

Voyage 1 Limited

1 Uppingham Gardens

Inspection report

Caversham

Reading

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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



Overall summary

The inspection took place on 15 and 20 July, and was unannounced.

1 Uppingham Gardens is a care home which offers accommodation for people who require nursing or personal care. Although registered to provide a facility for up to seven people, the location currently has six people using the service.

The home is required to have a registered manager. The manager has been in post

since November 2014, and has completed registration with the CQC. 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.

Staff knew how to keep people safe by reporting concerns promptly through a

Summary of findings

procedure that was displayed in the office. Systems and processes were in place to recruit staff who were suitable to work in the service and to protect people against the risk of abuse. There were sufficient numbers of suitably trained and experienced staff to ensure people's needs were met.

We observed good caring practice by the staff. Relatives of people using the service said they were very happy with the support and care provided. People and where appropriate their relatives confirmed they were fully involved in the planning and review of their care. Care plans focussed on the individual and recorded their personal preferences well. They reflected people's needs, and detailed risks that were specific to the person, with guidance on how to manage them effectively.

People told us communication with the service was good and they felt listened to. All relatives spoken with said they thought people were treated with respect, preserving their dignity at all times.

People were supported with their medicines by suitably trained, qualified and experienced staff. Medicines were managed safely and securely. We were unable to find the protocols for PRN medicines; this was raised with the registered manager, who assured us this would be written up immediately. PRN medicines are used on an as need basis. Staff were able to verbally describe the protocol, and the Medication Administration Record (MAR) sheets did not suggest disproportionate usage.

People who could not make specific decisions for themselves had their legal rights protected. People's care plans showed that when decisions had been made about their care, where they lacked capacity, these had been made in the person's best interests. The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty.

People received care and support from staff who had the appropriate skills and knowledge to care for them. All staff received comprehensive induction, training and support from experienced members of staff. They felt supported by the registered manager and said they were listened to if they raised concerns.

The quality of the service was monitored regularly by the provider and the Operations Manager. A thorough quality assurance audit was completed quarterly with an action plan generated, and followed up during identified timescales. Feedback was encouraged from people, visitors and stakeholders and used to improve and make changes to the service.

Summary of findings

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 was safe.

People were safeguarded from abuse and staff understood how to report any concerns they had. Procedures were on display within the home outlining steps to take.

Risk assessments, and plans in an emergency were in place. These were robust, providing succinct details.

The provider had a strong recruitment procedure in place. People were kept safe with the current staffing ratios. Medicines were managed safely.

Good



Is the service effective?

The service was effective.

People and their relatives were involved in making decisions about their care. Where people did not have capacity to make decisions, support was sought from family members and healthcare professionals in line with legal requirements and safeguards.

People were offered choices of meals and drinks that met their dietary needs and when necessary people were supported to eat and drink. People received timely support from appropriate health care professionals.

Staff received regular supervision, training and appraisals.

Good



Is the service caring?

The service was caring.

Staff worked in a caring, patient and respectful way, involving people in decisions where possible. They respected people's dignity and privacy.

Staff knew people's individual needs and preferences well. They gave explanations of what they were doing when providing support.

Good



Is the service responsive?

The service was responsive.

Care plans reflected people's needs and were reviewed regularly. People's views were listened to and acted upon.

There was a system to manage complaints and people and relatives felt confident to make a complaint if necessary.

People and their relatives were asked for their views on the service and they felt confident to approach the management with concerns.

Good



Summary of findings

A programme of activities was provided to suit a range of interests. Outings were being introduced to enable people to more easily integrate with the community.

Is the service well-led?

The service was well-led. Staff, relatives and professionals found the management approachable and open.

Effective processes were in place to monitor the quality of the service. Audits identified where improvements were required and action was taken to improve the service.

Good



1 Uppingham Gardens

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 15 July 2015 and 20 July 2015. The first day of the inspection was conducted by two inspectors and the second day by one. This was a comprehensive unannounced inspection.

