Voyage 1 Limited

Lowther Road

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?	Outstanding ☆
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 1 and 13 April 2016. The first day was unannounced. It was carried out by one inspector.

Lowther Road is a care home for up to four adults with a learning disability. There were four people living there during our inspection.

There was a registered manager, which is a condition of the service's registration. 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.

People and their relatives were highly complimentary about the service. People told us they liked living there. A relative explained how moving to the service had been positive for their family member, and said that this had been beneficial for the family also. They said, "It's the loveliest place in the world" and described their relative as "a changed person".

The service had a strong ethos of person-centred care and support. People received care and support that met their needs and respected their preferences and choices. Staff worked creatively to ensure that people were involved in making decisions about their care. The manner in which staff spoke with people, with each other and with us reflected that they valued people as adult individuals actively living their lives. Where a person did not have the mental capacity to make particular choices and decisions, staff followed the principles of the Mental Capacity Act 2005 to ensure the person was nonetheless involved in the decision as much as they could be.

With support from staff, people had access to a range of their preferred activities at home and in the wider community. They were encouraged to maintain relationships with friends and family members who were important to them.

The service had a homely atmosphere and people used communal areas in a confident manner, knowing where they could find what they needed without seeking permission from staff. People were encouraged to be as independent as possible, whilst any risks this posed were assessed and managed safely. Staff supported people to do things for themselves rather than simply taking over from them because this was easier.

People were supported by staff who understood their care and support needs. Staff were themselves well supported through training, supervision and ad hoc support from the registered manager and senior staff. Staff morale was good; staff members commented that the service's management were approachable and that they were part of a supportive team.

There was a robust quality assurance system to help ensure the service maintained and improved on its high standards. Regular checks were undertaken by the registered manager, by their manager and by the provider's quality department. Any matters raised were addressed promptly.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from avoidable harm and potential abuse.

There was a positive approach to risk taking, balancing people's safety with their needs and wishes to have varied and enjoyable experiences. Where people behaved in a way that challenged others, staff supported them to manage this in the least restrictive way possible.

Accidents and incidents were reviewed by the registered manager and by the provider's management team for developing trends and action was taken to reduce the risk of reoccurrence.

Is the service effective?

Good

The service was effective.

Wherever possible people's consent was sought to their care. Where people had difficulty making choices about their care and support, staff were confident in using the Mental Capacity Act 2005 to uphold their human rights and make decisions in their best interests.

Staff had found innovative ways of supporting people to make choices about their diet.

People were supported by staff who were themselves well supported through training and supervision.

Is the service caring?

Outstanding

The service was very caring.

People and relatives were highly complimentary about the caring nature of the staff team.

There was a clear, strong, person-centred culture. The staff team were committed to helping people express their views and worked creatively to respect people's preferences.

People were encouraged to be as independent as possible. The staff team valued each person as an adult actively living their life rather than passively receiving care and support.

People were treated with kindness, compassion and dignity in their day-to-day care.

Is the service responsive?

Good

The service was responsive.

People received care and support that was focused on their individual needs. Staff understood people's needs and preferences.

People took part in a range of activities at home and in the wider community, according to their individual interests and preferences.

People were encouraged and supported to maintain relationships with people who were important to them.

Is the service well-led?

Good

The service was well led.

There were robust quality assurance processes and action was taken to address any shortcomings and drive improvements.

The staff team were motivated and confident in the registered manager's leadership.

Lowther Road

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.

This inspection took place on 1 and 13 April 2016. The first day was unannounced. It was carried out by one inspector.

Prior to the inspection we reviewed the information we held about the service. This included notifications we had received from the service since the last inspection. A notification is information about important events that the provider is required to send us by law.

We spent time with all four people who lived at the home. We also spoke with two visiting relatives and with four staff who provided people's care, the registered manager, and the operations manager for the service who visited on the second day of the inspection.

We looked at two people's care and support records, two people's medicines administration records and other documents about how the service was managed. These included three staff files, audits, meeting minutes, maintenance records and quality assurance records.

Good

Is the service safe?

Our findings

People said they felt they or their relative were safe living at the home. People approached staff confidently and looked comfortable in their company.

