

Voyage 1 Limited

23 Barncroft Street

Inspection report

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Ratings

Overall rating for this service	Requires Improvement ●
Is the service safe?	Requires Improvement ●
Is the service effective?	Requires Improvement ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Requires Improvement ●

Summary of findings

Overall summary

Our inspection took place on 02 May 2017 and was unannounced.

At our last inspection on 09 February 2015 the service was meeting all of the regulations that we assessed.

The provider is registered to accommodate and deliver personal care to four people. People who live there may have a learning disability or associated need. On the day four people lived at the home.

The manager was not registered with us as is required by law. However, they had applied for registration to address this. 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.

Medicine systems did not always demonstrate safety or confirm that people had been given their medicines as they had been prescribed. Staff were available to keep people safe, to allow care and support to be provided flexibly and to meet all people's needs. Staff knew the procedures they should follow to ensure the risk of harm and/or abuse was reduced. Recruitment processes ensured that unsuitable staff were not employed.

Documents had not been completed to ensure that external professionals would have all of the information they required to meet people's needs safely or in their preferred way. Staff had received the training they required to give them the knowledge they needed to support people safely. Staff knew that people must receive care in line with their best interests and not be unlawfully restricted. People were encouraged to make decisions about their care. Meal options were offered to ensure that people's food and drink preferences were catered for. Input from external healthcare professionals was secured to meet people's healthcare needs.

The provider ensured a homely friendly atmosphere within the service. People were supported by staff who were kind and caring. People were treated with dignity and respect. People were encouraged to make decisions about their care and support and their independence was promoted. People could see their family when they wished to.

People were involved in their pre-admission assessment of need and follow on reviews. Systems were in place for people and their relatives to raise their concerns or complaints if they had a need to. People could attend religious services of their choice if they wished to. People accessed leisure activities on a regular basis that they enjoyed.

Although people felt that the quality of service was good a consistent manager had not been available. The manager and provider undertook regular audits but these had not always determined shortfalls that could

have an impact on people's safety. People were aware of who the new manager and deputy manager were and were relaxed in their company. The provider had made money available to enhance some areas of the premises.

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 consistently safe.

The provider had not taken sufficient action regarding health and safety issues to ensure that people could be kept safe.

Medicine systems did not always confirm that people had been given their medicines as they had been prescribed.

Staff were available to keep people safe and allow care and support to be provided flexibly to meet people's needs.

Recruitment systems helped to minimise the risk of unsuitable staff being employed.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

Records were not available to provide key information to external healthcare professionals about people's conditions, needs, risks, communication or preferred support methods.

People felt that staff had received the training they required and had the knowledge and skills to provide appropriate support.

Staff had understanding and knowledge regarding the Mental Capacity Act and the Deprivation of Liberty Safeguarding (DoLS), people were supported appropriately and were not unlawfully restricted.

Is the service caring?

Good ●

The service was caring.

People felt that the staff were kind and caring.

The atmosphere of the home was warm and friendly.

People's dignity, privacy and independence were promoted and maintained.

Is the service responsive?

Good ●

The service was responsive.

People's needs and preferences were assessed and reviewed to ensure that their needs would be met in their preferred way.

People were supported to engage in activities that they enjoyed.

Complaints procedures were in place for people and relatives to voice their concerns if they had the need.

Is the service well-led?

Requires Improvement ●

The service was well-led.

Checks and governance had not always been effective in identifying shortfalls in service operations.

Staff felt that the new manager [when fully in post] would give better consistency of leadership that had been lacking.

People knew who the manager was and felt they made themselves available and was approachable.

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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.

Our inspection was unannounced and took place on 02 May 2017. The inspection was carried out by one inspector.

We asked the provider to complete 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. The form was returned so we were able to take information into account when we planned our inspection. We asked the local authority their views on the service provided. We also reviewed the information we held about the service. Providers are required by law to notify us about events and incidents that occur; we refer to these as 'notifications'. We looked at the notifications the provider had sent to us. We used the information we had gathered to plan what areas we were going to focus on during our inspection.

