLS authorisation. All people were deemed to have capacity and residing there voluntarily. People we spoke to confirmed that they had made the decision to go to Venmore as a step towards returning home. People were free to move around the building, access the community and leave should they wish to.

The staff we spoke with said they received regular supervision from their line manager, although there was some discrepancy as to how often these occurred. One told us, "We have these every few months. However our line manager is on the floor with us, so they see us regularly and we can discuss things with them as and when." Another said, "We have supervision every six months or so. If anything crops up in between, we can discuss this with the team organiser." Another stated, "I have had three since January plus other meetings in between. Usually have supervision every three to four months." The service had a supervision matrix in place in order to track the completion of meetings. This was overseen by the registered manager.

We looked at how the service sought consent from people. Each care plan contained consent forms, which had been signed by the person themselves. These covered consent to care and treatment, consent for their picture to be used along with confirmation that the care plan had been discussed with them. We asked people using the service whether staff sought their consent on a daily basis. All agreed that staff did so, with one stating, "Staff always ask for my consent." Another added, "They always knock on my door and always ask for my permission."

We saw the service worked closely with other professionals and agencies, both to meet people's health needs and monitor their progress. Upon admission people's weight, diet, pressure relief and food/fluid intake were automatically assessed for 72 hours. If any issues were noted the relevant referral was made to speech and language therapy (SALT), district nurse, physiotherapy or occupational therapy (OT). Each new admission was reviewed by a GP and each of the therapists within 48 hours, with the GP also visiting the

service three times weekly, to address any health needs or concerns. A Multi-Disciplinary Team (MDT) meeting was held each week, involving a GP, nurses, therapists such as OT's and physios, social workers and staff from Venmore. During the meeting each person using the service was reviewed with updates on progress and future goals discussed.

We spoke to a social worker and physiotherapist who were both involved with Venmore. Their feedback commended staff for their follow through with any tasks or requests asked of them and in providing person centred care. They also reported the service maintained good communication with external professionals and worked together in order to improve practice and the provision of care.

Good

Is the service caring?

Our findings

The people we spoke with told us they liked the staff and found them to be kind and caring. One said, "You don't know what you are coming to or what it will be like, but they really look after you, nothing is too much trouble." Another said, "All of them have got a good nature and are very kind." We asked two relatives for their views, they told us, "All the staff are very good, [relative] has been well cared for." The social worker and physiotherapist who linked in with the service echoed these views, telling us the staff were very empathic, caring and approachable and that people at Venmore were well looked after.

We asked people using the service if staff treated them with dignity and respect. All the people we spoke to confirmed that they did, with one telling us, "Yes, they treat me with dignity and respect all the time." Another said, "They are very discreet with personal care, which I like as this was something I was worried about." Whilst speaking to staff we asked how they ensured people were treated with dignity and respect. One told us, "I cover people with a towel and make sure doors are closed." Another said, "I think to myself how would I want my family to be treated and then treat people in this way." A third said, "I make sure I knock and wait for a reply, ensure people are covered up and are happy with what I am doing."

Due to the type of service provided; short term intermediate care, reablement and rehabilitation, the promoting of people's independence was the main service objective. People we spoke with talked positively about the support they received. One person said to us, "They didn't push; they waited to see what I could do, what I was comfortable with." Another stated, "I'm given time to do things for myself, I never feel rushed, which helps a lot." A third person said, "I am gaining the independence I need to move on, they help me with this, help me get better."

Staff were enthusiastic and knowledgeable about the importance of promoting and maintaining independence. One told us, "We mainly provide assistance on this unit, unless someone is physically unable we tend to just prompt and encourage. It's important they re-learn or carry on doing things for themselves." Another said, "We have physios in every day. They have a lot of input into what support we need to provide. We let people do what they can but if they need help we will step in." A third said to us, "It's important to let people try to do things for themselves, whether this is washing their face or getting dressed. They will need these skills when they move on."

As the service provides short term placements, staff have less time to form relationships with the people they support. We asked staff how well they knew the people they cared for and how they knew what they wanted. One told us, "Everyone here has got different needs, whatever these are we aim to meet them. This information can be found in the care plan and from speaking to people." A second staff member said, "When people first come in we will have a chat with them, find out more about them, what they like and want from their time here. We then have ongoing discussions with them." Another added, "The people who stay here are very vocal so can tell you. We discuss things with them when they first come in and then just chat whilst we are supporting them."

Over the course of the inspection we spent time observing the care provided on each floor of the service. We

saw staff interaction with people was warm and friendly. There was a sense of familiarity within these interactions, which was appropriate and in keeping with the vocabulary used by people residing at the service. For example, we heard staff ask people, 'Are you okay, love?' and 'Would you like a cup of tea, my lovely.' Whilst people using the service used words like 'dear' and 'love' when responding to the staff.

Upon entering the dining area or communal lounge, people were greeted warmly and encouraged to sit with others in an effort to promote conversation and interaction. We observed staff members sitting in the lounges chatting to people about a variety of topics, they made a point of trying to engage everyone present in the conversation, although respected the wishes of those who chose not to.

