Voyage 1 Limited

Ashleigh House

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

Ashleigh House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and we looked at both during this inspection. Four people with a learning disability and physical disability were receiving residential care at Ashleigh House. They were between the ages of 33 and 53. Ashleigh House has been adapted to provide accommodation over two floors, with a vertical lift between floors.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At the last inspection, the service was rated Good.

At this inspection, we found the service remained Good.

Why the service is rated Good.

People were protected by the arrangements for their safety. This included recruitment, staffing, preventing infection, maintaining the premises, assessing, and managing risks. Staff knew how to protect people from abuse and discrimination.

Arrangements were in place should there be an emergency which required evacuation of the premises. The positioning of a 'grab bag', kept in a first floor office, appeared unwise, to both the inspector and the registered manager. We recommend that the provider reviews the arrangements for an emergency situation.

Arrangements for managing medicines on people's behalf included clear, detailed records, protocols, and safe administration. The current storage arrangements for medicines, which required specialist storage, did not meet current legislation. However, the provider had identified this and was making the required changes.

Staff were skilled, confident and effective in the care and support they provided. A health care professional said, "I can't really fault them."

People's legal rights were understood and upheld with as little restriction as possible.

Dietary challenges were being met so that people received sufficient, nutritious food and fluids to their liking, and in a safe way.

People's health care needs were understood and met. Staff had recognised, and responded quickly, when a person was ill and needed medical attention. Routine health care needs were met through regular contact with external health care professionals.

People received a caring service, which recognised their need for privacy and respect. All engagements between staff and people using the service were friendly, relaxed and made people feel valued and cared for. People's family members said (their family member) was happy at Ashleigh House and staff were friendly.

People were supported to live active and full lives according to their preference and ability. The premises were adapted so that people had equal access to shared areas and there were plans for further improvement. People's rooms were individual to them. One family member said, "The room is lovely."

Support plans were detailed and reviewed regularly. People's needs were understood through effective communication, in which staff were skilled.

Staff were supervised and supported. Audits and checks were carried out in-house and through the provider, so any problem could be identified and rectified.

The registered manager understood and met their legal responsibilities.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Ashleigh 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.

This was a comprehensive, announced inspection. It took place on 8 March 2018. We gave the service 48 hours' notice of the inspection visit because the service was a small care home for younger adults who are often out during the day. We needed to be sure that they would be in.

The inspection team included one adult social care inspector.

Prior to the inspection, we looked at previous inspection reports. We also reviewed the information we held about the service and notifications we had received. A notification is information about important events, which the service is required to send us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

None of the people using the service were able to provide verbal feedback about their experience of life there. During the inspection, we used different methods to give us an insight into people's experiences. These methods included both formal and informal observation throughout the inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not comment directly on their experiences. We were able to observe how staff interacted with people to see how care was provided.

We met two of the four people using the service; two we saw briefly. We spoke with four current people's family members and a prospective family member, three staff and the registered manager.

We reviewed three people's care records. We sampled information from on-line staff files, saw minutes of a staff meeting, and looked at quality monitoring information relating to the management of the service and safety records. Feedback was received from two health care professionals and we saw other feedback from

questionnaires the service had received during 2017.

Good

Is the service safe?

Our findings

The service continued to be safe. People's family member said they believed people were safe.

There were arrangements in place should an emergency occur. For example, regular fire safety training for staff, and a sister home should the premises need evacuating.

There was a 'grab bag' containing equipment should there be an emergency evacuation. However, this was kept in the manager's office, on the first floor behind a key coded door. Each person had a personal evacuation plan, but these proved hard to find and were also kept in the office. This meant that important equipment and information might not be readily to hand in an emergency.

We recommend the provider to review the arrangements for an emergency.

Medicine management protected people. No person was able to manage their own medicines and so staff did this for them. Staff had been trained and were competent in administering medicines, including medicines needed in a medical emergency.

