Voyage 1 Limited

Tate Lodge

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?	Good

Overall summary

We carried out an unannounced inspection of Tate Lodge on 2 December 2015.

Tate Lodge is a residential service offering support for eight adults with learning disabilities and mental health needs. There are eight en-suite bedrooms and communal areas spread over two floors. The service is located close to local shops and amenities.

At the time of the inspection eight people were living in the home.

A registered manager was 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 2008 and associated Regulations about how the service is run.

Prior to the inspection we had received information of concern from the registered manager regarding the unsafe behaviour of one of the people living at the home.

Summary of findings

We saw that the registered manager had taken appropriate steps to minimise the risk and keep people safe. All of the people that we spoke with told us they felt safe living in the home.

Staff were trained in recognised techniques to diffuse and de-escalate situations that might become unsafe. We saw that staff used their training to safely manage a situation with one person living in the home.

We looked at the care files for three people and found that some of the pre-admission information relating to risk was not sufficiently detailed. We spoke to the registered manager about this and were assured that they would request more detailed pre-admission information in future. We saw from care files that risk had been regularly reviewed once people had started living in the home and that they had been actively involved in the process.

The registered manager completed a series of safety checks for the home on a regular basis. People had personal emergency evacuation plans (PEEP) in place to show staff how to support people out of the building in an emergency.

Staff were deployed in sufficient numbers to meet the needs of the people living in the home.

Medicines were stored and administered safely by appropriately trained staff.

Staff were trained in a range of relevant subjects including learning disability, challenging behaviour and mental health.

Staff communicated effectively with people living in the home, relatives, professionals and each other.

The service generally operated in accordance with the principles of the MCA and DoLS, but we saw one example where an assessment indicated that the person did not have capacity in relation to the locked door policy.

We saw that people were supported to maintain their physical and mental health in conjunction with a range of healthcare professionals. This included access to general medical services in the local community and specialist services as required.

We had limited opportunity to directly observe people, but throughout the inspection we saw that people were treated with kindness and respect by staff. Staff knew the people that lived in the home well and were able to describe their care and support needs in detail. Staff took time to discuss things with people and responded to their views. They spoke in a gentle and re-assuring manner when people showed signs of anxiety.

The people living in the home were given choice and control over their care and support. Where choices created risk the situation was clearly explained before a decision was made.

Each person living in the home had a person-centred plan which was regularly reviewed. These plans recorded how people wanted to be supported and were responsive to people's changing needs. People were supported to follow their interests by staff.

People were encouraged to share their experience of the service and to complain if necessary. A copy of the complaints procedure was displayed in the foyer. None of the other people that we spoke with said that they had ever had cause to raise a formal complaint.

All of the staff and professionals that we spoke with told us that the home was well managed and that communications were open and honest.

Managers were actively involved with people living in the home and staff throughout the inspection process. They demonstrated an awareness of the culture of the home and the current issues for each person living there.

Staff had a clear understanding of their roles which reflected the culture, visions and values of the home. They were motivated to provide high quality care and support and to promote people's independence.

The home operated a robust process for monitoring quality. The approach included the completion of weekly checks by the registered or deputy manager covering a number of quality indicators such as; compliments, complaints, incidents and accidents. A quarterly audit was completed by an operations manager with an additional audit undertaken each year by a member of the quality team.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff were trained in recognised techniques to diffuse and de-escalate situations that might become unsafe.

Staff were deployed in sufficient numbers to meet the needs of the people living in the home.

Medicines were stored and administered safely by appropriately trained staff.

Good

Is the service effective?
The service was effective.

The service generally operated in accordance with the principles of the MCA and DoLS. We saw one example where paperwork had not been completed correctly.

Staff communicated effectively with people living in the home, relatives, professionals and each other.

Staff were trained in a range of relevant subjects.

Good

Is the service caring?
The service was caring.

People were treated with kindness and respect by staff who knew them well.

The people living in the home were given choice and control over their care and support.

People's privacy and dignity were supported in all aspects of the service.

Good

Is the service responsive?
The service was responsive.

Each person living in the home had a person-centred plan which was regularly reviewed.

People were supported to follow their interests by staff.

People were encouraged to share their experience of the service and to complain if necessary.

Good

Is the service well-led?
The service was well-led.

Managers were actively involved with people living in the home and staff throughout the inspection process.