We saw that in line with the reablement model, staff support was focussed on ensuring the person remained safe whilst encouraging them to complete as much of a task as possible, regardless of how long this took. We observed staff supporting people to mobilise from the dining area to the lounge, verbal guidance and encouragement was provided throughout, with the staff member talking the person through the steps needed to stand up using their waking aid, before walking alongside the person at their own pace, offering encouragement and reassurance about taking their time, before talking through how to sit down safely.

Each person's care plan was reviewed weekly by care staff and within the MDT. During a review staff looked at the following areas; mobility, personal care, diet, weight, night staff input, independence and any other relevant information. Information was focussed around the amount of support and input required and the person's engagement in the therapy. Updates and amendments were then made depending on progress. For example in one person's file we noted that for washing and dressing they initially required physical assistance and verbal encouragement, however through gradual changes to the programme and support provided, when reviewed at week four, the person was completing these tasks independently.

Good

Is the service responsive?

Our findings

The people we spoke with told us they had been involved in setting up their care and reviewing progress. One person told us, "I wasn't pushed into doing anything, I agreed to all my care." Another said, "They discuss my progress with me and will tell me if they don't think I am doing as much as I could."

We asked people if staff talked to them to find out what was important to them, to ensure care was person centred. One person said to us, "Yes, they discussed this with me. Although they don't allow pets here, they let my family bring my cat in before it had to be put to sleep, so I could say goodbye, they knew how important it was to me." Another stated, "At night the staff will sit and chat to me, get to know me and what I like, things like that." A third said, "Yes, they chat with me to find out what they can, they also do the same with my family. All the staff are very friendly."

Throughout the inspection we saw evidence of person centred practice. The nature of the service meant that people had therapy and exercises which needed to be completed, however outside of these times; they could determine how they spent their time. People were encouraged to rise at a particular time, to ensure they were able to complete daily living skill tasks and have breakfast before any therapy sessions or appointments commenced. This led to some of the people we spoke to feeling they were unable to choose when to get up. However when asked what would happen if they said to staff I feel like stopping in bed today, they stated that staff would likely encourage them to get up, as they were here for rehabilitation, but would abide by their wishes. We observed people attend breakfast at a time of their choosing and decide where and what they wished to eat. We observed staff supporting people to go through menus for the following day and make choices.

We looked at whether the home was responsive to people's needs. The care plans we viewed were split into three main sections, with one section containing specific information about each person, including a social history, person's background, religious beliefs, cultural needs along with their views and expectations of the reablement process. This enabled staff to have a good understanding of each person, provide areas for discussion and know what was important to the people they supported. The remaining two sections covered monitoring, daily and professional records and charts and all completed and ongoing assessments.

We were told by the physiotherapist that due to a changing population and the increase in obesity, the service had identified the importance of being bariatric friendly, as a result they had ordered a range of bariatric equipment, to ensure this was in place should it be needed. Bariatric equipment caters for the larger person and features increased weight capacities, heavy duty supports and wider widths to fit the person's needs.

We saw that an admission checklist had been formulated which detailed what needed to be done following admission for each person. This acted as a prompt sheet for staff to ensure the person's care was set up correctly and they had everything in place. Each person also had a detailed assessment form which covered the person's past medical history, reason for admission, any identified risks, communication ability, personal care needs, daily living skill needs, mobility issues and aids in use, mental health needs and the

person's goals. In collaboration with the MDT, this information helped formulate each person's programme.

Prior to admission, a referral form was received from either the hospital or service the person was currently at. During the inspection the registered manager told us that the quality of information received on the referral form varied widely depending on who was completing it. A physiotherapist mirrored this finding and indicated that they were working with the registered manager on transitions from hospital, to ensure they got all the necessary information. A new referral form was being drawn up, which should make things easier and ensure they got the right type and quality of information. We were also told that with any complex cases that are highlighted for admission, links were made whilst the person was still in hospital, to ensure that everything was set up correctly and the service could meet their needs.

We saw that one person's referral form indicated they were a high falls risk, had issues with nutrition and hydration and skin integrity. Upon admission, as well as implementing the standard 72 hour monitoring, the service completed a body map within an hour of admission, completed a falls risk assessment and made referrals to occupational therapy and physiotherapy. These measures remained in place until it was determined they were no longer areas of risk.

One area of concern for some of the people we spoke to was the activities available outside of therapy or exercise times. One person said, "There's nothing much to do, I thought there would be more going on." Another told us, "You have to make your own entertainment, I find things to do as it's important to occupy your mind." Conversely another person said to us, "I read, watch television, chat to other people here, there's always something going on."

We spoke to the registered manager who said that some people who come to the service have an expectation that it will be like a care home, which they have to explain to them is not the case. The focus for people using the service is to complete their rehabilitation or reablement programme and then move on, in most cases back home. This model of service would not benefit from a full activity schedule, as this may discourage people from wanting to move on and would also be hard to replicate for most people when they went home.