Prior to the inspection the local authority care commissioners were contacted to obtain feedback from them in relation to the service. We referred to previous inspection reports, local authority reports and notifications. Notifications are sent to the Care Quality Commission by the provider to advise us of any significant events related to the service.

During the inspection we spoke with five members of staff, including the three care support workers on shift, the deputy manager and the Registered Manager. We spoke with four relatives of people who live at the service. An observation was completed over lunch time, focusing on the interaction of people with one another and with the staff team, through verbal and nonverbal communication.

Care Plans, health records, medication records and additional documentation relevant to support mechanisms were seen for three people. In addition a sample of records relating to the management of the service, for example staff records, complaints, quality assurance assessments and audits were viewed. Staff recruitment and supervision records for three of the regular staff team were looked at.

Is the service safe?

Our findings

People were being kept safe, by robust recruitment procedures. This included obtaining references for staff in relation to their character and behaviour in previous employment and a Disclosure and Barring Service check (DBS). A DBS enables potential employers to determine whether an applicant has any criminal convictions that may prevent them from working with vulnerable people. A robust system had been implemented by management to ensure staff were able to carry out their duties both safely and effectively. This included declaration of health and fitness, a documented interview process, reference character checks, gaps in employment explained – all of which were obtained and qualified prior to employment being offered.

Family members told us they felt their relatives were kept safe. One family member stated: “Yes, happy with everything there, [name] is kept safe”. Another relative stated, “When I take [name] out, she is always looking forward to going back, she must feel well cared for and safe there”. We found that staff had a comprehensive understanding of safeguarding and whistleblowing procedures. They understood the types and signs of potential abuse. Training records showed all staff had undertaken training in safeguarding people against abuse, and that this was refreshed on a regular basis. In addition the manager had visual aids and a reference in place within the office to reinforce the safeguarding protocol and how this is to be implemented. Details were given of external agencies that should be contacted in circumstances where the staff thought that either the manager or the organisation were involved in the abuse – this included, the police, local authority, safeguarding team or the CQC. One member of staff when asked about reporting abuse stated “Straight away, no delays, we’re here to protect people.” In general staff felt both able to raise concerns and felt that management would effectively deal with these.

People were kept safe by staff with the use of appropriate risk assessments, to ensure least restrictive options were used and proactive plans implemented as necessary. For example, activities and diversion to the garden were written as useful proactive strategies. These were reviewed regularly; with evidence illustrating legal representatives had been consulted where appropriate and applicable. For example people accessed the community with staff as it was felt this was safer than them going into the community alone.

Medicines were supplied by a community based pharmacist. They were stored safely in a locked medicines cabinet within the office. Medicines that required storing in a refrigerator were stored appropriately. Temperature checks were recorded and carried out daily. Medicines were ordered and managed to prevent over-ordering and wastage using a Monitored Dosage System (MDS). Each person’s MDS held a copy of their photo, to reduce the risk of error. Medication Administration Record (MAR) sheets were signed and dated correctly, with no medicines errors seen. Audits of the MAR sheets were carried out by the manager weekly, to identify any errors.

We found the records of ‘as required’ (PRN) medicines did not provide sufficient information on when these should be administered. Reference was made to a PRN protocol however this could not be found. This is a document that gives guidance to staff on what action to take prior to offering a person PRN medicines. This is to ensure that medicines are only given when absolutely necessary. The MAR sheet was checked in relation to the frequency of this being used, and was found not to be a frequent measure employed by staff. Staff were able to describe appropriately when PRN medicines should be administered. The registered manager recognised that the document needed to be in place, and assured us this would be completed as a matter of urgency.

Incident and accidents were monitored, although none had been reported since implementation of

Is the service safe?

these records. Systems were in place for trends to be noted, which would then alert the manager to complete written guidance to prevent the likelihood of similar incidents.

