Voyage 1 Limited

Woodham Grange

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

This inspection took place on 7 June 2017 and was unannounced. This meant the staff and provider did not know we would be visiting.

Woodham Grange provides care and accommodation for up to eight people with a learning disability. On the day of our inspection there were seven people using the service. The home had a spare room for people who stayed at Woodham Grange for respite care.

The service did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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 previous registered manager had recently left the service. A new manager was in place who had applied to CQC to become registered.

We last inspected the service in 2015 and rated the service as 'Good.' At this inspection we found the service remained 'Good'.

Accidents and incidents were appropriately recorded and risk assessments were in place. The registered manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

The provider had an infection prevention and control policy and procedure in place and an annual statement was produced outlining the service's systems for the prevention and control of infection.
The home was clean, spacious and suitable for the people who used the service and appropriate health and safety checks had been carried out.

Appropriate arrangements were in place for the safe administration and storage of medicines.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Staff were suitably trained and received regular supervisions and appraisals.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA) and was following the requirements in the Deprivation of Liberty Safeguards (DoLS).

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of visits to and from external health care specialists.

Family members were generally complimentary about the standard of care at Woodham Grange.

Staff treated people with dignity and respect and helped to maintain people's independence where possible. Care plans were in place that recorded people's plans and wishes for their end of life care.

Care records showed that people's needs were assessed before they started using the service and care plans were written in a person-centred way. Person-centred is about ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

Activities were arranged for people who used the service based on their likes and interests and to help meet their social needs.

The provider had an effective complaints procedure in place.

Staff felt supported by the management team and were comfortable raising any concerns. The provider had appropriate auditing processes in place and people who used the service, family members and staff were regularly consulted about the quality of the service.

Some statutory notifications were submitted in a timely manner however six statutory notifications for DoLS authorisations had not been submitted to CQC. We are dealing with this matter outside the inspection process.

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 is now Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service was not always well-led. Statutory notifications for Deprivation of Liberty Safeguards (DoLS) notifications were not submitted in a timely manner. Staff were regularly consulted and kept up to date with information about the service. The provider gathered information about the quality of the service from a variety of sources and had an appropriate quality assurance process in place.	**Requires Improvement**

Woodham Grange

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 7 June 2017 and was unannounced. One adult social care inspector and an expert by experience took part in this inspection. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to inform our inspection.

During our inspection we met with the seven people who used the service however due to the nature of their disability we were unable to communicate verbally with them. We spoke with three family members over the telephone. We also spoke with the manager, area operations manager and three care staff.

We looked at the care records of four people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

Good

Is the service safe?

Our findings

Family members and staff we spoke with did not raise any concerns about safety at Woodham Grange. A staff member told us they were, "Not allowed to hoist people until they had appropriate training." Another staff member told us people's care managers were, "Very involved and respond quickly when asked to help resolve any issues."

There were sufficient numbers of staff on duty to keep people safe. We discussed staffing levels with the manager and looked at staff rotas. Staffing levels were determined by the needs of the people using the service and whether anyone was using the respite room at the home. The manager told us staff absences were covered by the home's own staff and bank staff were also available to cover shifts. Staff and people who used the service did not raise any concerns regarding staffing levels at the home.

The provider had an effective recruitment and selection procedure in place and carried out relevant security and identification checks when they employed staff to ensure staff were suitable to work with vulnerable people. These included checks with the Disclosure and Barring Service (DBS), two written references and proof of identification. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults.

Accident and incident reporting procedures were in place. Accidents and incidents were appropriately recorded, analysed and investigated. Risk assessments were in place for people who used the service, staff and visitors. These described potential hazards, who might be harmed and the control measures in place to reduce the risk. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents from occurring.

The provider had an infection prevention and control policy and procedure in place and an annual statement was produced outlining the service's systems for the prevention and control of infection. The home was clean. Daily cleaning checks and regular mattress inspections were carried out. Appropriate personal protective equipment (PPE) was used and guidance on hand washing and hand hygiene was available throughout the home.

Hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance Health and Safety in Care Homes (2014). Equipment was in place to meet people's needs including hoists, bath and shower equipment, and wheelchairs. Where required, we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER).

Electrical testing, gas servicing and portable appliance testing (PAT) records were all up to date. Risks to people's safety in the event of a fire had been identified and managed. For example, fire alarm and fire equipment service checks were up to date, fire drills took place regularly and a fire risk assessment was in place. People who used the service had Personal Emergency Evacuation Plans (PEEPs), which meant

appropriate information was available to staff or emergency personnel, should there be a need to evacuate people from the building in an emergency situation, such as a fire or flood.
The provider had a 'Safeguarding of children, young people and adults at risk' policy in place. Local authority guidance, including a risk threshold tool, was available which provided guidance on the different types of abuse. We found the manager understood safeguarding procedures and had followed them, and staff had been trained in how to protect vulnerable people.

We checked how medicines were managed. Medicines were stored in a locked cabinet in the manager's office. A separate locked cabinet for controlled drugs was in the cabinet, however, there were no controlled drugs in use at the home at the time of the inspection. Controlled drugs are drugs that are at risk of misuse.

Medicines audits were carried out weekly and staff received annual competency checks. Medication administration records (MARs) were accurate and up to date.

People had 'Medication management' support plans in place that described people's skills and abilities to take their own medicines and if applicable, what level of staff support they may need. For example, "Staff must encourage [name] to open his mouth for medications. [Name] must be encouraged to swallow any medications in his mouth but staff have to be patient with [name] as well. Staff must always check they have been swallowed." This meant appropriate arrangements were in place for the safe administration and storage of medicines.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. A family member told us were very impressed at the speed with which all the equipment their relative needed had been put in place when they moved into Woodham Grange. Family members also told us they were kept up to date and were, "Well informed" about their relative's care and that staff, "Did their best".

Staff were supported in their role and received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Staff mandatory training was up to date. Mandatory training is training that the provider deems necessary to support people safely and included dementia awareness, epilepsy, end of life, fire safety, health and safety, infection control, mental capacity, moving and handling, management of actual or potential aggression (MAPA), nutrition and safeguarding vulnerable adults. New staff completed an induction and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and a set of minimum standards for new staff working in health and social care.

People who used the service were supported with their dietary needs. Staff we spoke with told us that due to their needs, people who used the service did not get involved in preparing food. Staff had good knowledge of people's dietary needs.

Some people were at risk of dysphagia. Dysphagia is where people have difficulty in swallowing. We saw these people had been referred to speech and language therapists (SALT) and guidance issued by these professionals was included in the care records for staff to follow when delivering care. For example, the type and amount of food the person should be eating, ideas for meals, what support staff should provide at mealtimes, and the use of appropriate cups and cutlery. People were weighed monthly and malnutrition universal scoring tools (MUST) were in place. MUST is a screening tool used to identify whether people are at risk of malnutrition.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. We saw DoLS applications had been submitted to the local authority for all the people who used the service. Staff had been trained in the MCA and the manager understood their responsibilities with regard to the MCA.

People had 'Decision making profiles' in place. These described how the person liked to be given information about decisions, what was the best way to present choices, what ways staff could help the person understand, and when was the best and worst time for making a decision. We saw records of best interest decisions that had been made for people and these recorded who was involved in the decision making process.

People had 'Communication plans' in place. These provided an overview of the person's communication skills and preferred method of communicating. They included a guide for staff on what it meant when a person did or said something, and what staff should do in response. For example, if one person put their hands out to staff it meant they wanted to be supported to get up and walk to another part of the home.

People who used the service had 'Hospital passports' in place, had access to healthcare services and received ongoing healthcare support. The aim of the hospital passport is to assist people with learning disabilities to provide hospital staff with important information about them and their health when they are admitted to hospital. Care records contained evidence of visits to and from external specialists including GPs, dentists, podiatrists, psychiatrists, nurses and speech and language therapists. Notes and outcomes from these visits were clearly recorded in the care records.