We saw that each of the lounges contained a television, DVD player, music system, along with books, board games and puzzles. Staff supported people to complete group exercises in the lounges, which included bouncing balls and carpet skittles. These sessions also served as an opportunity for people to chat amongst themselves. A hairdresser visited the home twice weekly and the service organised entertainers and events on regular basis. People who used the service were also able to link in with any of the activities and events completed at the day centre, which was attached to Venmore.

As people's stay at the service tended to be short term, we were told they were only asked to complete quality assurance questionnaires prior to discharge. The survey, entitled 'intermediate care exit survey' asked people to rate the environment, quality of care, attitude of the staff as well as asking if they would change anything about the building or service and for any other comments. We looked at the last five surveys, all of which had been rated as very good in all areas. Some of the comments included, 'very pleased with care, really good staff, could not do enough for me, my recovery is down to the staff and the care I received, the food is wonderful too.'

The service's complaints procedure was prominently displayed along with details of alternative services and organisations people could contact to report concerns. We asked people using the service if they knew how to complain. One told us, "I have not had any complaints, but wouldn't be afraid to speak up and tell one of the staff if I did." Two other people also indicated that they knew who to speak to, but 'not had anything to

complain about.' The service stored complaints received electronically. We looked through this information and saw that only one complaint had been received in the last six months, which was from a relative. The service had dealt with this complaint comprehensively including replying in writing, holding a face to face meeting to review the concerns and discuss action points to address these. This had then been followed up with additional correspondence to confirm completion of the agreed action points.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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.

The service had a clear management structure in place. Each of the three floors was overseen by a 'team organiser', who reported directly to the registered manager. The team organiser was responsible for the people and staff on their floor and were seen as the direct line management for care staff during their shift.

Staff told us they felt the service was well-led and managed and they enjoyed working there. One told us, "I love it here, I am really enjoying it, what we do is massively rewarding." Another said, "I enjoy coming into work, it's nice and relaxed and you can have a laugh whilst getting the work done." A third said to us, "It's such a nice place to work, it's no surprise that some of the people we support don't want to go home."

We asked staff whether they felt supported in their roles. One told us, "We are well supported here. They were very supportive a while ago when I was unwell, very accommodating and really helped me out." Another said, "Most definitely, there is lots of support provided here." A third stated, "Yes, I do. There is always someone around to listen, if you have any questions they are very responsive."

We saw that team meetings were completed on a regular basis. Minutes were taken and action points generated, along with who was responsible and date for completion. Staff informed us that additional meetings also took place, to supplement the formal team meetings. One said, "On our floor we will call a meeting just to update on what is happening, any changes coming up." Another told us, "[Registered manager] holds a big meeting for all staff every six weeks or so, but we had a separate meeting on our floor about three weeks ago as well."

The service's policies and procedures were stored electronically and accessed via Liverpool City Council's intranet. These included key policies on medicines, safeguarding, MCA, moving and handling, equality and diversity and dignity in care. Policies were updated by the council and uploaded onto the intranet; this meant that the most up to date copies were always available. All staff had access to the intranet and a document was in place which all staff had signed to confirm they were aware of the policies and knew where to access them.

We saw that a range of systems were in place to monitor the quality of the service. Survey feedback from people who used the service was displayed on the visitor's notice board, this covered a six month period up to April 2016 and was due to be refreshed at the end of October. This allowed anyone visiting the home to look at how people had rated the service and what the service had done to address any concerns raised.

The council's community manager, who oversaw Venmore along with other council services, completed an 'assistant operations manager's audit' every six months. This was a comprehensive audit which looked at

people's experience of using the service, staff's experiences and feedback, the environment and completion of all documentation including care files, staff records and any monitoring in place. An action plan was generated following each audit, which was reviewed six weekly with the registered manager. We looked at the latest report which was completed in August and saw that all of the previous action points had been signed and dated as completed along with a description of what had been done.

Internally the service completed monthly audits of medication management, care plans and the building, grounds and workplace as a whole. Each audit incorporated what areas had been looked at, any comments or findings and the action taken to address any issues.

During the inspection we noted that the service provided a work placement for a local person with a learning disability, this had been set up via the council. This person had been made part of the domestic team and attended five days per week with support from a carer, completing a range of cleaning tasks and duties.

There was a clear sense of the service having a holistic and multidisciplinary approach to the work they carried out. Two local authority social workers were based in the building and facilitated the discharge process in collaboration with the care team at Venmore, occupational therapists and physiotherapists visited daily to provide input, a GP from a local practice the service had linked with visited three times per week and the service also received input from district nursing. The service also had links with Broadgreen hospital, with the physiotherapists supporting some of the people who used the service to attend an upper limb group there each week, as part of their recovery. All of the professionals spoken to described the positive links that had been forged with the service and the effective working relationship they had, which benefitted all of the people they supported.