Voyage 1 Limited

Twyford House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Twyford House is a residential care home providing accommodation and personal care to 11 people at the time of the inspection. The service is registered to support up to 14 people.

People's experience of using this service and what we found

Right Support
The service did not always support people to have the maximum possible choice, control and independence as possible. Peoples views about the service they received, and the support provide by staff was not sought. People did not always have a voice in their own care.
Staff supported people with their medicines in a way that promoted their independence and achieved the best possible health outcome.
The size of the service was larger than current best practice guidance. However, was set back from the street and there were no signs to identify it as a service for people with learning disabilities and autism.

Right Care
There were times where there were not enough staff to provide the support people were assessed as needing and people did not receive this support.
Staff understood how to protect people from poor care and abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Right culture
Staff turnover had been high, which did not support people to receive consistent care from staff who knew them well. Staff recruitment processes had been followed to ensure staff were safe to provide support to people.
Governance processes had not always been effective in ensuring there was up to date information for staff.
There were areas where staff practice could be improved to ensure people were treated with kindness, dignity and respect. For example, how some staff spoke to people.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 19 February 2019)

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support, right care right culture. We received concerns in relation to staffing levels, the management of the service and the support provided to people in relation to risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the Safe and Well-led sections of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Twyford House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two Inspectors carried out the inspection.

Service and service type
Twyford House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. This included feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in

this report. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
People did not communicate with us verbally. We observed people's support as provided by staff when people were in shared areas of the service such as the lounge, dining room and kitchen. We spoke to five relatives about their experience of the care provided. We spoke with ten members of staff including the registered manager, deputy manager, operations director, senior care staff and care staff.

We reviewed a range of records. This included parts of five people's care records and five medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We reviewed further information in relation to risks and staffing levels. We reviewed written feedback submitted to CQC by some staff.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- When incidents and safeguarding's occurred, some actions had been taken to reduce the risk of re-occurrence. People had been referred to health and social care professionals, mental health and behavioural specialists to provide support. However, staff did not always take other actions needed following these incidents. For example, following one incident involving hot water the person's care plan was not reviewed to consider how specific risks around hot water could be reduced. We raised this with the registered manager during the inspection who spoke to staff about ensuring hot water was not left in the kettle once this had boiled.
- There was not always a clear oversight of trends of incidents to monitor where incidents were increasing and to enable staff to identify new triggers for emotional based behaviours. Staff had access to the support of a behavioural specialist through the provider. Where people had been referred to this specialist trends in incidents were analysed. However, there was no analysis of trends for other individual people who were not referred to the behavioural specialist. The provider had analysed trends for the service overall. However, the registered manager was not aware of this.

The provider had failed to fully assess, monitor and mitigate the risks relating to the health, safety and welfare of people. This is a breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had training on how to recognise and report abuse and they knew how to raise concerns where this was appropriate. There was information displayed in the service for staff regarding how to whistle-blow. Staff knew how to whistle-blow if they had concerns about practice at the service.
- Safeguarding concerns were reported to the local authority and investigated where needed.

Assessing risk, safety monitoring and management

- Agency staff were reliant on other staff telling them about people's risks. For example, one agency staff was given a person's communication summary to read. This plan did not include details about the person's risk of falls. The management team had failed to ensure new agency staff had received a sufficient induction necessary to keep people safe. The agency staff then supported the person to go out for a walk alone and there was a risk the agency staff member would not know how to support the person safely.
- Guidance for staff about the risks for people was not always up to date. For example, the positive behaviour support plan for one person included de-escalation techniques which staff no longer used. There was a risk new staff or agency staff would not have the information they needed if the person became upset to keep them and other people safe.

● Risks assessments in relation to emergency evacuation, such as in the event of a fire, were not up to date. One person's plan said they rarely displayed emotional based behaviours which was not accurate, and the plan had not considered how the person's increase in emotional based behaviours would be supported in the event of a fire.

The provider had failed to do all that was reasonably practicable to mitigate risks to people. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risk management for people needed to be improved. One person was at risk from choking. When asked staff told us they would use a de-choker if the person was choking. De-chokers are suction devices for the purposes of removing an obstruction if a person is choking. The use of de-chokers is not recommended by the resuscitation council. The care plan for the person did not include guidance for staff to use other more established interventions. We raised this with the management team during the inspection. The care plan was updated during the inspection and staff were reminded that the use of the de-choker was a last resort.
● People were not always involved in managing risks to themselves and in taking decisions about how to keep safe. People were not always involved, where possible, with developing their support plans in relation to risks.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA. Appropriate legal authorisations were in place to deprive a person of their liberty.
● Staff understood people had the right to make choices and knew how to support people to make decisions where this support was needed.