We met and spoke with all of the people who lived at the home. We spoke with three care staff, the deputy manager, the manager and a senior manager. We looked at the care files for two people, medicine records for two people, recruitment records for two staff, training and supervision records for two staff, complaints, safeguarding and quality monitoring processes. We also looked at provider feedback forms that had been completed by people who lived at the home.

Is the service safe?

Our findings

We identified some small areas of exposed hot water pipes that could be a potential burn risk. We highlighted these to the manager who told us that they would assess the rest of the premises and address this issue to reduce any risk of burns. We also found by looking at safety checks that the staff had completed weekly, that the emergency light above the patio doors in the dining room had not been working for some time. This could mean that in the event that the premises lighting failed due to a fire for example, people may not know where to access the premises to remain safe.

A person shared with us, "I am safe". Another person told us, "I am kept safe. If I go out the staff go with me". Other people we spoke with also told us that they felt safe. The completed Provider Information Return [PIR] highlighted, "People have support plans, and risk consideration records, which are reviewed every three months, but also when a change is identified, these records are then updated". We saw that risk assessments had been undertaken regarding for example, for when people went out into the community, showering and eating. We saw that incidents and accidents that took place within the home were recorded appropriately following the providers procedures. A staff member told us, "They [person's name] have had a few falls and we supervise them to reduce a risk of falls". Staff told us and records that we saw confirmed that the manager monitored these for trends so appropriate action could be taken to reduce any risks to people. Records confirmed that where people were at risk of falls for example, they had been referred to external health professionals for assessment and equipment to decrease any risks.

A person told us, "The staff keep my tablets and I am alright with that". Another person said, "I always have my tablets when I should". However, when we checked on person's Medicine Administration Records (MAR) we saw that a prescribed cream and solution had not always been signed to confirm that the person had been supported to apply or use these. We also found that another person had refused their medicine on a regular basis. Staff told us that this had been raised with the person's doctor but there was no documentation to support this. This meant that people were not always being supported to take their medicines as they had been prescribed to maintain their health. We also found that an 'example staff signing document' was not available. This meant that it could be difficult to determine the definite staff member who gave people their medicines on any particular day if the need arose.

Staff told us and training records and certificates that we saw confirmed that staff had received medicine training. We also saw that staff who managed medicines had been assessed as being competent to manage medicines. We saw that medicines were stored safely and that there were protocols in place to instruct staff when "as required" medicines should be given. This would ensure that people received prescribed pain killers if they had pain, or calming medicines were not given without good cause. We found that the provider had systems in place both for the ordering of medicines and the return to the pharmacy for medicines that were not needed.

A person confirmed, "There are enough staff here and to take me out". Another person told us, "I do things for myself but there are always staff if I need them". Staff told us that the staffing levels meant that people were supported and supervised adequately. The manager told us that staff covered each other during

holiday time and that there were staff that could be called upon to cover staff absence. This gave people assurance that they would be always be supported by staff who were familiar to them and knew their needs.

A person shared with us, "No I have not been abused". Another person said, "No way have I had anything like that [abuse]". Staff we spoke with told us about the training that they had received in how to safeguard people from abuse. A staff member said, "If I saw anything that concerned me I would report it to the manager". There had been three incidents of concern since our last inspection. These had been reported to the local authority safeguarding team and to us as is required to help keep people safe. We saw that processes were in place to ensure that people's money was kept safely. We saw that records were maintained to confirm money deposits and money spent. These processes would prevent people from experiencing financial abuse.

A staff member told us, "I was not allowed to start here before all my checks had been done". Other staff also told us that checks had been carried before they were allowed to start work. We checked two staff recruitment records and saw that pre-employment checks had been carried out. These included a completed application form and a check with the Disclosure and Barring Service (DBS). The DBS check would show if potential new staff member had a criminal record or had been barred from working with adults. These systems minimised the risk of unsuitable staff being employed.

Is the service effective?

