

Voyage 1 Limited

Welland House - Occupation 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?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Requires Improvement ●

Summary of findings

Overall summary

We inspected the service on 24 October 2018. Welland House – Occupation Road 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 both were looked at during this inspection. The service accommodates up to 12 people who may have profound and multiple learning disabilities and complex needs. The service is split across two buildings on one site.

On the day of our inspection 9 people were using the service.

The care service had not originally 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. However, people were given choices and their independence and participation within the local community encouraged.

At our last inspection in June 2016 we rated the service 'good.' At this inspection we found the evidence continued to support the overall rating of 'good'. However, the service was rated 'requires improvement for 'well led' at this inspection. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

The service did not always notify the Care Quality Commission (CQC) of certain events and incidents, as required. We found some safeguarding alerts had been raised by the service to the local authority, but they had not been sent in to the CQC to notify us.

There was a registered manager in post, although they were not available on the day of our inspection. 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 had a good understanding of abuse and the safeguarding procedures that should be followed to report abuse and incidents of concern. Risk assessments were in place to manage potential risks within people's lives, whilst also promoting their independence.

Staff recruitment procedures ensured that appropriate pre-employment checks were carried out to ensure only suitable staff worked at the service. Adequate staffing levels were in place. We saw that staffing support matched the level of assessed needs within the service during our inspection.

Staff induction training and on-going training was provided to ensure they had the skills, knowledge and support they needed to perform their roles. Specialist training was provided to make sure that people's

needs were met and they were supported effectively with any complex needs they may have.

Staff were well supported by the registered manager and senior team, and had regular one to one supervisions. The staff we spoke with were all positive about the senior staff and management in place, and were happy with the support they received.

People's consent was gained when possible, before any care was provided. Relatives of people and social work professionals were involved in best interest meetings for people as and when required.

Staff treated people with kindness, dignity and respect and spent time getting to know them and their specific needs and wishes. Care plans reflected people's likes and dislikes, and we saw that staff spoke with people in a friendly manner.

People were involved in the aspects of their own care they were able to be. People and their family were involved in reviewing their care and making any necessary changes.

The provider had systems in place to monitor the quality of the service as and when it developed and had a process in place which ensured people could raise any complaints or concerns. Concerns were acted upon promptly and lessons were learned through positive communication.

The five questions we ask about services and what we found

We always ask the following five questions of services.

<p>Is the service safe?</p> <p>The service remains good.</p>	<p>Good ●</p>
<p>Is the service effective?</p> <p>The service remains good.</p>	<p>Good ●</p>
<p>Is the service caring?</p> <p>The service remains good.</p>	<p>Good ●</p>
<p>Is the service responsive?</p> <p>The service remains good.</p>	<p>Good ●</p>
<p>Is the service well-led?</p> <p>The service was not always well led.</p> <p>Management did not always notify CQC of certain events.</p> <p>Staff felt well supported by the management.</p> <p>Quality assurance systems were in place and effective.</p> <p>The service worked in partnership with outside agencies.</p>	<p>Requires Improvement ●</p>

Welland House - Occupation 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 comprehensive inspection took place on 24 October 2018 and was unannounced.

The inspection team consisted of one inspector. Prior to this inspection, we reviewed information that we held about the service such as notifications. These are events that happen in the service that the provider is required to tell us about. We also considered the last inspection report and information that had been sent to us by other agencies such as the local authority.

The people using the service were mostly non-verbal, and not able to speak with us, however, we were able to meet people and observe staff interact with them. After the inspection, we contacted the relatives of two people to gather their feedback. During the inspection, we spoke with the deputy manager, the operations manager, and two staff members.

We looked at the care records of two people who used the service. The management of medicines, staff training records, staff files, as well as a range of records relating to the running of the service. This included audits and checks and the management of fire risks, policies and procedures, complaints and meeting records.

Is the service safe?

Our findings

People were protected from the risk of harm because there were processes in place to minimise the risk of abuse and incidents. Relatives we spoke with told us they thought their family members were in a safe environment and received safe support from staff. Staff had received training in relation to these aspects of care and support. Safeguarding investigations were carried out and lessons learned were shared with the staff team. Staff understood and told us about their responsibilities to protect people's safety. For example, one staff member said, "I think people are very safe here, I have faith in the management here, that any concerns would be followed up appropriately."

Risk assessments were detailed, individualised and up to date. They covered all the potential risks present for people and the environments they were receiving support in. Assessments we saw were integrated with care plans to clearly explain to staff what risks were present. For example, assessments around the manual handling of people, were alongside their personal care routines, so that staff were fully informed of the best and safest way to provide this support.

