Voyage 1 Limited

177-179 Spring Grove Road

Inspection report

177-179 Spring Grove Road
Isleworth
Middlesex
TW7 4BA

Tel: 02085684428
Website: www.voyagecare.com

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 8 November 2016 and was unannounced.

The last inspection took place on 1 February 2016 when we found breaches of five Regulations relating to dignity and respect, person centred care, safe care and treatment, good governance and notifications of incidents. At the inspection of 8 November 2016 we found that improvements had been made. In particular people were receiving better support with their health and the care was safer. In addition the registered manager had introduced systems to monitor and manage the service which had improved the way in which people were cared for. However, we found that further improvements were still needed. In particular care was not always provided in a person centred way.

177-179 Spring Grove Road is a care home for up to eight adults with a learning disability. At the time of the inspection six people were living at the home. Some people also had physical disabilities, a range of complex health needs and were not able to communicate their needs verbally. Voyage 1 Limited is an organisation providing care and support to people with learning disabilities, autism and brain injury throughout the United Kingdom in residential, outreach and day services.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

People living at the service did not always have care which reflected their individual needs and preferences.

There had been improvements to the way in which the service was managed and run. This had impacted on the lives of people who lived there. In particular there had been improvements to the way in which their health needs were monitored and met. There had also been improvements to their safety and the way in which they were supported to eat and drink.

People living at the service could not tell us about their experiences, but their relatives told us they thought they were happy living there. Relatives and professionals told us they recognised the improvements at the service and felt that these were positive. They expressed some concerns that further improvements were needed. In particular they felt that not all the staff working at the service had embraced the changes and this meant that people's needs would not always be met.

The staff were well supported and trained. There was clear information about their roles and responsibilities and the registered manager was accessible and supportive. There were enough staff employed to meet people's needs.

There had been improvements to record keeping and the way in which the service was monitored. The registered manager had introduced systems to make sure care was delivered safely and appropriately and these systems were followed.

People received their medicines in a safe way although further improvements were needed to some of the records and auditing of medicine supplies. People were safe and there were procedures to protect them from abuse and to safely recruit the staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The environment was safe and clean.

There were enough staff.

People received their medicines in a safe way.

There were procedures designed to keep people safe, which included the safe recruitment of staff and assessment of risks.

Is the service effective?

Good

The service was effective.

People had consented to their care and treatment and the staff acted in accordance with the Mental Capacity Act 2005.

People were cared for by staff who were well trained and supported.

People's healthcare needs were met and they had access to other healthcare professionals as needed.

People were offered a range of freshly prepared and nutritious food.

Is the service caring?

Requires Improvement

The service was not always caring.

People were cared for by kind and polite staff, but sometimes the staff focussed on tasks they were performing and did not give people the care, attention and support they needed.

The staff respected people's privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive support which was person centred and took into consideration their holistic needs.

There had been improvements to the way in which care was planned and recorded.

There had been improvements to the way in which people's health needs were being met.

There was an appropriate complaints procedure and action had been taken to investigate complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager had introduced some positive changes and these had meant that people were better cared for and the service was better organised. In addition record keeping had improved.

However, other stakeholders did not always feel confident that the improvements would last and they felt further improvements were needed to change some of the ingrained ways of working.

177-179 Spring Grove 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 checked whether the provider was 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 8 November 2016 and was unannounced.

The inspection visit was carried out by one inspector. Following the visit, an expert-by-experience telephoned and spoke with four relatives of people who used the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience supporting this inspection had personal experience of caring for someone who used registered services.

Before the inspection visit we looked at all the information we held about the service. This included notifications of significant events and the last inspection report.

During the visit we met the people who lived at the service. None of them were able to tell us about their experiences or how well the service met their needs. Therefore we observed how they were being cared for and we spoke with the relatives of four people after our visit to ask for their feedback. During the visit we spoke with the registered manager and other staff on duty who included, the deputy manager, senior support workers and support workers. Following the visit we had contact from the provider's operations manager. We also spoke with two external professionals who worked with people at the service.