Our findings

A person shared with us, "It is good here I am happy". Another person told us, "I like it here in many ways". A staff member said, "I think people's needs here are met. They [people] get a good service".

The National Institute of Clinical Excellence [NICE] recommend that information is shared between providers and healthcare staff to ensure that personalised and safe care is provided. We found that although people required support and could not all communicate proficiently; communication or hospital passports were not available for all people. These documents are used to inform health care professional people's likes and dislikes, conditions and how they best communicate. Without these documents people could be at potential risk of not having their needs met in a safe or preferred way. We also found that people were not weighed regularly to monitor their nutritional state. The last record for weight monitoring was February 2017. This could mean that staff would not identify an early stage if people were at risk of the complications of weight loss or weight gain.

A staff member confirmed, "The induction I had was good. I did a lot of training and worked with experienced staff". There was documentary evidence on staff files to confirm that induction processes were in place. The provider had introduced the Care Certificate and new staff had completed this. A staff member confirmed, "I did the Care Certificate". The Care Certificate is an identified set of nationally recognised induction standards to equip staff with the knowledge they need to provide safe and compassionate care.

A staff member told us, "I am supported. There is always a senior here or a manager, or someone on call we can ring". Staff we spoke with confirmed that they received supervision sessions. Records that we looked at confirmed this. We noted that where there were issues with staff performance that these had been raised and discussed in staff. Supervision sessions are used to evaluate staff members work and performance and give the staff the opportunity to raise issues relating to their support or training needs.

A person said, "The staff do what they should for me. I think they are trained". Another person smiled and shared with us, "The staff know how to look after me right". A staff member told us, "I have had all the training I need. We have refresher training when it is needed. I know how to do my job". Throughout the day we saw that staff communicated with people in an appropriate friendly manner and provided support confidently. We saw that one person became agitated. Staff quickly noticed this and implemented calming methods for example, speaking calmly and kindly and suggesting that the person have a drink. These methods worked and very quickly the person was calm and smiling. This demonstrated that staff had the knowledge they needed to support the people who lived at the home.

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. The application procedures for this in care homes and

hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the staff were working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that they were. We saw that MCA assessments had been carried out to determine people's capacity levels. The manager told us and records that we looked at confirmed application for DoLS had been made and approvals granted. Staff we spoke with were aware of the principles of MCA and DoLS and knew that people should not be unlawfully restricted in anyway.

A person shared with us, "The staff ask me before they do anything. I don't need much though". We observed that staff sought people's consent before they provided support at mealtimes. We heard staff ask people if they wished to go out into the community and where they would like to go rather than telling them that they should do. We saw that staff waited for a response from people before they provided support.

A person shared with us, "We [the people who lived at the home] have a meeting with staff to decide what we want to eat the following week. If we decide we want something different that is fine". Another person said, "I have food that I like". Staff told us that they offered people the food and drink that they preferred. At mealtimes we heard staff asking people what they would like to eat and drink. We saw that food stocks were ample and that fresh fruit and vegetables were available. We saw that people were offered and encouraged to have drinks during the day.

A staff member told us, "We [staff] know who we need to observe at mealtimes to prevent choking". We saw that care plans highlighted information that ensured that people were supported effectively and safely when eating and drinking. We identified that where staff had concerns about people's dietary needs, or that people may be at risk of choking, they had made referrals to the dietician and Speech and Language Therapist (SALT) for advice.

A person confirmed, "I have hospital appointments and see the doctor". Other people told us that they had their eyes tested and had dental checks. The completed Provider Information Return [PIR] highlighted, "Individuals [people] are registered with a GP, dentist, optician, and any other specialist agencies such as the dietician and continence nurse". Records that we looked at highlighted that staff worked with external healthcare professionals to access input to meet people's healthcare needs. This included GP's, specialist health care teams, local mental health teams, occupational therapy for falls and SALT.

Is the service caring?