Managers demonstrated an awareness of the culture of the home and the current issues for each person living there.

The home operated a robust process for monitoring quality.

Good

Tate Lodge

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 2 December 2015 and was unannounced.

The inspection was carried out by a team of two inspectors. The team included an adult social care inspector and one specialist advisor with experience in learning disability and mental health.

The provider had 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 any improvements they plan to make.

We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all of this information to plan how the inspection should be conducted.

We spoke with people using the services, their relatives, professionals, staff and managers. We also spent time looking at records, including three care records, three staff files, three medication administration record (MAR) sheets, staff training plans, complaints and other records relating to the management of the service. We contacted social care professionals who have involvement with the service to ask for their views.

During our inspection we spoke with five people living in the home. We also spoke to one family carer. We spoke with the deputy manager, the registered manager and two other staff.

Good

Is the service safe?

Our findings

Prior to the inspection we had received information of concern from the registered manager regarding the unsafe behaviour of one of the people living at the home. We saw that the registered manager had taken appropriate steps to minimise the risk and keep people safe. All of the people that we spoke with told us that they felt safe living in the home. One person said, "I wasn't looking after myself at home. It's better here." Another person said, "I feel safe once I'm in." A professional that we spoke with said, "[Person] has been very well supported. Staff have managed the risks well and they are now moving to a supported tenancy."

Staff were trained in recognised techniques to diffuse and de-escalate situations that might become unsafe. We saw that staff used their training to safely manage a situation with one person living in the home. They were warm and reassuring to the person while they engaged with them. When incidents or accidents occurred staff were required to analyse them as part of the de-briefing process. This was in accordance with the training that staff had completed.

We looked at the care files for three people and found that some of the pre-admission information relating to risk was not sufficiently detailed. We spoke to the registered manager about this and were assured that they would request more detailed pre-admission information in the future. They also said that they would review what information regarding risk was already on people's care files. A member of staff told us, "People's lives change and risks are constantly re-assessed." We saw from care files that risk had been regularly reviewed once people had started living in the home and that they had been actively involved in the process.

The registered manager completed a series of safety checks for the home on a regular basis. These were recorded in a health and safety file and covered; security, water temperatures, routes of escape and fire equipment. Fire drills were completed quarterly. External checks on gas safety, electrical safety and fire-fighting equipment had been completed in accordance with the appropriate schedules. A covered smoking area had been installed at the back of the house to encourage people living in the home to smoke outside. People had personal emergency evacuation plans (PEEP) in place to show staff how to support people out of the building in an emergency.

Staff were aware of whistleblowing procedures. Whistleblowing can be used to raise concerns outside of the organisation with anonymity if required. One staff member told us, "All the numbers are available. I could go to CQC or safeguarding."

The home deployed a minimum of eight care staff which was in accordance with the assessed needs of each person. At the time of the inspection additional staff were on duty because one person was being given two to one support. The registered manager and deputy manager were also available to provide support as required. The home did not employ dedicated domestic staff or cooks. These tasks were undertaken by care staff in conjunction with people living in the home where it was appropriate to develop their independence.

We were shown the facilities for the storage of medicines. The home had a locked room which was specifically for the storage of medicines and the associated records. Medicines were stored correctly. Room and fridge temperatures were monitored and recorded. The home used a pre-packed system for the ordering, storage and administration of medicines. Medicines were supplied by the pharmacy in named blister packs. Each medicine had a Medication Administration Record (MAR). We looked at six records and found that they had been completed correctly. Some people had protocols in place for PRN (as required) medicines. At the time of the inspection the home was not responsible for the storage and administration of any controlled drugs (CD). CD's are prescription medicines covered by legislation. The home had appropriate storage facilities if they were required to store CD's in the future. We were told that two trained staff were responsible for taking deliveries from the pharmacy and for administering medicines. We saw that staff had signed records to confirm that this arrangement had been adhered to. Stocks of medicines were checked as part of each staff handover.

Good

Is the service effective?