We looked at the care records for three people, staff recruitment, training and support records, records of complaints, meeting minutes and other records the provider uses for providing the regulated activity. We also looked at how medicines were stored, administered and managed and the environment.

Good

Is the service safe?

Our findings

At the inspection of 1 February 2016 we found the staff did not always support people in a safe way to eat and drink and this put them at risk of choking.

At the inspection of 8 November 2016 we found improvements had been made. Directly after the last inspection the provider's operations manager had updated information about the risks of people choking. They had consulted with health care professionals to make sure the guidance about food and fluid consistency was correct for each person. They had ensured information about this and risks to people was easily accessible for all staff, including new and temporary staff. In addition they had consulted other professionals to ensure that people were seated in the correct position when eating and drinking.

We saw the staff supporting people to eat and drink in a safe way. They thickened fluids according to instructions and were aware of the guidance around this. They also ensured that people sat appropriately and were supported to eat food of a consistency appropriate to their needs.

At the inspection of 1 February 2016 we found people received their medicines as prescribed and in a safe way. However some of the protocols for administering medicines to individuals and records of stock medicine were not up to date or accurate.

At the inspection of 8 November 2016 we found that improvements had been made to the way in which medicines were stored, recorded and audited. People were administered their medicines safely and there were robust systems for checking this and making sure medicines were stored safely and at a safe temperature.

However, we found that tablet counts for medicines did not always included packages of medicines which were no longer in use but were also stored in the medicine cupboard. There were a number of medicines such as these, some which had not been used for several months, which had not been returned to the pharmacist. In one instance there was no record of one particular medicine on the person's medicines profile, medication administration sheet or tablet counts. In addition we found two packets of medicines where the packaging had been damaged exposing the tablets. These practices could lead to errors when administering medicines. We spoke with the registered manager about these concerns and they agreed to carry out a full audit of the medicine supplies and ensure information was up to date and correct and to dispose of unused or damaged medicines.

One relative told us they felt their relative was not safe at the service. They told us they did not think the staff always followed guidance on how to support their relative and this concerned them. They told us they had discussed their concerns with the registered manager. However, other relatives told us they felt the service was safe. One person said, ''Everything is taken into consideration to keep [my relative] safe. [They have] been there a long time and I've not been worried. They ring me if there is anything at all – if [they] has a cold for example.''

The provider had a procedure for safeguarding adults. The staff had received training about this and were able to explain what safeguarding meant and what they would do if they were concerned about someone being abused or at risk of abuse. The provider had acted appropriately when allegations of abuse had been made. For example, one visiting professional had raised a concern about the safety of a person following an incident where they had been put at risk. The provider had taken steps to ensure the person was safe and reduce the risk of reoccurrence. They had also worked with the local safeguarding authority to investigate the incident. They had notified the appropriate organisations, including the Care Quality Commission and there were clear records of the incident and action taken.

The provider had a contingency plan for the staff to follow in event of different emergencies. Information about this and contact details for managers who were on call was available for all the staff, including temporary and new staff.

The building was safely maintained. The provider responded to any damage to the property or equipment. Checks on the health and safety of the environment were carried out and problems identified and reported. The building was equipped with fire safety equipment, window restrictors, hoists and a lift. These were regularly checked and action taken when concerns were identified. There was evidence of appropriate checks on water safety, electricity and gas supplies. The staff checked food storage and cooked food temperatures daily. There was an appropriate fire safety procedure, which included information about how each person should be supported in event of a fire. The staff took part in regular fire drill practices.

The risks people were exposed to had been assessed. The staff regularly reviewed and updated these assessments. The assessments included the support people needed to minimise the likelihood of harm. The staff had a good understanding of how to support people so that they were not placed at risk. They had read and understood individual risk assessments. Where relevant, the risk assessments reflected the guidance from other health care professionals.