Our findings

A person told us, "The staff are nice". A second person said "The staff are kind". A staff member told us, "I think the staff are all kind here". The Provider Information Return [PIR] read, "The team [staff] have a caring nature and this is something that is demonstrated in our practice". We saw that staff were friendly and showed people compassion. We saw staff greeting people and smiling and took an interest in people and asked them how they were.

A person shared with us, "It is nice here". A person said, "I like the other people here". A staff member said, "All people here are kind to each other". We found that the atmosphere was warm and friendly. We saw that people had made friends with others and saw them chatting to each other in a friendly way.

A person said, "I get up and go to bed when I want to". Another person told us, "I go out when I want to and do what I want". Staff told us what people's preferred daily routines were and we saw that these were documented in people's care plans for staff to follow. A person said, "Staff help me to decide". Another person shared with us, "I decided what I want to do each day and the staff let me". Staff told us that they encouraged people to make their own choices as far as possible about how they wished to live their lives. We found that the provider included people in the running of the service wherever that was possible. During the day a prospective staff member came for an interview and a person was involved in the interview process.

A person said, "Staff are polite to me". Another person shared with us, "I like time on my own in my bedroom". We saw from records that staff had asked each person the name they preferred to be addressed by and used that name when speaking with or referring to each person. We observed that people went in and out of their bedrooms during the day as they wished. We saw that staff knocked people's bedroom doors before entering. Staff we spoke with gave us a good account of how they promoted people's privacy and dignity. They gave examples of closing curtains and doors and encouraging people to do what they could so as not to impose, for example, when they were showering and attending to other personal hygiene needs.

A person told us, "I do cleaning and wash up. Another person shared, "I tidy my bedroom". Staff told us that they encouraged people to develop and maintain their daily living skills. We heard staff encouraging and supporting people to prepare their breakfast and to do small tasks for themselves.

One person went out into the community and visited their relatives on a daily basis on their own. A person told us, "I see my family often". Another person said, "I go on the bus to see my mum". Staff told us that having contact with their family and friends was important to the people who lived at the home. They confirmed that visiting times were open and flexible.

A person shared with us, "I dress myself. I put on what I want to". Another person told us, "I choose my clothes every day and I go and buy my clothes". On the day people were going out and we heard staff suggesting that a light coat may be beneficial. We saw that people wore clothing that reflected their

identity and was appropriate for the weather.

Information was on display that gave contact details for advocacy services in case people wished to access this service. The manager told us that people had access to an advocate if they requested this or it was felt it was in a person's best interests to help them make decisions. An advocate can be used when people have difficulty making decisions and require this support to voice their views and wishes.

Is the service responsive?

Our findings

A person told us, "I visited here before I moved in to see if I liked it". Another person told us, "Staff asked me things about me". The manager confirmed that people were invited to spend time at the home before they moved in to help them decide if they liked the place and if it would be suitable for them. Records that we viewed confirmed that an assessment of need was carried out for each person and information from their funding authority had been obtained in order for the staff to know about people's needs, preferences and risks.

A person said, "I am reviewed and I help with that. There is my file". The person pointed to their care records that confirmed they were familiar with them. Another person shared with us, "I go to my meetings and tell the staff what I like". People said that staff knew them and their needs well. We looked care plans for two people. We saw that reviews had been undertaken. For one person a social worker visited during the day to help review their needs. Staff we asked knew about people's needs and risks. The staff gave us an account of those that confirmed that staff knew of people's needs, preferences and risks.

A person told us that they could attend church if they wanted to but wished not to at the time. Staff confirmed that if a person wanted to attend a place of worship they would be supported to do so. Records that we looked at confirmed that people had been asked about their preferred faith and if they wanted to follow this.

A person told us, "I go out on my own. Shopping and to see family". Another person told us that they went out regularly. Other people told us that they accessed the community regularly during the day included going to the cinema and bowling. During the day three people went out. One independently and two with staff support. All three people told us that they enjoyed their time out. People told us that they liked to read, listen to music and watch their television as relaxation when at home.