Our findings

Staff were trained in a range of relevant subjects including learning disability, challenging behaviour and mental health. In addition to mandatory (required) training, there was evidence that staff had accessed additional external training at diploma level. The training matrix (monitoring record) provided indicated that staff training was up-to-date and that refresher training was identified at appropriate times. One member of staff told us, "I did two weeks induction and read the support plans." All staff confirmed that they had received an annual appraisal and regular supervision. We saw evidence that supervisions were scheduled every month, but did not always take place according to this schedule. We were told that this was because supervisions were sometimes cancelled when staff were unavailable and not re-arranged. We spoke with the registered manager about this and were told that missed supervisions would be re-scheduled in future. A member of staff said, "I feel supported. All of the managers know your name." Another member of staff told us, "I'm after a senior position. If I ask the manager for development they will support me."

Staff communicated effectively with people living in the home, relatives, professionals and each other. There was handover at the end of each shift where important information was shared and tasks were allocated. This process was supplemented by the completion of daily records. Staff meetings were scheduled every month and provided a further opportunity for information to be shared. We saw evidence that these meetings had taken place.

We looked at records relating to training. Some records were held on staff files, but the majority were held on an electronic database. The records that we saw indicated that all staff training was up to date. Training was delivered through a mix of e-learning (computer-based) and face to face activity. The training relating to challenging behaviour was externally accredited.

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).

The service generally operated in accordance with the principles of the MCA and DoLS, but we saw one example where an assessment indicated that the person did not have capacity in relation to the locked door policy. We asked the registered manager about this and were assured that the person did have capacity and understood the need for the policy. They agreed to check the process and the relevant documentation for each person living in the home.

We looked at the kitchen and the arrangements for the planning and provision of food. The kitchen was readily accessible for the preparation of drinks and snacks. All of the people living in the home that we spoke with were positive about the planning of meals. There were weekly menu planning meetings were individual requirements and preferences were discussed. Staff assisted some people with the preparation of food to support their independence and choice. One person told us, "I made little cakes." Another said, "I make bacon and cheese butties." A third person told us, "Every day we have two choices. Last night I had steak and fries. It was gorgeous."

We saw that people were supported to maintain their physical and mental health in conjunction with a range of healthcare professionals. This included access to general medical services in the local community and specialist services as required. Decisions regarding treatment options were discussed and recorded on people's care files. One person told us that they had stopped smoking with staff support.

Good

Is the service caring?

Our findings

We had limited opportunity to directly observe people because they were engaged in activities away from the home, but throughout the inspection we saw that people were treated with kindness and respect by staff. Staff knew the people that lived in the home well and were able to describe their care and support needs in detail. Support plans contained details about people's histories, their needs and their aspirations. Staff supported people in accordance with these plans. One person told us, "They [staff] are lovely," A visiting healthcare professional said, "[Registered manager] is a kind individual and the team are warm and committed."

Staff took time to discuss things with people and responded to their views. They spoke in a gentle and re-assuring manner when people showed signs of anxiety. The delivery of support was focused on the needs of the individual and was not task led. We saw on more than one occasion that people wanted to talk with staff when they were engaged in other activities. On each occasion staff stopped what they were doing to talk with the person before completing the activity.

The records that we saw and the observations that we made showed that people were actively involved in the planning of care and making decisions. One person had asked if they could start to attend a local library. A social worker told us, "They are being supported to attend the library on their own. Staff initially went with them, but now they go by themselves." Staff had originally followed the person at a discrete distance to ensure that they were safe. We saw that this had been planned and recorded on the appropriate care record.

The people living in the home were given choice and control over their care and support. Where choices created risk the situation was clearly explained before a decision was made. For example, a healthcare professional told us, "Staff have managed the risks well and they [person] are now moving to a supported tenancy." A number of people living in the home had regular access to an independent advocate. These advocates had been involved in multi-disciplinary meetings where care and support had been reviewed and plans put in place for more independent activity. Multi-disciplinary meetings are attended by health and social care professionals as well as the person and their representatives.

Each person living in the home had their own private bedroom with en-suite facilities. Although the majority of people were receiving one to one support their privacy and dignity were further promoted by staff who understood people's need for time alone. Staff were vigilant in monitoring situations and intervened appropriately when people's dignity was in danger of being compromised by their behaviours. We saw staff offer a distraction when one person became agitated. When this didn't help the person to reduce their anxiety levels, staff encouraged them to take time-out in their room until they felt better. Staff checked on the person who later returned to their activity. All of the people that we spoke with said that staff always knocked and asked for permission before entering their rooms.

Good

Is the service responsive?