There were enough staff on duty to support people and keep them safe. The registered manager told us that the senior staff team had been restructured to provide better support for the staff. They also told us there had been recent recruitment to vacant posts. Vacancies and staff absences were covered by the provider's own bank of temporary staff and external agency staff. However the registered manager told us they tried to use the same temporary staff so they were familiar with the people who they supported. We saw evidence of this on the staff rota and we spoke with one member of agency staff who told us they had worked at the service several times before. They said they had been given a good induction into the home, and we saw a file of information for new and temporary staff which covered key aspects of the role and people's needs.

Shortly before the inspection the provider had reviewed whether two waking members of staff were needed at the service at night. They had previously had two. However, due to the reduction in numbers of people living in the service and having reviewed their needs, the provider reduced this to one waking and one sleeping member of staff who would be available on call. Some of the staff told us they were not happy with this arrangement and the sleeping member of staff was being regularly disturbed. The registered manager told us they were reviewing this situation and had not found evidence of this, however they had agreed to keep the matter under review. They also told us that if a sleeping member of staff was regularly disturbed they were able to leave in the morning and were not asked to stay and work during the day in recognition of the fact they would be tired.

The provider had appropriate systems for recruiting new staff. These included a formal interview with the manager. Prospective staff were also observed interacting with people who used the service as part of the selection process. The provider carried out checks on staff identity, references from previous employers,

criminal record checks and eligibility to work in the United Kingdom. These checks were carried out by the provider's central human resources department. Information was then passed to the registered manager. We saw that staff files were generally complete but some of the information for the most recently recruited staff members had not been shared with the registered manager, although there was evidence these checks had taken place.

Good

Is the service effective?

Our findings

At the inspection of 1 February 2016 we found people's health needs and how these had been treated were not always recorded. Some health needs had not been met.

At the inspection of 8 November 2016 we found that improvements had taken place. At the time of and shortly after the February 2016 inspection, the operations manager had made contact with each person's GP and other healthcare professionals to ensure healthcare information was up to date and accurate. They had also arranged for people's health and medicines to be reviewed. They had followed up where appointments had not taken place and made sure that each person saw the healthcare professionals they needed. Therefore, at this inspection, we found that there was clear and up to date information about each person's health. There was evidence they had met with different professionals. The staff had a good understanding of each person's health needs and had responded appropriately to changes in health. The registered manager had supported people to attend health appointments. There were records to show the staff monitored people's health each day.

At the inspection of 1 February 2016 we found that people received a varied and nutritious diet but the staff did not always keep accurate and contemporaneous records of the drinks they had given people who were at risk of dehydration. The staff had not always responded to changes in people's weight.

At the inspection of 8 November 2016 we found that improvements had been made. There was clear information about people's dietary intake, including monitoring amounts for people who had been assessed as at nutritional risk. The staff regularly weighed people and they had consulted dietitians regarding changes in people's weight or food intake. There was evidence of consultation and action taken to support people.

Food was freshly prepared each day and people were able to make choices about what they ate. The staff used photographs to help people make choices and they told us they knew about individual preferences.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. The registered manager understood their responsibilities under the MCA and made DoLS applications appropriately.

People living at the service did not have the capacity to make decisions about complex aspects of their care or health. The provider had carried out best interest meetings which included representatives from people's families (where they had family involvement), advocates and other professionals. There was information about how decisions were discussed and reached. There was evidence that individual meetings had been held about each specific decision.

People were able to make choices about some aspects of their lives. Care records included information about how they made decisions and their level of understanding. The records also included information about when and where they found decision making easiest.

The staff had the training and support they needed to care for people safely. New staff took part in comprehensive training and shadowed experienced staff. The staff we spoke with from all the services told us they had been given a suitable induction which helped them learn about their role and responsibilities. One member of staff told us they would like more opportunities for a vocational qualification, however others told us they were given this opportunity by the provider. The registered manager told us they were organising for staff to undertake qualifications once they had completed inductions. The staff were supported to complete the Care Certificate (a nationally recognised set of training standards). The provider organised training updates when these were needed.