Each person had their own personal fire evacuation plan. The staff were able to correctly identify what actions needed to be implemented in the event of a fire. Fire drills were regularly undertaken, so to ensure that both staff and people were familiar with the procedure. We were told that people now understood what they had to do during an evacuation, with some people leading the way to the evacuation point. Fire equipment was regularly checked to ensure it was safe to use. A contingency plan had been prepared for staff to follow should an emergency occur resulting in the building needing evacuation. This contained alternative accommodation address, contact details for staff and professionals to call in case of the emergency. A 'grab bag' had been prepared for such incidents that contained items such as contact lists, torch, batteries etc.

All maintenance safety checks were up to date e.g. Fire systems, emergency lighting, moving and handling (LOLER) equipment. A crack in the masonry of an outside wall had been surveyed to ensure the building was structurally sound. The

operations manager had organised a meeting with the building maintenance department to discuss the findings of the report. Potential movement of the building structure was being monitored to ensure people's safety.

The registered manager told us that three staff worked on early shifts and three on late shifts with one person on duty awake and one sleeping in on the premises each night. Rotas showed staff shortfalls were initially covered from within the team if possible, If this was not possible, staff from one of the provider's other services were sought. In emergencies only known staff from an external agency were employed. There were sufficient staff working per shift to keep people safe. Staff, stated additional staff would enable more community activities to be undertaken.

The home was clean and tidy. Personal protective equipment (PPE) such as gloves and aprons were readily available for staff to use as required. Colour coded systems for cleaning products and kitchen equipment was visible throughout the home This reduced the risk of cross contamination.

Is the service effective?

Our findings

People were cared for by a team of staff who underwent a comprehensive induction process. This included completion of mandatory training and additional training that would be supportive to their role. For example, all staff had completed training in epilepsy which was relevant to the people they supported. Before commencing work they shadowed experienced staff until they felt confident to work independently. The training matrix showed that 98% of all required and suggested training had been completed, with the remaining 2% having been booked. An IT system was used by the home that alerted the manager one month in advance to when training was due to expire. This was effective in ensuring that staff knowledge and skills were continually updated. The registered manager told us that she checked the competency of her staff team following training, so that she was confident staff were able to put into practice the learnt theory, and therefore ensure effective care was delivered.

Staff received regular supervision. This provided both the staff and the registered manager the opportunity to discuss their job role in relation to areas needed support or improvement, as well as areas where they excel. This was then used positively to improve both personal practice and the practice of the service as a whole. The registered manager stated she felt it was beneficial for staff motivation and for the service being offered that staff gained recognised qualifications in social health care. The deputy manager had been enrolled on a Diploma relevant to her work. Annual appraisals were carried out. Staff told us they found both the supervision and appraisal process useful. One said, "I can come in and get things off my chest, then I feel better."

Staff understood the principles of the Mental Capacity Act 2005 (MCA). They told us they had received training in the MCA and understood the need to assess people's capacity to make decisions. The MCA provides the legal framework for acting and making decisions on behalf of

individuals who lack the mental capacity to make particular decisions for themselves. They all stated how they asked for permission before doing anything for, or with a person. The requirements of the Deprivation of Liberty Safeguards (DoLS) were being met. Staff were able to describe why people were on DoLS and the implications for caring for them.

We saw staff seeking consent by asking people if they wanted to do something and giving appropriate explanations. Staff were able to describe examples of best interests decisions, for example whether a person should have a flu jab. They could tell us who had been involved in best interest meetings and the importance of involving people who knew the person well to help make a decision. This was evidenced within the care files for relevant people.

Each person had a decision making profile in their care plan indicating those decisions which required a best interest decision. The registered manager told us everyone living at the service had been reviewed in line with recent changes to DoLS. This was to ensure people's freedoms were not restricted unnecessarily.

People were involved in planning their meals. Meetings were held to decide the menus for the upcoming week. Every week a different person residing in the service would choose the food offered. A weekly menu planner was available with a pictorial format. This ensured that all people were able to understand what options they had. Staff told us that if a person wanted food that was not on the menu, where possible they would attempt to accommodate this. If this was not an option, then an alternative was offered. During the lunchtime observation, we saw people were able to make a choice of filling for their sandwiches. Staff ate with people which provided a homely atmosphere. The registered manager stated, "this is their home. We treat it like that. We would eat together if we were at home." If a person preferred to eat on their own, they were able to do so. We

Is the service effective?

observed one person make the decision to eat in the lounge. A member of staff supported the person both with their decision and where applicable with eating.