Our findings

Each person living in the home had a person-centred plan which was regularly reviewed. These plans recorded how people wanted to be supported and were responsive to people's changing needs. People were supported to follow their interests by staff. One person told us about a local weekly disco. They said, "I love it. They have karaoke and I have a dance." Other people were supported to access bowling and crazy golf. Activities were reviewed on a weekly basis. Care planning often took place away from the home in a local healthcare office. A member of staff told us, "Everyone is able to contribute and express their views."

The home supported people with their wishes and preferences. Two people who were due to move into supported tenancies one member of staff said, "People are supported by the company to move on. In this case it's good that we can carry on supporting them [in their new home]." People's histories, preferences and aspirations were captured in person-centred plans. These plans were detailed and gave staff information which helped them get to know the person and to support them in achieving their goals. The plans also contained information which instructed staff about situations that might cause anxiety and how to intervene.

People were given choice about how and when support was given. Information was recorded in plans about the timing of support and what to do if support was refused. We saw that people were able to identify if they preferred male or female staff. The registered manager told us that the home always tried to match staff to people based on their preferences. The care records and staff files that we saw contained sufficient information to allow this to happen.

People were encouraged to share their experience of the service and to complain if necessary. A copy of the complaints procedure was displayed in the foyer. We asked to see the records relating to complaints. The book was empty and the registered manager told us that they had not received any formal complaints recently. They said that this was because they maintained regular communication with people living in the home, their relatives and professionals and that issues were dealt with at the earliest stage. We asked some of the people living in the home what they would do if they were unhappy about anything. One person said, "I would just speak to staff." Three other people told us that they did not know how to complain if they were unhappy with aspects of their care. We discussed this with the registered manager who told us that they would speak to everyone living in the home regarding the complaints procedure.

None of the other people that we spoke with said that they had ever had cause to raise a formal complaint. A relative told us that they had raised a concern over shift patterns and the impact that this had on activities. They said that the matter was raised with the staff team and resulted in a speedy and effective resolution. We were also told that menus and activities had been changed as a result of feedback from people living in the home.

Good

Is the service well-led?

Our findings

A registered manager was in post. All of the staff and professionals that we spoke with told us that the home was well managed and that communications were open and transparent. One member of staff said that, "Openness, honesty and valuing people are at the heart of our culture." The registered manager was highly visible throughout the inspection. They were able to respond to requests for information and evidence while supporting the staff team. Staff told us that they were confident in approaching managers and in raising issues. One member of staff told us, "We have 'See Something, Say Something' which has all the numbers [of senior staff]. I could also go to CQC or safeguarding." All of the staff had received training in whistleblowing and were able to outline the process for reporting outside of the organisation if required.

Managers were actively involved with people living in the home and staff throughout the inspection process. They demonstrated an awareness of the culture of the home and the current issues for each person living there. They contributed to the care and support of people as well as attending to management responsibilities. One member of staff told us, "The operations manager is fantastic and the chief executive is coming to work on shift in January."

Staff had a clear understanding of their roles which reflected the culture, visions and values of the home. They were motivated to provide high quality care and support and to promote people's independence. We saw that these values were applied in the provision of care and support and had resulted in significant change and development for some people currently living in the home.

We spoke with the registered manager about responsibilities in relation to their registration. They demonstrated that they understood the role and the need to deliver quality in accordance with the regulations. They also understood the need to inform the commission about important events. We saw from records that this requirement had been met. We discussed a number of recent notifications regarding one individual. The registered manager acknowledged that the home could no longer provide a safe or effective service for this person. They had taken measures to ensure that the risks to people living at the home and staff were minimised while more suitable accommodation was identified. This had been done in conjunction with health and social care professionals.

The home operated a robust process for monitoring quality. The approach included the completion of weekly checks by the registered or deputy manager covering a number of quality indicators such as; compliments, complaints, incidents and accidents. A quarterly audit was completed by an operations manager with an additional audit undertaken each year by a member of the quality team. Each audit process identified actions for completion by a named individual within an agreed timescale. The home had recently been audited by the quality team, but had not yet received the results. The registered manager told us that the previous audit was completed in September 2014 and that the home had achieved a score of 81%. They told us that the actions identified during this audit had been completed. Staff confirmed that the results of audits were fed back to them and that targets for improvement were set.