Precious Homes Limited

Vermont House

Inspection report

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Ratings

Overall rating for this service	Good
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 and rated the service 'Good' in all areas. After that inspection we received concerns in relation to the safety of the service. We undertook an unannounced focussed inspection of this service on 25 April 2016 to look into these concerns. At that time we identified concerns relating to monitoring of the safety of the equipment at the premises and found that the registered provider had breached a regulation. After the inspection the registered provider sent us an action plan detailing what they would do to address the issues identified at the inspection.

We carried out this unannounced focussed inspection on 26 August 2016 to see if the registered provider had followed their plan and to determine if they were now meeting legal requirements. 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. 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. During the inspection we spoke with the current manager of the service who was undergoing a period of induction into the service with the aim of applying to become the registered manager. We contacted the registered manager and a representative of the registered provider following the inspection.

We found that some improvements had been made to ensure the premises and equipment kept people safe and the provider was no longer breaching regulation. Although improvements had been made systems in place were not robust and had failed to ensure regular monitoring was undertaken. Records that detailed the individual support needs of people in the event of a fire had not been updated which placed people at risk of receiving inconsistent support.

Other areas of concern that were raised at the last inspection around the skill mix of staff and management of medicines had not been fully addressed as per the provider's action plan. We found that although the management of medicines given on an 'as required' basis had improved the monitoring of medicine administration required further improvement.

Following the inspection the registered manager sent us an action plan detailing how they would ensure these issues 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.

Action had been taken to improve the safety of the premises although systems in place still required further improvement.

Whilst improvements had been made to the management of medicines given on an as required bases other aspects of medicines management was not always safe.

The provider had not considered that staff had the right skills and competencies when planning rotas.

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 26 August 2016. This inspection was carried out to check that improvements to meet the legal requirements had been made. The one inspector who carried out this inspection inspected the service against one of the five questions we ask about services: is the service safe?

As part of the 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 manager, three people who lived at the home and three staff members. We sampled records including one medication administration chart, staff rotas, staff training information and maintenance records. On the same day as the inspection we spoke with the registered manager and a representative of the registered provider on the telephone.

Requires Improvement

Is the service safe?

Our findings

At our last focussed inspection on 25 April 2016 we found that people did not always receive safe care and treatment as the provider had failed to ensure that equipment relating to the health and safety of people living at the service was in working order. At this focussed inspection we found that progress had been made to address some of the areas and the home was no longer in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However some areas still required further improvement.

At this inspection we found that the registered provider had taken action to ensure that faults in fire safety equipment had been resolved and in testing electrical items for safety. The service conducted fire safety audits which included testing the fire alarms to ensure they were in working order. However we found that these did not occur at the frequency the registered provider had specified and did not clearly state what had been tested and whether all the equipment was in good working order. The records we viewed did not confirm that servicing of equipment had taken place as planned. The manager of the service had discussed this with staff and had plans in place for a more robust system to carry out these tests routinely. The registered manager had also arranged for staff to be re-trained in fire safety to improve their awareness and understanding of this subject. This re-training was due to take place shortly after our inspection. Although the safety aspects of the service had improved the systems in place to ensure the premises was maintained required further improvement.

Following our last inspection the registered manager had developed systems to check on the safety of the environment in the home. We saw that these had been carried out regularly and that any faults were reported to a named person within the organisation who would take action to repair any faults.

We spoke with people and staff about action they would take in the event of a fire. People told us the specific support needs they had which the two staff we spoke with confirmed they were aware of. We looked at the information available for staff about how to support people in the event of a fire and found that it did not reflect what people and staff told us. We saw that information about people's individual needs had not been improved since our last focussed inspection. There was still a risk that staff could have an inconsistent approach in supporting people in the event of an emergency evacuation.

People that we spoke with told us they felt safe at the home and that staff were always available should they need support. One person told us that the service had increased the level of staff support they received to enable them to stay safe on a trip they had wanted to take part in.

At our last focussed inspection we had raised concerns about medicine management and the skill mix of staff supporting people. The registered manager had detailed a plan of how they were going to improve these areas so we reviewed this to see if improvements had been made.

We looked to see if the provider had addressed our concerns about ensuring staff had the right skill mix to support people safety. We found that training around key topics such as safeguarding had still not been

provided to some staff. These staff were providing support to people out in the community on their own. The provider had not followed their plan to address our concerns.

We found that some improvements had been made to the management of as required medicines following our last inspection. We looked at one person's medicine record and found that action had not been taken to ensure the person received their medicines as prescribed when they chose to stay with friends and family. Although the majority of medicines had been administered we saw that one dose of medicines could not be accounted for. The service had not sought advice on the effects of the person missing any dose of medicines. Medicine audits had not been carried out at the frequency planned and therefore these errors had not been identified. The systems around medicines were not entirely robust.

Following the inspection the registered manager sent us information about how they were going to address the issues identified at this inspection.