Fruit was available to people at all times. Drinks were regularly offered to keep people hydrated. Staff showed people the various options available, so that an informed choice could be made. Where possible people were offered the opportunity to make a drink, staff were on hand to support them with this if needed.

Each person had a nutritional profile and health plan in place. If a person had dietary requirements for medical, cultural or religious reasons, these were catered for. Documents were prepared through multi agency working with the local speech and language therapist (SALT), which meant a thoroughly comprehensive care plan had been prepared. Visual aids for staff on how to

prepare foods were also provided. This minimised the potential for error, and ensured effective management of health and dietary needs at all times.

People's health care needs were met. Care records provided evidence of all visits to or from health professionals including GP, optician, dentist, chiropody and SALT team. Information arising from their advice was included in the care plan and health plans. Hospital passports were created for all people using the service. This was a document that provided essential information about the person, including personal preferences, important contacts, as well as medical information.

A wet room had been created for people to help them maintain their independence and dignity when using the service. This offered ground floor access for wheelchairs and support systems to help independent moving.

Is the service caring?

Our findings

The service was caring towards the people supported. Staff spoke respectfully and were approachable. People appeared comfortable approaching staff for assistance or for general interaction. There was a calm and peaceful atmosphere within the home. Positive interactions were observed during lunch time and people's participation in activities.

People were able to be involved in decisions related to their care. A key worker system had been implemented within the service. This meant that one member of staff held primary responsibility to ensure that all documentation related to the care the individual received was in line with their needs and how they wished to have a service delivered. The care plans were reflective of this, for example we found that where appropriate these were written in the first person, with "I would like staff to help me with..." The care plans were also reviewed with the individual where possible. For people who were nonverbal a pictorial system was implemented.

People were encouraged to gain independence and strive towards achieving this. The registered manager told us that two residents enjoyed regularly attending church. They got up independently on Sunday mornings and went to church with a volunteer and a member of staff. Another example was of a person who did not have the opportunity to spend much time with an aging relative; staff had arranged a holiday to allow the person to spend quality time with their family. Within the home people were encouraged to do things for themselves, for example, assisting in food preparation, making drinks and baking. This was reflected within the care plans that offered guidance on how staff should engage and encourage independence. The registered manager advised that she was in the process of developing plans to encourage and promote people's involvement in doing their own laundry.

She stated "this is their home they should be able to do things". Minor adjustments were being made to the laundry room, after which this plan would be actioned.

It was evident that all staff had read the care and support plans for all people within the service. A list was retained on file detailing date read and signed by each staff. Staff knew the needs of each person in detail and how they wished to be supported, as well as what their likes and dislikes were.

We observed one incident during the inspection process when a person became anxious at our presence within their home. Staff promptly responded to the needs of this person, reassuring them and explaining why we were there. Staff then engaged with the individual by spending time on an activity that they enjoyed doing. They successfully managed this person's anxiety.

Relatives reported they felt that the service was caring. One family member stated, "Happy with everything there. They know her and look after her properly." Another relative said, "he seems happy, looks well. I've noticed some changes in the way he behaves – positive."

House meetings were held monthly. This was used as an opportunity to address generic house related issues with people using the service. A pictorial format was used to communicate with people unable to communicate verbally. They were actively encouraged to express their views and be involved in making decisions. We found examples of this with menu planning. People were able to advise of which foods they would like to eat. This was documented, and where possible, implemented within the menus.

The home encouraged people to have advocates. A poster was on display for staff providing contact details for the Independent Mental Capacity Advocate (IMCA). The registered manager told us that advocates visited people once a month. They aimed to focus on the needs of the individual and ensure their best interests were at the heart of everything related to their care. The home further

Is the service caring?

emphasised the importance of respecting people's dignity. A dignity charter was on display identifying how staff should work to ensure this was maintained. One member of staff was identified as the dignity champion.