People were protected against the risks of potential abuse. The registered manager and other staff had the knowledge and confidence to identify safeguarding concerns and to act on these to keep people safe. Safeguarding was regularly discussed in staff meetings and during staff supervision. Money stored and administered on people's behalf was signed for and checked regularly to ensure it was all accounted for. It was handled only by senior staff. We checked cash balances held on behalf of two people and these both tallied with the people's financial records.

Positive risk taking was integral to people's support plans, with plans in place to ensure they were as safe as possible whilst going about their daily lives and enjoying their chosen activities. Risk assessments were undertaken for new activities. For example, a person had wanted to try out archery. Staff risk assessed the activity and considered how they could support the person to take part safely. They arranged trip to a local archery club with an enclosed space where person could try the activity. Another person loved horse riding. Staff undertook a risk assessment with advice from the riding stables, and staff from the stables and from Lowther Road worked together during riding trips to ensure the person's safety and that they had the support they needed to communicate. A further person had frequent falls that presented a risk when they went out. Rather than restricting the person's access to the community, staff had considered how the risks could be managed whilst the person went out. Support guidelines were put in place accordingly.

A person had at a previous service been assessed as being 'severely challenging', with a history of behaving in a way that was challenging to others. Their needs had been assessed carefully before they moved to Lowther Road and their transition to the home was planned in conjunction with other people and agencies from the person's circle of support. An emotional and behavioural support plan had been devised by a behavioural therapist, and staff were trained in physical intervention techniques, or safe holding, that might be needed to ensure the person's safety if they tried to hurt themselves or others. However, since moving to the home the person had not required physical intervention, and the incidence of behaviour that challenged others had decreased. Their care plan had been updated so that it was the least restrictive possible, whilst supporting the person to remain safe. Staff training in physical intervention had been downgraded accordingly.

Risks associated with people's medical conditions, such as epilepsy, were also assessed and managed, based on specialist advice where appropriate. For example, a person with epilepsy had a seizure management plan drawn up by a specialist nurse, so that staff knew what to do when the person had a seizure, including how and when to administer 'rescue' medication and when to call for emergency medical assistance. Staff were familiar with this plan and we observed that they followed it during the inspection.

Hazards in the home were risk assessed and managed. There were up-to-date maintenance contractors' reports, including the landlord's gas safety certificate, the electrical wiring, and the safety of electrical

appliances. Fire equipment was checked and serviced regularly, as was a person's specialist bed.

When people had accidents, incidents or near misses these were recorded and monitored for developing trends. The registered manager reviewed incident records for anything further that could be done to help ensure people's safety. The records were uploaded to the provider's reporting system for monitoring of trends by the registered manager and for the organisation's quality, health and safety and behavioural therapy teams.

There were sufficient staff on duty to meet people's individual needs safely. Where people required one-to-one support from staff this was provided. Each person needed someone with them when they went out and staffing levels enabled everyone to participate in regular activities away from the house. Several vacancies for support workers had been filled during the past year, reducing the reliance on agency or temporary staff. Staff told us that although they were sometimes busy, staffing levels were sufficient for them to do meet their responsibilities.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role, including checks with the Disclosure and Barring Service (criminal records check) and references from previous employers. Staff files included an application form, a full employment history with reasons for leaving employment and reasons for any gaps, records of interview, proof of identity and entitlement to work in the UK.

Peoples' medicines were managed safely and people received their medicines as prescribed. Medicines were stored securely. Medicines administration records (MAR) contained the required information, such as details of people's allergies. Staff initialled the MAR each time they administered a medicine and if a medicine had not been given they had recorded the reason why. Where people were prescribed medicines on an as necessary ('PRN') basis, there were clear instructions for staff so they could recognise when the medicine was needed and how to administer it. Medicines received from and returned to the pharmacy were recorded and there were regular checks on MAR and medicines stocks to ensure that all medicines supplied were accounted for.

Good

Is the service effective?

Our findings

People and their relatives felt that living at Lowther Road had been positive for them. A relative told us, "X has learned how to relax. [They]'d never done that before". A staff member told us how someone we had met at the last inspection was now happier and more active since they had started a particular outside activity.