Medicines were stored behind locked doors in locked cupboards. However, some medicines required specialist storage. This was not in place, but arrangements were in progress to get the specialist storage cupboard required.

People were protected from abuse and harm because staff understood the types of abuse and how to respond to any concerns. Staff had received safeguarding training, which was regularly updated. The registered manager had informed the safeguarding team appropriately, when there had been a requirement to do so. Safeguarding concerns were handled correctly in line with good practice and local protocols.

People were protected from discrimination. The registered manager had a good understanding of the Equality Act 2010 and said they were "Passionate" about equal rights for the people they supported. For example, equal access to the community, such as sailing in the summer months.

People's finances were protected. People's allowances were kept securely on their behalf and regular checks were made to ensure they were correct.

Recruitment arrangements protected people. There were recruitment processes in place coordinated through the provider organisation. These included pre-employment checks including references from previous employers and Disclosure and Barring Service (DBS) checks. A DBS check helps employers to make safer recruitment decisions by providing information about a potential staff member's criminal record and whether they are barred from working with certain groups of people. Staff confirmed that they did not work at the service until all checks had been completed; one described how any gap in employment history was robustly followed up.

Sufficient numbers of staff ensured people were safe, in accordance with their assessed needs. Staff said the staffing arrangements worked. They had taken additional shifts when recently some staff had left. Staff from sister homes were asked to help if staffing gaps remained. New staff were now employed, although the service was not completely up to required staffing numbers. People were seen to be supported in a timely manner, in a relaxed and unhurried way, by competent staff.

Staffing arrangements were flexible when necessary. For example, during a challenging situation a person and their family members were supported whilst the person was in hospital. This showed that staffing arrangements met people's individual needs.

People were protected from infection. Staff received training in infection control and food hygiene and the premises were clean and fresh. A colour-coded system was in use for mops. Personal protective equipment, such as gloves, protected staff and reduced the possibility of cross contamination. Some people had continence issues and laundry equipment was suitable for their needs.

The premises were in a safe condition because a programme of maintenance and servicing was in place. For example, the level of risk was always assessed. The provider organisation employed maintenance personnel for the upkeep of the premises. A maintenance issue in relation to coded doors, was quickly followed up, which ensured people remained safe.

Maintenance ensured vehicles were in a safe condition and roadworthy before used.

Risks to people were understood and mitigated. For example, risk management was included in their support plan. Records showed that there were very few accidents. The registered manager and provider organisation monitored these.

Good

Is the service effective?

Our findings

The service continued to be effective.

Appropriate health care was provided in accordance with people's medical needs. For example, arrangements were in place for people to receive dental, eye, foot, and hearing checks as necessary. Staff were proactive in protecting people's health. A health care professional said they "Couldn't fault" the way the service responded to a concern about one person's health. They described the monitoring of people's health as "Good" and said they had "No concerns at all" about the service provided.

Staff completed an induction when they started work at the service This meant they had the skills to start providing people with support. The nationally recognised Care Certificate was included in induction as required. The Care Certificate is an identified set of induction standards that health and social care workers should adhere to when performing their roles.

A staff team who had the skills and knowledge to effectively meet their needs, cared for people. The provider organisation provided regular training for staff and records showed this monitored. Health and safety, and training specific to people's support needs, such as administering emergency medicines, and epilepsy, were included in the training.

Supervision and support helped staff in their role. A senior staff member described the arrangements for supervision and records indicated that the supervision programme was up to date. A staff member said that staff were friendly; they felt supported and could take any question to a senior staff member without embarrassment.

People's consent to care and treatment was in place, mostly through offering choice and understanding individual communication methods. Advocacy helped to ensure people's rights upheld. An advocate said staff understood communication well.