People's privacy and dignity was respected and maintained. A number of examples of people being asked discreetly if they wanted to use the bathroom were seen during the inspection. Staff told us they maintained dignity for people by doing things like making sure people's clothes were properly adjusted. One gave the example of a person who like to sit cross legged on the sofa which could result in their clothes riding up and

them being undignified. They told us staff were vigilant about this and would assist the person to adjust their clothes or maintain a more dignified position.

Health records, care folders, medication records, were all kept within the office. However the daily records were not kept in a confidential manner. These were located in a hallway accessible to visitors as they came to the home. We spoke with the registered manager regarding this, who informed us that these would be moved to the office, where they could be locked away with other records to maintain confidentiality.

Is the service responsive?

Our findings

People had their needs assessed prior to them moving into the service. The home had one vacancy at the time of the inspection which was soon to be filled. The registered manager advised that an assessment of the person's needs had been completed to ensure the home could meet them. The person was also assessed to ensure their needs were compatible with people currently living at the service. The registered manager stressed that it was essential that any new person's needs would not disrupt the lives of the people already residing there.

Care plans focussed on the individual. Information such as, their past life history, how they liked things done and how they communicated their everyday care needs. Care plans were amended as required, however these were not always signed to say they had been reviewed. We spoke to the registered manager regarding this, and she recognised the need to demonstrate continual reviewing of care plans. We were told that care plans were working documents that were amended as people's needs changed, she would ensure that these showed when updates had been made.

People had a document in their care plan that advised staff how they liked to be supported. This gave detailed examples of a person's personal preferences including such things as favourite T.V. and radio programmes, times they liked to eat, foods particularly liked or disliked and how they would like to be addressed. A one page pen portrait had been completed as quick reference that contained all pertinent information related to the person. This was located at the front of the care file, and offered concise details of importance.

We observed that staff were responsive to people's needs. They were able to recognise when people were becoming distressed or needed assistance. For example, in one instance when a

person was becoming upset whilst completing an activity, a member of staff approached the person, and sat next to them, gently talking them through and assisting them with the activity.

At lunchtime we noted that people's sandwiches were presented differently being cut into various shapes. The registered manager explained that each individual's preferences were being respected regarding the presentation of their food. Some people liked to have their sandwiches cut into small triangles as this helped them in independent feeding. We found these preferences were reflected within the care plans. This illustrated that the service was responsive to people's individual preferences and choices.

Another example, of this was the bedrooms. We found that each bedroom had been decorated differently, with a number of personal items on display. For example we found in one bedroom there was a pictures of farms and the countryside. On further exploration, we learnt that this person had grown up on a farm. They had happy memories of this, which the home, through consultation with the person, used as a focus for their bedroom décor. Another person liked the colour purple. The bedroom was decorated with items in various shades of purple. The colour co-ordination and personal individuality of bedrooms was evident in items such as the laundry basket, matching the person's choice of scheme.

Activities were currently under review and the registered manager told us the aim was to make them as individualised as possible instead of offering generic activities. Staff confirmed this was taking place and one commented, "There is a tremendous effort at the moment to widen the variety of activities. We want more trips into the community and more one to one activities for people." Individual activity plans were on display within the home. These were presented in pictorial and written format so they could be understood by everyone.

Is the service responsive?

Key worker meetings and sessions were offered by staff. This method of interaction on a one-to-one basis with each person, allowed the key member of staff to learn about the preferences and needs of the individual person, ensuring the care package was responsive to their needs. This information was then shared with the team, through updated plans, handovers, and team meetings. We found documentation related to this in the team meeting minutes and observed this during handover.

Relatives advised us that reviews were held within the home either six monthly or annually. They would be involved, where appropriate in the way the home responded to the needs of the people within the home. The general consensus was that the home aimed to facilitate a high level of care that catered to the needs of the people.