The registered manager met with all staff individually and as a team to discuss the service and the performance of the staff. The staff all told us they had opportunities to discuss their work in private with the registered manager whenever they needed.

Requires Improvement

Is the service caring?

Our findings

At the inspection of 1 February 2016 we found some staff did not treat people with dignity and respect. They did not always consider people's feelings or offer them opportunities to make decisions.

At the inspection of 8 November 2016 we found that improvements had been made. The way in which the staff spoke with people was polite, caring and kind. Relatives told us that the staff were caring and they did not feel there were any deliberate acts of unkindness. One relative told us, ''I have no complaints. There is one staff member who my relative really likes.''

At the inspection of 1 February 2016 we found that some of the staff tended to focus on the task they were performing rather than the person they were caring for.

At the inspection of 8 November 2016 we found whilst there had been some improvements, there was further room for improvement in this area. For example, during our inspection visit, the staff did not have any sustained interactions with the people who they were supporting. They attended to tasks such as cleaning, cooking and paperwork rather that interacting with the two people who they were supporting for the majority of the morning. Relatives and professionals confirmed that this continued to be the case in their experience. They told us that they thought the staff did not really know how to interact with people on a personal level unless they were supporting them with a specific task. One relative told us, ''It just seems like there is a genuine lack of care.'' Another relative said, ''They do not really do things with people, they might have an idea but if this does not go to plan, then they do not do anything else.'' One relative told us, ''It feels like they have just given up on [my relative]. They do not seem to appreciate that [the residents] are living people not just things.''

The majority of people who lived at the service could not communicate verbally. We found, and others told us, that the staff tended to focus on communication with those who could speak rather than those who could not. In addition the majority of staff interactions were with each other. During our observations these interactions tended to be about the practicality of tasks and which staff member was going to undertake a specific task. The interactions we witnessed from the staff towards the people they were supporting were the staff telling people what was happening or what they were about to do, or requesting that people sat down, offering the television or hot drinks and food. This was an improvement from the last inspection where the staff did not always tell people what they were doing and carried out tasks without any communication. But, there was still little attempt to engage in a social interaction with people or to communicate on their level.

People were not given much support to learn new skills or develop independence. The staff tended to do things for people rather than think about ways they could encourage people to achieve things for themselves. Care plans did not include information about how people could be supported to learn new skills or become more independent in an area.

People's privacy was respected. The staff carried out care behind closed doors and made sure people were appropriately dressed. When supporting people to move, eat their meals or put on additional clothes (such as a coat) they took care to explain what they were doing and made sure the person was comfortable and happy with this support.

Requires Improvement

Is the service responsive?

Our findings

At the inspection of 1 February 2016 people were not always supported to take part in varied social activities which reflected their needs and preferences.

At the inspection of 8 November 2016 the registered manager and staff told us they had introduced more planned social activities. There was some evidence of this, however, further improvements were needed in order to ensure that people received more opportunities for social and leisure time. The records of the care provided did not always show that people took part in a range of meaningful and varied activities. Therefore further improvements were needed in this area. We saw some evidence of increased and different activities, including the use of the provider's resource centre to provide a place for activities in the evening.

We spoke with the relatives of people who lived at the service. Some of their comments included ''The staff do not make meaningful attempts to engage with the residents'', ''The staff are always doing their paperwork'' and '''There is nothing. No attempt at engagement. People just sit slumped in front of the TV and the staff are sitting doing paperwork.'' The provider responded to these comments by telling us, ''Voyage Care have worked very hard to develop close relationships with the relatives of people living at the service and are not aware of any more than one family who have consistently visited the service.''

The professionals who we spoke with told us they felt the staff were very task based. One professional said, ''When I have visited the service the staff are often sitting talking with each other or carrying out paperwork. If they are not supporting people with personal care or to eat, or cleaning they do not seem to know what else to do.'' Another professional said, ''There seems little meaningful engagement from the staff [with people who use the service].''