People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles. Staff confirmed they were readily able to access the training they needed for their roles, and that they were reminded when they needed to attend update training or complete courses online. Core training, which staff undertook when they started work at the service and updated at intervals thereafter, covered topics that would be expected in a learning disability care setting. These included first aid, food safety, health and safety, fire, moving and handling people, infection control, medication, epilepsy including emergency rescue medication, safeguarding adults, and the Mental Capacity Act 2005. Staff had also been trained in Makaton, a sign language used by some people with a learning disability, including one of the people in the house. In addition, staff had periodic training in a recognised system of physical interventions, or safe holding, in case people ever needed this to be safe.

Staff had opportunities to work towards qualifications appropriate to their role. New staff with little or no experience in health and social care studied towards the Care Certificate, a nationally recognised qualification for staff new to care. After completing their probationary period and gaining the Care Certificate, staff were encouraged to work towards diploma level qualifications in social care.

Staff spoke with enthusiasm about their work, telling us they were well supported by the registered manager and their colleagues. They had regular supervision meetings with the registered manager or another designated supervisor, where they discussed their work and any training or development needs they had. A member of staff who had recently joined told us that the registered manager and other staff were "always here for me… will always take time to talk me through things".

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 where 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 service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager believed all four people were being deprived of their liberty. They had made DoLS applications to the relevant

supervisory body. Two applications under DoLS had been authorised without conditions and the others were awaiting assessment by the supervisory body. The DoLS authorisations had not expired.

People's rights were protected because the staff confidently made use of the MCA, ensuring that people were involved as far as possible in decisions about their care so their human and legal rights were sustained. Staff spoke confidently about how they used the MCA in the course of their work. People and their relatives were routinely involved in care planning and where people had mental capacity to make decisions about particular aspects of their care, their consent was sought to this. Where people did not have the mental capacity to consent to aspects of their care, staff made best interests decisions in line with the MCA. Care records detailed clearly the steps that staff should take with each person to help them understand the decision being made and how they could be involved in this, even if a best interests decision was needed on their behalf.

People were supported to make choices about what they had to eat. People prepared as much as possible their own breakfast, lunch, snacks and drinks with the assistance they needed from staff to do this. They also took turns to be involved in choosing and preparing the main meal. Following the 2015 annual service review, people had been supported to make more varied main meal choices. Illustrated cookery books had been purchased and staff also encouraged people to look at recipe websites, supermarket food magazines and printed pictures. There was a 'new food night' every month or so, where different dishes, such as paella, were introduced.

People's dietary preferences and needs were known by staff and were clearly recorded in their care records. For example, a person had been identified as being at risk of malnutrition. A dietitian had given advice about promoting the person's nutritional intake. This advice, such as providing supplies of the person's favourite finger foods, was being followed. Staff had noticed how person's appetite improved when their prescribed fortified juice had been out of stock at the pharmacy and were liaising with the GP regarding updated nutritional guidelines for the person. Another person was at risk of weight gain that could adversely affect their mobility, but they really enjoyed eating. As the person lacked the mental capacity to decide about limiting their food intake, a best interests decision had been made with the involvement of their family, to set out guidelines about the amounts and types of food they should eat at each meal.

People were supported to maintain their health and wellbeing. Their health care needs were monitored. Any changes in their health or well-being prompted a referral to their GP or other health care professionals, such as district nurses or the community learning disability team. Some people had changeable health conditions and staff responded quickly to these changes, following people's care plans and obtaining any professional support that was needed.

Where necessary, adaptations had been made to the building and specialist equipment provided to accommodate people's mobility needs. A person's bathroom and bedroom had been adapted in response to anticipated changes in their health and mobility, in order that they could continue to live at Lowther Road.

Outstanding ☆

Is the service caring?

Our findings

People who were able to told us they were happy living at Lowther Road and liked the staff. Everyone looked relaxed and contented in the company of staff. Relatives were most complimentary about the caring nature of the staff team and the extent to which they were kept informed about their relative's care. One said, "It's the loveliest place in the world" and described their relative as "a changed person". They said they were kept well informed, telling us, "I know exactly what's going on… I can ring them at any time". Another commented on the "happy thoughts, nice occasions" they had at the home, saying, "The whole world has changed for us because of Lowther Road".

There was a strong and visible person-centred culture. Throughout the inspection staff spoke with each other about choices people had made and how they would organise their work so that those choices were respected. They constantly ascertained what people wanted to do and supported them in their choices, such as what they wanted to eat and where they wanted to go out to. Care plans and records reflected the person-centred ethos of the home. Team meeting minutes and supervision notes also showed a positive view of the people living there and a focus on their needs and choices.