There was a complaints procedure and information on how to make a complaint was displayed. People and their relatives told us they were aware of how to make a complaint. We reviewed the complaints log and noted that no complaints had been made since the new manager had been in post. We asked the registered manager to explain what she would do should a complaint arise. She told us that she would make sure her management of the concern was entirely transparent. A full investigation would be carried out, with the complainant being told of the outcome. People's relatives were confident that the service would correctly deal with a complaint. One relative stated, "I'd go straight back to the home. She [the registered manager] seems very good with managing." This relative went onto state that "She [the registered manager] is earning my trust".

Is the service well-led?

Our findings

At the time of the inspection the registered manager had been in post for less than a year. Within that time positive changes had been implemented within the culture of the home. One member of staff reported, “the service is moving in the right direction.” The registered manager had an open door policy. People using the service, staff, relatives or other professionals had the opportunity to raise any concerns or complaints with the registered manager at any time. We observed people would comfortably knock and enter the office to have a general chat with the registered manager, or seek reassurance about a task they had to complete during the course of the day. For example, one person was due to go out with staff to purchase her daily newspaper. She was aware that the route she was due to take would pass a post box. She approached the registered manager to check if there was any mail that needed to be posted so that she could undertake her activity as soon as possible. The registered manager immediately ensured there was nothing holding up the process, empowering the person to take a lead in directing her activity. This was a positive case of leading by example. The registered manager, illustrated how to quickly deflect and manage a situation.

There was an honest and open culture in the home. Staff showed an awareness of the values and aims of the service. For example, they spoke about giving the best care and respecting people. One staff member said, “We give it our 100%.” Staff told us the registered manager regularly checked on the care provided, whilst engaging with people. They told us they felt able to voice their opinions or seek advice and guidance from her at any time. They told us the registered manager was open and approachable and created a positive culture but was not afraid to speak to staff if they did not perform to the standards expected. One staff member said “Hand on heart, this is a lovely home and [the registered manager] is on the ball, she makes sure we do a good job.”

Another said, the registered manager: “Is bubbly, the guys love her, it’s more homely now, the best it’s ever been.” This was replicated with a relative stating, “She’s very good. I know there’s going to be consistency amongst staff now”. The provider further emphasised the importance of staff being able to raise concerns. Confidential telephone lines had been set up allowing staff to whistle-blow or speak in confidence.

In one incident a family member had stated they were unhappy following a review meeting. The registered manager had considered the concerns raised and responded to them appropriately. This illustrated that management were transparent in their handling of complaints and concerns. The registered manager referred to the new Duty of Candour (Regulation 20 of the Health and Social Care Act 2008 Regulations 2015). We found that the communication within the home was good. Handover and shift planners were used. These were verbally worked through and completed on paper so reference could be made to them during the course of the shift. A communication book was in place which allowed supplementary information to be passed onto staff. A diary was used to detail appointments, schedule meetings and indicate training bookings.

There was strong evidence of working in partnership with external professionals. The local authority (Quality Commissioning Team) had up until December 2014 been involved in providing additional support to the home. This was welcomed and their advice had been adhered to. Evidence of other professionals having been involved in care planning was evident in people’s files. For example, we found that guidance from a psychologist and psychiatrist had been incorporated into the care plan for one person. This was reviewed as required, with risk assessments completed in relation to this.

The registered manager completed weekly and monthly audits of paperwork. These had commenced in March 2015. These were signed to

Is the service well-led?

show they had been carried out but did not identify what files had been audited. The registered manager advised that this information would be included in future.

Quality Assurance Audits were completed quarterly by the Operations Manager. These generated an action plan, where issues were noted. For example, the audit from April 2015 identified some medication errors. The registered manager had introduced a system of weekly audits to ensure these errors were not repeated.

We found the Quality Assurance format used by the operations manager reflected the CQC guidelines, to ensure services were safe, effective, caring, responsive and well led.

We found there to be good management and leadership. The registered manager was supported by an operations manager who offered ongoing guidance and support. The registered manager stated that she did not hesitate to ask for assistance to ensure the service was well led.