Staff worked in accordance with the Mental Capacity Act 2005 (MCA). No person using the service had capacity to make all necessary decisions relating to their care and support. The MCA provides a legal framework for making 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. Decisions made, following assessment, did relate to people's capacity to consent. Where an assessment identified they lacked capacity to consent, records showed people who knew them best did this for them on their behalf.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interest and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). There had been a DoLS application for each person using the service for their protection and one legal

authorisation had been agreed and put in place to lawfully deprive them of their liberty, for example, to stay at the service. The registered manager had a system for ensuring they reapplied for authorisations in good time for review.

Restraint was not used at the service and an advocate said that (a person) was not deprived of anything unnecessarily. The premises contained many keypads, which potentially restricted where people could spend time. The registered manager had identified that there might be better options available. They said they would research how technology might be used to better effect.

People's different dietary needs and preferences were met. For example, some were at risk of choking and staff needed to prepare their food and drink appropriately. New staff were aware of this and understood the importance of providing safe food options.

Different meal options, provided for people at lunch, met their preference and dietary safety. One had ham, egg and chips and one had homemade carrot and coriander soup. Menu choices were in accordance with people's known preferences, and choices they made in the moment. For example, one person, offered two cereal choices at breakfast, would choose one, or, on occasion, indicate that neither was acceptable that day; other options were then offered. One person's family said, "(The person) definitely likes the food."

Monitoring people's weight helped staff know if the weight was of concern. One person's family was concerned about weight loss but we found the person's weight was stable. People, whose dietary habits were a medical concern, had increased their weight to a healthier level. This showed an understanding of providing safe menu options and helping people to make healthy choices.

The premises met people's diverse needs. Large, en suite bedrooms benefitted people. Adaptions were introduced as needed. For example, the registered manager described how adapting a bathroom would meet the future needs of one person.

Shared space at Ashleigh House included a large, comfortably furnished lounge, a dining room, also used for arts and crafts, a kitchen/diner, and a conservatory overlooking the garden. The conservatory was said to be an underused spaced and the registered manager said they had plans to make it more user-friendly. A lot of space, in a large garden, was available to people. One person would spend all day in the garden in the summer months, according to staff and the person's family. A vertical lift helped people with limited mobility move between floors.

Where people moved across services, the serviced did this in their best interest. Staff, and a person's family member, confirmed that the prospective person had visited the service many times to meet staff, people using the service and choose their room. Their own furniture would come with them. The person's family member said, "(The service) has been brilliant, and helpful to us."

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Good

Is the service caring?

Our findings

The service continued to be caring.

People were not able to tell us if the service was caring but family members said, "It's a lovely place. (The person) seems very settled" and "(The person) has never been as happy as they are now." A health care professional said, "Staff really worry about (people)."

People received a friendly, relaxed service and had fun. One person 'beamed' when the registered manager engaged with them. People, on their return from an outing, came in and went to each member of staff in turn to make contact. This showed that people were relaxed and happy in staff presence.

Staff demonstrated empathy in their conversations with people and in their discussions with us about people. For example, one person strongly valued their privacy, choosing to spend a lot of time alone in their room. Staff supported the person, in a timely manner, when they decided they wanted to go out for a walk.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People receiving support had a learning disability, were non-verbal and used varying communication methods. This included sign language. Staff used a variety of communication methods to give information to people. A health care professional with knowledge of people said, "Staff understand (people's) communication well."

The service promoted people's privacy. Staff knew people's preferred gender of staff to provide personal care. People had their own, en-suite, bedroom. People communicated when they wanted privacy and it was provided.

Record keeping complied with the Data Protection Act 1998. This meant personal information was only available to people with a need to access it and records contained only necessary information.

The registered manager said the service was caring because support was provided in a person centred way, they promote the rights of people, see through a person's disability and it was "People's home". We observed this, and people's family members agreed.

People received support with personal relationships. There were numerous photographs of people spending time with their family during 2017. People's family said how often they visited. They said they were "Always made welcome."

Good

Is the service responsive?

Our findings

The service continued to be responsive.

One person's family member said, "Whatever has been required (the staff) have done it."