People were encouraged to be as independent as possible. The manner in which staff spoke with people, with each other and with us reflected that they valued people as adult individuals actively living their lives rather than passively receiving care and support. We observed that people went to get food and drink when they decided they were ready for a drink, snack or meal, rather than at a meal time set by staff. As far as possible people prepared their own drinks and snacks, with staff on hand to assist where needed rather than taking over from them. The registered manager showed us how food and kitchen equipment people used was deliberately stored within their reach.

There was a range of opportunities for people to voice their views about their care and support. Throughout the inspection, we observed staff and the registered manager talking with people about their plans for the day and the coming days. In addition, people had monthly meetings with their key worker where they were encouraged to discuss how they were finding things and their goals for the next month. A key worker is a named member of staff that is responsible for ensuring people's care needs were met, including included supporting them with activities and spending time with them.

Reviews were conducted in a person-centred way. On the first day of the inspection, a person asked us if they could have a meeting. We spent some time with them and they were interested in our paperwork. Staff later explained that the person liked having meetings. The registered manager recounted how at their latest review, the person had chosen what music would be on, what biscuits there would be, and had sat with a clipboard and called people to order. Although the person did not have the mental capacity to understand all of the decisions discussed, the registered manager and staff had worked creatively to ensure the person was as involved as they could possibly be in the decisions that affected them.

People received care and support from staff who had got to know them well. Staff had a detailed understanding of people's likes and dislikes and what was important to them. This information was clearly

set out in people's care records, including for quick reference a one page profile. Each staff member also had a one page profile with similar information, which was available for people and their relatives to see. In addition, there was a photo board in the hall with pictures of the staff on duty each shift.

People were encouraged and supported to develop and maintain relationships with people that mattered to them. People told us they had regular contact with family members, which they looked forward to. During the inspection, a person was looking forward to their family visiting and they went out with them when they arrived. This was something they did routinely. Staff assisted someone else to get ready for a trip to see their family and to go to the theatre, with the support of a staff member.

Staff understood people's individual communication skills, abilities and preferences. They communicated in each person's preferred manner and were alert to signs that people wanted or needed something. They spoke with people clearly, checking they understood and gave time for them to process what had been said and to respond. A person communicated using Makaton, which is a sign language used by some people with a learning disability. Staff received training in Makaton and used it when communicating with the person. Another person communicated using their own, subtle signs, which staff understood and watched for.

People were treated with kindness, compassion and dignity in their day-to-day care. All of the interactions we observed were supportive and polite, with staff respecting people as adults. This was reflected in the way staff spoke about people, with each other and with us. When people needed assistance, staff responded to this quickly and discreetly. For example, when a person had seizures staff immediately and calmly ensured they were safe, afterwards reassuring them and observing for signs of pain or distress. Staff noticed when the person looked tired and checked whether they would like to go and lie down. When another person dressed in clothing that might not be warm enough for their trip out, staff sensitively encouraged the person to consider what they were wearing and what else they might like to take with them. This was done in a dignified manner and the person decided they would like to put some additional clothing in their bag.

Although no-one was at the end of their life when we visited, end of life care planning had been addressed where a person's health conditions suggested this might be necessary. The registered manager had worked with the person, their family, the palliative care team and other health and social care professionals to plan the support the person and people close to them needed currently. This included planning a range of experiences and events for the person and their family to build special memories for the future. End of life care was an unfamiliar topic for the staff, and the registered manager and the person's key worker had attended end of life care planning conferences and training events organised by a local NHS body, with a view to understanding how best to support the person.

Good

Is the service responsive?

Our findings

People told us about an array of activities they were involved in and that they got the support they needed. Relatives said they were pleased with the way their family member's needs were being met, and one commented on the person's "amazing timetable".

People had their needs assessed before they moved in, to ensure the home would be able to meet their needs. Information was sought from the person, their family and health and social care professionals. People and their families remained involved in care planning after people moved in. Care records contained details of different kinds of people who were important to the person and should be consulted, such as family members and health and social care professionals.

People's needs were reviewed regularly and as required, with care and support plans updated accordingly. For example, a person's condition had been very changeable when they were discharged from hospital and their care and support was revised daily to meet their changing needs. Each person had a keyworker, who was a named member of staff responsible for supporting them with activities and spending time with them. Routine key worker care reviews took place each month. These included developing goals based on people's interests and skills they needed and reviewing how people were progressing with their goals.