On the day of our inspection visit four people were supported to access a day centre run by the provider and situated next door to the house. The other two people remained at home. During the morning one member of staff spent the majority of the morning cooking the lunch, another member of staff spent time cleaning the house and a third member of staff, who was newly employed, spent time familiarising themselves with the service's records. There was very limited engagement with the two people who lived at the home. One person was seated by the kitchen window. The staff member who was cooking the lunch told us, ''[The person] likes to watch the traffic.'' They did not engage with the person or offer an alternative activity. The person's care plan identified that they did enjoy watching traffic. The provider told us the person was also offered a hand massage. The other person spent some time in the kitchen, in the lounge and in other communal rooms. The staff did not spend much time engaging with the person and we did not see them offer the person any activities or stimulation. One member of staff told us, ''We asked [the person] if they wanted to go for a walk but it was too cold for them.'' The provider told us the person had refused to go for a walk when they were offered this activity.

When this person had finished their lunch they spent time trying to get back into the kitchen. The door was closed to prevent them from doing this. This was an agreed part of their care plan as they would be a risk to themselves and others if they entered the room whilst other people were eating. A newly employed member

of staff was seated in the lounge familiarising themselves with care plans. Whilst we recognise this was an important part of their induction, they did not engage with the person or offer them an alternative activity. The person may have benefitted from engagement which helped distract them from their wish to gain entry to the kitchen.
Before people left for the day centre one person was lying on the sofa facing the wall. The staff did not interact or engage with this person until they told them it was time to leave the house.

After lunch people were seated in the lounge and the television was turned on.

The daily records for people contained information about how their personal care needs were met and what they ate. There was limited evidence of social activities, engagement or pursuing leisure interests. For example, the only leisure activities recorded in the records for one person for the previous month were attending the day centre, going for a walk, listening to music, spending time in the lounge, going on one bus ride and going for one meal out. Where the records indicated the person had been for a walk or spent time listening to music or in the lounge, we asked the staff what other activities the person had taken part in during those days. They were unable to tell us and stated that they did not have the house mini-bus to take people out in this, and that it was too cold to spend long outside the house. Other people's records had a similar lack of information about how their social, emotional and leisure needs were being met.

Some people had been assessed as requiring support to complete exercises designed specifically for them by a physiotherapist. One person spent the majority of their time in a wheelchair. The physiotherapist had highlighted how important it was for the person to spend time out of their chair each day and completing their exercises. The provider's care plan for this person recommended they took part in exercises at least four times a week. However, records indicated that the person did not receive this support as often as the physiotherapist had recommended and that the staff had recorded they had not ''had time'' to support the person in this way.

The provider's operations manager told us they were hoping to provide some additional training for the staff on techniques for intensive interaction, so that they could better support people who had limited verbal communication.

The registered manager told us they had increased the organised activities and events since the last inspection and people were being given more opportunity to leave the house for trips. In addition they told us they had been able to use the facilities at the day centre when this was not in use so that some people had accessed the day centre's sensory room in the evenings.

The provider told us that a recent accomplishment for the service was that one person who had previously refused to go out of the house for walks had recently started to do this.

Each person had a comprehensive care plan which included information about their communication needs, preferences and how the staff should meet their needs. Information was detailed and had been regularly reviewed and updated. In addition the registered manager and operations manager had produced shorter summaries of the care plans which new and temporary staff could read and access quickly so that they had an overview of each person's needs.

There was an appropriate complaints procedure and this was on display at the service. The relatives of people told us they knew how to make a complaint. Records of complaints included information about how these had been investigated, the outcome of these and action taken to improve the service. One relative told us they did not always feel confident that complaints would be acted upon or changes made to

improve things. However, the other relatives told us they felt comfortable raising concerns and that these would be acted upon. One relative told us, ''[My relative] is very clear what he likes and dislikes and I know he'd demonstrate if he wasn't happy but I don't see that.''