A person told us, "I filled out a form". Another person said, "I am happy with everything. I am asked what I think. We saw provider feedback forms on care files that had been completed by people. The feedback forms had been produced in words and pictures to make them easier to understand. The overall feedback was positive, people had highlighted, "I am happy", and, "I like the staff". This confirmed that people were happy with the service provided.

A person shared with us, "I would tell the staff if I was not happy about something". Another person said, "I would let the staff know if I was not happy. I do that". We saw that a complaints procedure was in place and that an easy read version was also available. An easy read complaints procedure is produced in different formats for example large print, or with some text represented by pictures or symbols to ensure that it is easier to read. No recent complaints had been received.

Is the service well-led?

Our findings

A staff member said, "Checks are carried out regularly". However, we found that the governance systems in place were not always effective. Staff had documented that there had been a fault with the emergency lighting in the dining room. All checks documented throughout April 2017 highlighted a fault and that the issue, "Had been reported". We asked the deputy manager why it had taken so long for the fault to be rectified. The deputy manager told us that they were not aware of the fault. They phoned the maintenance team who also had not been made aware of the fault. This meant that the providers checking processes had failed to ensure that staff had reported the fault to a manager or to the maintenance team for it to be rectified. We noted that one person's bedroom carpet was not fitted properly and had holes in it that could be a potential trip hazard. The manager told us that it was clear that the carpet had been like that for some time. Although the manager told us and showed us documents to confirm that the carpet was now to be replaced this had not been addressed in a timely manner. We found that checking processes regarding medicines were not always effective. There were different stages of checks. The first and second check had not identified that there were gaps in one person's medicine records on two days. This meant that the checks put in place did not protect people from being at risk of not being supported to take their prescribed medicines.

A person shared with us, "I think it is a good service". Staff we spoke with told us that the service had lacked some aspects of leadership as there had not always been a manager on site and the registered manager had left. The registered manager had left the service the month before our inspection. Another manager from within the organisation had since applied for registration. Staff felt that the new manager would provide better consistency. A deputy manager had up to recently responsible for the day to day running of the service. A deputy manager however, would not have the legal responsibilities to be accountable for as a registered manager would. During the day we saw both the new and deputy manager speak with and interact with people. People looked very relaxed and were confident to approach and ask questions confirming that they were familiar with the managers. Our conversations with the manager and deputy manager confirmed that they knew all of the people who lived there well.

Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found that the provider was working in accordance with this regulation within their practice. The manager was open and honest in their approach to our inspection by telling us where improvements were needed. The manager told us that the provider was undertaking a review of the service to determine if people's needs could be met better at the home or elsewhere. This was on-going. People told us that they were being consulted about this and a social worker had been involved regarding one person. This showed that the plans the provider was considering were being shared in an open transparent way.

We requested that the Provider completed a 'Provider Information Return' [PIR]. The PIR was completed and returned to us within the timescale we gave. With the exception of issues we identified during our inspection the PIR generally reflected our inspection observations.

Providers are required legally to inform us of incidents that affect a person's care and welfare. The provider had notified us of the events they were required to. It is also a legal requirement that our current inspection report and rating is made available. We saw that there was a link on the provider's web site to our last report and rating and the report was on display within the premises. This showed that the provider was meeting those legal requirements.

A person told us, "I have had new furniture in my bedroom". It looks nice. I like it". Another person said, "The lounge is posh". The provider had made money available to make improvements to the premises to make the environment a more pleasant place for people to live. The garden courtyard had been tidied and provided with a table and chairs and lights. People could safely access this area whenever they wished to. New flooring and soft furnishings had been provided in the lounge and bedrooms had new furniture.

Staff told us what they would do if they witnessed bad practice. A staff member said, "I would report anything I was worried about to a manager". We saw that a whistle blowing procedure was in place for staff to follow and that a dedicated whistle blowing telephone number was available for staff to use if they had any concerns. Staff we spoke with told us that they had read and understood the procedure. The whistle blowing process encourages staff to report occurrences of bad practice or concern without fear of repercussions on themselves.