Care plans were detailed and person-centred, setting out clearly the person's particular daily routines and the support they needed with them. They were based on an assessment of people's needs and covered areas such as communication, decision making, diet and healthy eating, health and wellbeing and managing money. Staff knew people well and were familiar with the particular support they needed.

People were supported to follow their interests and take part in social activities as they chose, at home and in the wider community. People went out individually with staff to their chosen activity rather than going on group trips, even if they were planning to do the same thing such as swimming. This reflected the service's ethos of person-centred care, with people choosing their activities and the venues for these. For example, when we first arrived, someone was getting ready to go to the library and later on someone else went to the beach, both with members of staff.

The organisation had a policy and procedure for complaints. The registered manager advised us that there was a recently established complaints and compliments line, so that people who had a complaint could approach the organisation directly rather than having to go through the registered manager and staff at the service. There had been only one complaint since our last inspection and this was being investigated in partnership with the other agencies involved.

Good

Is the service well-led?

Our findings

People told us they liked living at Lowther Road and we received positive feedback from their relatives about how the home was run. Comments included: "The whole place just fills me with confidence" and "They're really on the ball".

The service had a positive culture that was person-centred, open, inclusive and empowering. Staff were clear that they promoted independence, supporting people with things rather than doing things for them. The registered manager explained: "Four people live here. It is their home. We [staff] come here to support them living in their home".

The registered manager valued feedback from people, their families and staff and acted on their suggestions. An annual service review was undertaken, with questionnaires issued to people, their relatives and staff. The results were used to set up a quality development plan. The current annual service review was under way and feedback obtained so far had been very positive. The most recent completed review was dated April 2015; all four questionnaires issued to people had been returned as had the four sent to relatives, and eight of the 13 issued to staff. Results had been positive overall, but areas for development had been acted on. For example, there had been concern that some people did not have sufficiently varied meals. This was discussed at a team meeting, following which new ways of choosing meals were tried and adopted. There had also been feedback that relatives did not know all the staff. A summer barbeque was held so that people's families and friends all had the opportunity to meet the staff, a number of whom were new.

People and their relatives also had ongoing informal opportunities to tell the registered manager and staff what they thought about the service. The registered manager had stopped meetings for the people living at the service as people did not all have a say at these. They had introduced structured monthly key worker workbooks and meetings, where people had opportunities to give their views about the service.

The registered manager worked alongside staff and had good insight into things they found challenging. For example, there had been a period of staff vacancies during the past year and the registered manager had taken on all staff supervision to provide staff an opportunity to discuss openly the challenges they were experiencing. They had also initiated a service review so that staff had the opportunity to feed back any concerns more formally.

Staff had confidence the registered manager would listen to their concerns and would be received openly and dealt with appropriately. There were regular staff meetings, at which staff could raise topics for discussion alongside the registered manager's agenda items. Typically, meetings covered health and safety, quality assurance, training, and particular people's current care and support needs. At the most recent meeting, accidents and incidents had been discussed and staff had been reminded that they needed to record any injuries on a body map to accompany the accident form.

People benefited from staff who understood and were confident about using the whistleblowing procedure.

The wider organisation had a 'See something say something' whistleblowing advice line, which was regularly discussed with staff. Staff knew how to raise any concerns within the organisation and with outside agencies, such as social services and the Care Quality Commission (CQC).

The registered manager had notified CQC about significant events, as required in law. We use this information to monitor the service and ensure they respond appropriately to keep people safe.

Quality assurance systems were in place to monitor the quality of service being delivered. The registered manager maintained oversight of the quality of care at the home through regular supervision with staff, ad hoc conversations and informal observation as they worked alongside staff. The registered manager submitted monthly reports for review by their operations manager and the provider's quality department. There were quarterly audits conducted by the registered manager or one of his peers from another service. Additionally, the quality department conducted annual audits. These were comprehensive and detailed, covering all aspects of the service, such as care records and the maintenance and cleanliness of the building. None of the matters were major ones and the service had scored highly over all. The registered manager had produced an action plan in relation to matters identified by the quarterly audits and the most recent annual audit in January 2016. Items listed had all been addressed.