Staffing numbers were sufficient to meet people's needs. During our inspection we saw that people had the support they needed from care staff who were available for people at all times. All the staff we spoke with felt that the staffing numbers were sufficient to allow staff to provide people with care without rushing, and to enable meaningful activity and interaction. Rotas we saw confirmed that staffing was consistent and appropriate for people's needs. Some people were staffed on a one to one basis because of their needs, and we saw this support was consistent.

The provider followed safe staff recruitment procedures. Records confirmed that Disclosure and Barring Service checks were completed and references obtained from previous employers. These are checks to make sure that potential employees are suitable to be working in care. The provider had taken appropriate action to ensure staff at the service were suitable to provide care.

The staff supported people with the administration of medicines. We saw that each person had a medication cabinet within their own room to keep their medicines secure. We found that medicine administration records (MAR) were filled in accurately including records that were used for topical medicines and skin barrier creams. All staff administering medicines were trained to do so.

People were well protected by the prevention and control of infection. The home was clean and tidy in all areas. We looked around people's bedrooms, bathrooms, communal areas and kitchen, and found they were regularly cleaned and maintained to a high standard.

Incidents and accidents were recorded and reported accurately. The staff we spoke with felt that any learning that came from incidents, accidents or errors was communicated well to the staff team through team meetings and supervisions if required. For example, improvements to record keeping and dating documents had been discussed, as well as improvements required to the appropriate storage of equipment.

Is the service effective?

Our findings

People had their needs assessed before they began using the service to check that their needs were suited to the service and could be met. The deputy manager told us that once a referral had been received from the local authority, they would arrange to go and visit the person and if possible, family members. A needs assessment would take place followed by a tailored transition in to the service if possible for the person. The person would be assigned a member of staff to take a lead role in their care planning, and their placement would be regularly reviewed to ensure it was right for them and the other people using the service.

Staff had received the training they required to do their jobs and they also received regular supervision and appraisal. This meant that staff had opportunity to discuss their learning and development needs and their performance. Staff had an induction period and were supported to understand each person's needs, and new staff were able to study for the Care Certificate. The care certificate is a course which outlines the basic requirements and skills to provide care. Additional training had been arranged about people's specific needs, for example, percutaneous endoscopic gastrostomy (PEG) training. Several people using the service were not able to take medicines or food orally, so they required a PEG tube to ensure food, fluids and medicines could be taken. All staff were trained in this area to ensure this process was carried out safely and effectively for people.

People were supported to maintain a balanced diet. Food and fluid records were kept for people who required their intake to be monitored. Records we saw showed that people were receiving the correct amounts of food and fluid as described in their plan of care. For people who were able to eat food orally, staff made sure that different options were available to them. One staff member said, "Many people are not able to verbally say what food they want. We make sure people can try out different foods, and we know from their reaction and body language if they are enjoying it or not."

People had access to the healthcare services they required. Staff were knowledgeable about people's healthcare needs, they knew how to recognise when a person was unwell even when the person had difficulty communicating this. Staff requested healthcare support when this was needed and followed the advice given. There was good communication between staff and healthcare professionals such as speech and language therapists. Staff had received positive feedback from healthcare professionals about recognising changes to people's health and wellbeing.

The premises and environment met the needs of people who used the service and were accessible. We saw that each person's room was decorated to their choice and preferences, and that communal and outside areas were available for people to use. Hoists and ceiling tracks were available in each person's room to enable them to be comfortably and safely moved around rooms and bathrooms.

Consent was sought before care and support was provided. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their

behalf must be in their best interests and as least restrictive as possible. People's capacity to make decisions was assessed and best interest decisions were made with the involvement of appropriate people such as relatives and staff. The MCA and associated Deprivation of Liberty Safeguards were applied in the least restrictive way and correctly recorded.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We saw that detailed plans were in place to support people with decision making, and best interest meetings were held as and when required. Staff we spoke with fully understood the principles of the MCA.

Is the service caring?

Our findings

People were treated with kindness and respect. Relatives we spoke with were happy that staff treated their family members with dignity and compassion. One relative said, "The staff are all very nice. I think [name] has settled in really well, and they are actually more happy at Welland than they were where they lived before. I am very happy for [name] to be there." One staff member said, "We are here for the people, this is their home and we all work hard to make it a good place." Another staff member said, "The people in the service come first, always." During our inspection we saw that staff were interacting with people in a warm and friendly manner.