Requires Improvement

Is the service well-led?

Our findings

At the inspection of 1 February 2016 we found records about people's planned care and the care they received were not always accurately maintained.

At the inspection of 8 November 2016 we found that improvements had been made. The care plans had been updated and there was clearer information about people's needs and how these should be met. This included up to date profiles which gave a quick reference guide about people's needs for new and temporary staff. We saw that the staff had completed daily records to show what support they had offered people. The registered manager had introduced a new and improved system for recording the care given each day.

However, the professionals we spoke with told us that records of care provided and incidents which had taken place did not always match the information the staff gave. One professional told us they were supporting the staff to investigate a specific challenge the staff had reported someone presented but that there was no documented evidence of this, therefore it was hard for them to decide on how best to support the person. There was no evidence the staff had monitored this challenge and so the frequency and triggers for the person to behave in this way could not be identified.

At the inspection of 1 February 2016 we found that incidents and accidents had not always been investigated and the provider had not mitigated risks to people because of this. The provider had always not notified the Care Quality Commission about these accidents and incidents.

At the inspection of 8 November 2016 we found improvements had been made. There was evidence that the provider had taken action to investigate incidents and accidents. However, in one instance where someone had sustained an unexplained black eye, the investigation had been inconclusive and no further action had been taken. The provider had notified the Care Quality Commission of serious injuries, incidents (such as errors in administering medicines) and safeguarding alerts since the last inspection. They had also provided evidence of the action they had taken to investigate these and to put things right.

The registered manager had been recruited since the last inspection. They had experience managing supported living services for adults with a learning disability and a management qualification. The manager had introduced a number of changes and there was evidence of improvements at the service. For example, people were getting better support to meet their health needs, records of care planned had improved and people were receiving safer care.

The relatives of people who used the service told us that the new registered manager and operations manager were '''trying their best'' and there had been improvements at the service. One relative said, ''There is a massive improvement since the new manager came and her boss really cares about the people there.'' Another person told us, ''Definitely an improvement with the new manager. She is doing her best to get to grips with the problems but it's not easy.'' However, one relative also said, ''The managers efforts are

undermined by the historical and ingrained bad practices at the service.'' Another relative told us they thought the staff were not always willing to make changes to improve the service. They said, ''They [the staff] want to work in the same way they've always done which is just doing what is absolutely necessary and nothing more.''

One relative voiced their concerns about changes in management of the home, They commented, ''The trouble has always been that they [managers] just don't stay. They don't seem to be able to keep anybody and that is what causes disruption, every time somebody new takes over.''

The professionals who we spoke with told us they thought the registered manager was competent and understood the needs of the service. They told us they did not always feel the registered manager had the backing of the staff to ensure changes were effective. They went on to say that the staff had sometimes been resistant to ways of working or changes that they (the professionals) had suggested to the detriment of the people who they were supporting.

The registered manager told us that some of the changes to the service had been difficult to implement because the staff were used to working a specific way. They also said that some staff did not always understand why changes were needed. However, they acknowledged that it had been difficult for the staff because there had been four different managers in just over a year and periods of time with no manager in post. They praised the staff for carrying on through these changes of management and said they felt with the right support the staff would understand why improvements were needed. They also told us that new staff had been employed and that this was helping the whole staff team to share and learn good practice.

The service was managed by Voyage 1 Limited. They were an organisation providing care and support to people with learning disabilities, autism and brain injury throughout the United Kingdom in residential, outreach and day services. An operations manager oversaw the running of the home and had supported the registered manager and previous managers to help introduce changes.

The operations manager and registered manager had implemented new checks and audits. These included an improved handover of information when the staff on duty changed over, daily monitoring of records and daily audits of medicines management.

The provider carried out regular additional audits. These included a monthly audit but the operations manager looking at all aspects of the service, audits of financial records and a quarterly report which looked at compliance with Regulations and the provider's own standards.