People received the care and support they needed and staff were responsive to their needs. Some staff had known people for many years. They were skilled in understanding their non-verbal communication. A newer staff member was observed receiving instruction in how one person communicated their needs.

One person would stand next to an object or move to a particular part of the home. Staff then knew what they wanted, such as to go out for a walk. The registered manager said that staff now had a good understanding of this particular communication method and the person using the service was now "Much happier." The person's family member said, "(The person) always seems happy there."

Staff met people's choices when possible. We observed staff discussing with a person where they wanted to eat and whether they wanted a drink. When it was clear a person wanted or needed something and staff were not sure what it was they used the 'magic list' to identify the need. This meant that, until identified, staff would look at every possible thing the person might need or want.

Decisions, which were beyond the capacity of a person, were discussed with health care professionals or family acting on the person's behalf. An example described by a family member was that of health care concerns.

Each person had a support plan and health care file, which was regularly reviewed, taking into account the person's wishes and information from people who knew them best, such as family members. Support plans make sure that staff have all the information they need to provide care and support which is personalised to the individual, for example, a detailed plan of how a person was to receive the personal care which they needed.

Support plans were well organised with information easy to find and containing in-depth information relevant to the person. For example people's preferred routine, what made the person happy and relating to people's safety, such as a protocol should there be a seizure. Each person's yearly review, included people relevant to their care, such as family.

Staff had important information about people so they understood their needs. Staff were able to describe people's background, preferences and needs in detail. This included staff recently employed.

People enjoyed an active lifestyle according to their preferences. The registered manager said, "We see through people's disability" and "(Disability doesn't stop people having a good time".

People had opportunities for meaningful occupation in accordance with their abilities and interests. For

example, two people spent the day of the inspection at Longleat Safari park. Each person would go sailing in the summer months. People enjoyed shopping and eating out. There were regular arts and craft sessions at the service. For example, there were painted shells and several flags, which people had made, were flying and brightening up the winter garden.

One person's family member said, "(The person) will only do what they want to do"; Staff said that person refused to go out if it was raining. This showed that people had control over their daily lives

Staff described, and we saw, how they recognised if a person was unhappy for any reason. People's family members said, "I would go straight to (the registered manager) with any concern." They said the registered manager had listened in the past and responded to a concern they had raised.

One complaint, received at the service in the previous 12 months, was from a neighbour, not a person using the service or their representative. It was investigated and relevant action taken.

The Care Quality Commission had received no complaints about the service.

Good

Is the service well-led?

Our findings

The service continued to be well-led.

There was a registered manager at the service, registered with the Care Quality Commission in July 2016. They had worked at the service since 2009. 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.

The registered manager was visible and accessible. They demonstrated the values of supporting people to enjoy a good life regardless of disability and ensured people's human rights upheld. People using the service did not comment about the management but people's family members said how liked the registered manager was by people using the service. We observed this in practice. Staff said they felt fully supported. Health care professionals said they had "No concerns at all" about the service.

Supervision meetings and shared staff meetings kept staff up to date and informed them how to improve practice. For example, completed cooking and bath temperatures records. We checked those records and they were now complete.

The service looked for continual improvement, such as how best to manage room hygiene whilst promoting dignity and optimising staff time.

The service sought feedback about the service through questionnaires, which included professional visitors and people's family members. People's views were also sought on a day to day basis, using staff communication skills, and at care reviews.

Service quality monitoring was both internal, and external through the provider organisation. Action plans identified required improvements, the person who was responsible, and how the improvement should be achieved, for example, record omissions. Systems for auditing and monitoring the service were effective. For example, audits of medicine management and money kept on people's behalf.

The registered manager received support through the provider on-line systems, such as recording accidents and incidents, reporting maintenance issues and through regular contact with their line manager in the organisation.

The registered manager understood and complied with their Duty of Candour and understood and met their regulatory responsibilities.