Corridors were wide to accommodate wheelchair users and people's bedrooms, communal bathrooms and other communal areas were spacious. A family member told us their relative spent a lot of time lying in the corridor. Staff told us this was the person's favourite place and they had decorated it to make it more interesting. We looked at the corridor and saw it had been decorated with sensory lighting, Disney murals and mirrors. This meant the premises was appropriately designed for people who used the service.

Good

Is the service caring?

Our findings

People we saw were well presented and looked comfortable in the presence of staff. We saw staff speaking with people in a polite and respectful manner and people were assisted by staff in a patient and friendly way.

During the morning of our visit we observed people sat in the lounge and there was very little interaction with staff. Our observations at lunch time also showed little interaction between staff and people who used the service, and staff appeared to be task orientated. However, we observed good and positive interactions between staff and people in the afternoon, when the care appeared to be more focussed on the individual. We discussed this with the manager who told us it was possibly due to staff having a number of tasks to complete in the morning however they agreed to look into it and discuss with staff.

People's personal choices and preferences were recorded in people's care records. These included care records that described how to achieve a good day and night for people. They provided information on how the person was supported with morning routines, bathing, mealtimes, relaxation, mobility, continence, activities, bed time and sleeping. For example, "[Name] wakes up early between 5am – 6am. [Name] will get out of bed independently", "[Name] likes to have a nice relaxing soak in the bath", "A good day for [Name] will involve having a foot massage or her toe nails painted" and "[Name] prefers interaction with staff rather than TV or music but does seem to be interested in TV shows or movies, that are action based or black and white". This meant staff were aware of people's individual preferences.

We observed one person who used the service handling a glasses case. Staff told us the person "liked the noise it makes". The manager told us staff had donated their old glasses cases to the person because they liked to hold and fiddle with them.

We saw and heard staff knocking on bedroom doors and calling out to the person before entering their bedroom. People's care records described how staff were to promote dignity and respect people's privacy. For example, "Provide support with personal care and activities of daily living whilst maintaining dignity at all times", "Staff should monitor [name] throughout the day to ensure his dignity is maintained [with regard to continence care]", "Always knock on [name]'s door before entering his bedroom" and "Staff should ensure that the door is closed when attending to [name]'s personal care". Care records also described whether people preferred male or female care staff to assist them with their personal care. Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

People were supported to maintain their independence, for example at mealtimes or with their personal care. One person was encouraged to, "Put [name]'s hand over staff's hand so that they can assist with their feeding." A person was supported to access day services and be involved in craft and music sessions, and shopping trips. This meant that staff supported people to be independent where possible.

People were supported to take part in religious celebrations and activities. Where people could not verbalise

their needs or wishes, people who knew the person well were involved in the decision making process. For example, for one person it stated, "It is clear to those who know [name] that he benefits from partaking in religious celebration/activities. It is important for [name]'s continued wellbeing that staff supports [name] to regularly access religious celebration/activities." The manager told us people from the local church visited at Easter and Christmas, and one of the people who used the service went to church with their family member every Sunday.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. We discussed advocacy with the manager who told us one of the people using the service at the time of our inspection had an independent advocate and information was available for people and families if required.

We discussed end of life care with the manager. None of the people who used the service had end of life care plans in place but the provider had an end of life policy and staff had been trained in end of life care. The manager told us end of life arrangements would be discussed with people and family members when it was an appropriate time to do so.

Good

Is the service responsive?

Our findings

People's needs were assessed before they started using the service. This ensured staff knew about people's needs before they moved into Woodham Grange.

Each person's care record included a 'Personal details' sheet that contained important information about the person including emergency contact details, religious beliefs and the name by which they liked to be called. 'One page profile' summaries described what people liked and admired about the person, what was important to them and what staff had to do to support the person well. For example, "Understand the signs of distress", "Maintain foot care and refer to chiropody if needed" and "Maintain a good relationship with [name]'s mother and sister".

People's care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account. Support plans were in place and included medicines, health reviews, eating and drinking, finances, personal care, activities, religious beliefs, cognition, night time support and family contact.