People's families were made welcome and encouraged to be involved in making decisions about care and support where this was appropriate. Many of the people using the service were not able to be directly involved around making decisions about their care, but the relatives we spoke with felt involved. One relative said, "They [staff] know what [name] likes and doesn't like. They have got to know them. I always get informed and kept up to date, and I can input in to [name's] care."

People's privacy and dignity was respected. Relatives of people using the service told us that people were respected by staff at all times. We observed that staff interacted with people in a respectful and dignified manner. Care plans outlined the tasks that were required for people, and prompted staff to remember to respect each person's privacy and dignity at all times whilst doing so.

During our inspection, we discussed the details of people's care with staff members, who were always considerate of who was around when they were talking, and made sure that personal information was not shared with people inappropriately. People's personal information was stored securely, and staff were aware of keeping information safe and data protection.

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care planning outlined People's preferences about the way they preferred to receive care and support, were carefully recorded. Information about the way people communicated with body language, facial expressions, and vocalisations were documented to support staff understanding of each person's preferences. Care plans outlined things such as 'what people like and admire about me' and 'what's important to me'. For example, it was documented that one person took a pride in their appearance, and enjoyed wearing clothes that featured a range of different textures. They also enjoyed collecting carpet samples as the sensory experience of touching different textures was important to them.

People were supported to follow their interests and take part in activities that were socially and culturally relevant. We saw that people had been involved in Halloween themed crafts sessions and were preparing for a Halloween disco. The deputy manager told us that a disco and party had been arranged with people, with costumes and family members involved. Staff also told us that they had recently taken people on a cruise ship holiday, which they had all enjoyed.

People received information in accessible formats and the registered manager knew about and was meeting the Accessible Information Standard. From August 2016 onwards, all organisations that provide adult social care are legally required to follow the Accessible Information Standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss. The service had multiple examples of pictorial information to support people's understanding, including a pictorial service user handbook.

The provider had a complaints procedure in place. No complaints had been made but the system in place allowed for complaints to be recorded along with the outcome of the investigation and action taken. The relatives we spoke with confirmed they understood how to make a complaint, but had not required to do so.

No end of life care was being delivered by the service, but people's decisions, and that of their family, could be recorded within their care plans to document any wishes and preferences in this area.

Is the service well-led?

Our findings

The service was not always well led. The service did not always notify the Care Quality Commission (CQC) of certain events and incidents, as required. The service had made some statutory notifications to the CQC, after incidents had occurred. A statutory notification provides information about important events which the provider is required to send us by law. Providers are required to send us information about any abuse or allegation of abuse that is made. We found three safeguarding alerts had been raised by the service to the local authority, after medication errors had been discovered, but they had not been sent in to the CQC to notify us. We discussed this with the deputy manager and the operations manager, who told us that in future, all safeguarding alerts that the management raise, will be forwarded to the CQC.

There was a registered manager in post, although they were not available on the day of our inspection. 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.

There was a clear vision and culture that was shared by managers and staff. The culture was person centred and staff knew how to empower people to achieve the best outcomes. A staff member told us, "The office door is always open. All the management staff are very approachable." Another staff member said, "The communication within the team is very good. I am confident in the management of the service." During our inspection, it was clear that the deputy manager and operations manager were confident about implementing positive changes in the service, and was taking responsibility to ensure the staff team felt good about their roles, and were able to provide positive support to people. Staff held meetings where updates on the service were discussed, along with updates on the people being supported. The staff we spoke with felt this was a good opportunity to raise ideas and concerns if necessary.

Relatives of people who used the service were asked for their feedback and encouraged to participate in the development of the service. relatives were sent surveys to complete. We saw that the results were collated to show an overall impression of the service. Positive feedback was gained from relatives of people using the service.

Quality assurance systems were in place to help drive improvements. The management had carried out audits of all aspects of the service, and knew what areas needed updating and when. This included a 'Case Management System' which fed information in to a central system, so that the provider could have oversight on any accidents or errors that were occurring, and identify any trends so that sufficient action could be taken. Actions were created when any errors or faults were found. Learning points were brought to the attention of staff through team meetings or supervisions.

Staff worked in partnership with other agencies, including the local clinical commissioning group, who had carried out a monitoring visit of the service and scored them highly. Positive feedback about the service was given to them as a result of this monitoring. Information was shared appropriately so that people got the

support they required from other agencies and staff followed any professional guidance provided.

The latest CQC inspection report rating was on display at the home. The display of the rating is a legal requirement, to inform people, those seeking information about the service and visitors of our judgments.