Staffing and recruitment
● The service did not have enough staff employed. One person's support needs had changed and two to one support had been agreed for part of the day to support the person to go out. This was part of a plan to reduce their emotional based behaviours which had increased over time. The registered manager told us they were not able to consistently provide this support as they did not have enough staff to do so. They told us that the support was being provided on the second day of the inspection but was not provided the day before and was not going to be provided the day following the inspection.
● The registered manager told us there had been a high level of staff turnover. The service used agency staff to fill in shortfalls in the rota. However, they told us sometimes agency did not arrive for their arranged shift or they were late or left early. Feedback from staff was mixed. Some staff told us there was not enough staff to provide support to people. One staff said, "Sometimes when we are short of staff, we are running around doing things. We have a lot [of] agency in at times. A lot are good, but it can be more of a hinderance than a help as they don't know people well."
● The staffing levels during the night-time had not considered risks to people in the event of an emergency evacuation. There were two staff supporting people at night. There was no clear plan for how two staff could

support people to safely leave the building and remain safe whilst outside in the event of an emergency such as a fire. Staff had practiced evacuation procedures but had not practiced these for only two staff. Some people had emotional based behaviours. One person had a history of leaving the service and needed support from staff to remain safe. These risks had not been considered when planning night staffing levels.

The provider had failed to ensure there were sufficient numbers of staff deployed. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported by staff who had been safely recruited. Checks were completed to make sure new staff were suitable to work with people. For example, Disclosure and Barring Service (DBS) criminal record checks were obtained. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

● Staff followed effective processes to assess and provide the support people needed to take their medicines safely. This included where there were difficulties in communicating and when assessing risks of people taking medicines themselves.
● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles.
● Some people were prescribed medicines on an 'as and when' basis, for example to reduce anxiety. There was guidance for staff about when this should be offered. Staff recorded whether the medicine had had the desired effect.
● People were supported by staff who followed systems and processes to administer, record and store medicines safely.

Preventing and controlling infection

● The service used effective infection, prevention and control measures to keep people safe, and staff supported people to follow them. The service had good arrangements for keep premises clean and hygienic.

● Staff used personal protective equipment (PPE) effectively and safely.
● The service prevented visitors from catching and spreading infections.
● The service tested for infection in people using the service and staff.
● The service made sure that infection outbreaks could be effectively prevented or managed. It had plans to alert other agencies to concerns affecting people's health and wellbeing.
● The service supported visits for people living in the home in line with current guidance.
● All relevant staff had completed food hygiene training and followed correct procedures for preparing and storing food.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Governance processes were not always effective. There was a system of audits in place. However, auditing had not always led to improvements. For example, auditing had not led to people's support plans being up to date.
- There were areas where leadership needed to be improved. The management team had failed to put robust induction processes in place for new staff. There was an absence of responsibility amongst the staff team to ensure all staff had the right information needed to keep people safe and ensure their needs were met. During the inspection one agency staff, who was new to the service, was left to read people's communication plans. Staff did not engage with them and they were not provided with any direction. They remained waiting for direction until we identified a person needed some support and they volunteered to assist the person.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There were some areas where the culture of the service needed to be improved. We observed some staff engaged with people well such as supporting people to make their own drinks. However, other staff did not engage with people and some people sat without staff engagement for long periods. One person wanted to go out, staff told the person "You can go out, but you need your hygiene first. You have been prompted four times today for your hygiene." We asked if the person had gone out when we returned to the service. However, the manager was not able to evidence that they did and there was no record in the daily notes for the person until mid-afternoon. We raised this with the registered manager who agreed staff could have spoken to the person in a better way. We also heard staff telling people they could not go out when they asked to. This could have been presented in a more positive way such as explaining to the person they were going to go out later.
- Staff did not encourage people to be involved in the development of the service. There were no mechanisms in use to receive feedback from people about the service. The provider had a system in place to support people to provide non-verbal feedback. However, the registered manager told us this was not being used at the service.

The provider had failed to assess, monitor and improve the quality and safety of the service. The provider

failed to seek feedback from people. The provider had failed to keep an accurate, complete and contemporaneous record in respect of person. This is a breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Feedback from staff was mixed. Some staff told us there were tensions in the staff team and some staff were not happy in their role which impacted on the atmosphere at the service. One staff member said, "Some staff just stand back when there are incidents. A lot of staff attitude is to not get involved. We have always been a good team but not at the moment." However, another staff member told us, "I feel very supported by the team as a whole."
● The registered manager was aware of their responsibilities and legal requirements. Where notifications were required by law to be submitted to CQC they had been so. The rating for the service was clearly on display at the office and on the website.
● The registered manager was previously the deputy manager at the service, so they knew people well. They had applied to undertake a level 5 course in social care leadership and management but had not yet undertaken this.
● The registered manager had support from other managers within the provider's other services. They were also supported by a new area manager who was previously the manager at the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager was aware of their responsibilities under duty of candour. A duty of candour incident is where an unintended or unexpected incident occurs that results in the death of a service user, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident. We did not identify any duty of candour events.
● People's relatives told us staff kept them informed when things went wrong and were positive about communication from the service.

Working in partnership with others
● Staff worked with partners from other health and social care providers where this was appropriate. For example, staff were working with the learning disability team, local authority, and mental health teams to support one person with emotional based behaviours.
● Staff had access to an inhouse behavioural specialist team. Staff were able to refer people to this team for support where this was needed. The behavioural specialist supported staff to identify trends in behaviour, triggers and strategies to support people with anxieties.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that was reasonably practicable to mitigate risks to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to fully assess, monitor and mitigate the risks relating to the health, safety and welfare of people. The provider had failed to assess, monitor and improve the quality and safety of the service. The provider failed to seek feedback from people. The provider had failed to keep an accurate, complete and contemporaneous record in respect of person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of staff deployed.