People were involved in their support planning as much as they were able to. The provider did this by recognising people's individual skills and recognising the amount of interaction people could contribute. The support plans included; why a support plan was required, how to support the person, and what not to do. For example, one person required assistance from staff to manage their personal care, including bathing and showering, and required a hoist to get in and out of the bath. The support plan described the assistance the person required from staff. For example, "While being hoisted [name] must be supported by trained and empathic staff who should offer reassurance and carry out transfers in a calm, smooth and controlled manner" and "Staff must be trained in moving and handling so that they can use the bathroom hoist to assist [name] into the bath or on to shower bed". We checked staff training records and saw that all the staff had been trained in moving and handling.

Each support plan had a risk rating that described the level of risk before the support plan was implemented and the level of risk after the support plan was implemented. Where there was still an element of risk following the implementation of the support plan, a 'Risk consideration meeting' took place and the outcome recorded.

Care records were reviewed monthly and a full review took place annually that involved people's care managers and family members where possible.

Daily records were maintained for each person who used the service. Records we saw were up to date and included information on the person's routine, diet, activities and sleep pattern.

We found the provider protected people from social isolation. People had individual activity support plans in place that described what activities they enjoyed doing and what support they required in this area. For example, one person enjoyed going to the theatre and cinema, watching football, sensory activities, being in

the garden, and eating out. People's daily records showed that activities were regularly carried out with people and we saw photographic evidence of activities that had taken place around the home.

The provider's concerns, complaints and compliments policy was available in the entrance to the home. This described the procedure for making a complaint and how long the complainant would expect to wait for a response. There had been only one complaint recorded at the service in the previous 12 months, which had been appropriately dealt with. There had been several compliments made about the service. These included, "Staff are always positive, friendly, informative and there is always someone available to answer questions", "Really consistent, supportive staff team. Care is individually tailored and attention is given to ensuring people are restricted as little as possible" and "Brilliant atmosphere. Care staff are fantastic and very helpful. Always willing to help". This meant the provider had an effective complaints and compliments policy and procedure in place.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. The previous registered manager had recently left the service. A new manager was in place who had applied to CQC to become registered.

The provider was meeting the conditions of their registration and submitted some statutory notifications in a timely manner. However, statutory notifications for six DoLS authorisations had not been submitted to CQC. A notification is information about important events which the service is required to send to the Commission by law. We discussed this with the manager who agreed to submit retrospective notifications for these DoLS authorisations straight away. We are dealing with this matter outside of the inspection process.

We recommend the provider re-familiarises themselves with the requirements of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them, ensuring people's personal information could only be viewed by those who were authorised to look at records.

Staff were regularly consulted and kept up to date with information about the service and the provider. Staff meetings took place approximately every quarter and included a review of previous actions, health and safety, infection control, safeguarding, training, business and policy updates, and any other business.

We looked at what the provider did to check the quality of the service, and to seek people's views about it.

The provider carried out an annual service review, which included obtaining feedback from people who used the service, family members and friends, staff, and health and social care professionals. The results of the feedback were analysed and an action plan was developed. For example, from the surveys carried out in 2016 it was asked if more bank staff could be appointed. This resulted in a new bank staff member being appointed and staffing levels would be monitored.

The provider's operations manager and home manager carried out quarterly audits of the service, and the provider carried out an annual 'Internal quality and compliance audit' of the service. This was based on the CQC five domains of Safe, Effective, Caring, Responsive and Well-led. The audit checked areas under each domain and an action plan was put in place for any issues raised.

A 'Consolidated action plan' was developed based on issues identified in the audits, annual service reviews and from feedback generated from staff meetings. The action plan recorded the date the action was created, what the action was, when it had to be actioned by, and who the owner was. For example, it had been identified that the kitchen extractor fan needed repairing. It was reported to the provider and repaired.

This meant the provider gathered information about the quality of the service from a variety of sources.

The service had good links with the local community, which included local pubs, restaurants and shops, a local care centre where people used the hydrotherapy pool and accessed other kinds of activities and treatments, and the local leisure centre. The manager told us they regularly held open days at the home, which included charity coffee mornings and visits by representatives from the local church.