Voyage 1 Limited

Bethia Cottage

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

Summary of findings

Overall summary

Bethia Cottage is a care home that provides support and accommodation for up to five people with a learning disability or with autistic spectrum disorder. On the day of the inspection there were five people living at the home. All of the accommodation is on the ground floor. People have single bedrooms with specially adapted en-suite facilities, and there is a communal bathroom should that be required. Communal space consists of a kitchen / dining room, a living room, a sensory room and an enclosed outside area.

At the last inspection in April 2015 the service was rated as Good. At this inspection we found that the service remained Good.

Care plans described the person and the level of support they required in great detail. Staff demonstrated a good knowledge of people's individual support needs and every effort was made by staff to ensure people had an enhanced sense of well-being.

Care plans were reviewed regularly to ensure they remained an accurate record of the person and their day to day needs.

There continued to be sufficient numbers of staff employed to make sure people received the support they needed, and those staff had been safely recruited.

Staff had continued to receive appropriate training to give them the knowledge and skills they required to carry out their roles. This included training on the administration of medicines and on how to protect people from the risk of harm.

People were supported to have choice and control over their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff were kind, caring, supportive and patient and they respected people's privacy and dignity.

People's relatives told us they were aware of how to express concerns or make complaints and people were also given the opportunity to feedback their views of the service provided.

The manager carried out audits to ensure people were receiving the care and support that they required, and to monitor that staff were following the policies, procedures and systems in place.

The feedback we received and our observations on the day of the inspection demonstrated that the home was well led.

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 safe.	**Good**
Is the service effective? The service remains effective.	**Good**
Is the service caring? The service remains caring.	**Good**
Is the service responsive? The service remained responsive to people's needs.	**Good**
Is the service well-led? The service remains well-led.	**Good**

Bethia Cottage

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 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 was a comprehensive inspection that took place on 19 July and 26 July 2017 and was announced. We gave the service notice (less than 24 hours) as we wanted to make sure there would be someone at the home to assist us with the inspection. The inspection was carried out by one adult social care inspector.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) before this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was submitted within the required timescale.

On the first day of the inspection we spoke with a member of staff and the manager. On the second day of the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked around communal areas of the home and most bedrooms, with people's permission. We also spent time looking at records, which included the care records for two people who lived at the home, the recruitment and induction records for one member of staff and other records relating to the management of the home, such as quality assurance, staff training, health and safety and medication.

Following the inspection we spoke with two relatives and two members of staff over the telephone and received feedback from two health care professionals.

Good

Is the service safe?

Our findings

Staff described to us how they kept people safe. One member of staff said, "We make sure the premises are safe, like checking the fire alarms, bed rails and bumpers and water temperatures." A health care professional told us, "The staff are concerned about keeping the patient safe and respect their privacy and dignity."

Care needs assessments had been carried out, and when risks had been identified, action was taken to minimise potential risks without undue restrictions being placed on people. Any identified risks had been rated as high, medium or low and strategies had been put in place to minimise the risks. People had epilepsy management plans in place that advised staff how to assist people safely and when medical intervention would be required. When people required equipment such as beds, mattresses and cushions to help reduce their risk of developing a pressure sore, these had been provided. Staff had also completed MAPA (The Management of Actual or Potential Aggression) training to help them calmly manage any potentially challenging situations.

Staff had received training on safeguarding adults from abuse. They were able to describe different types of abuse they may become aware of and the action they would take to protect people from harm. Staff told us they were confident the manager would take the appropriate action. One member of staff said, "Staff would definitely take action – you can't be too cautious." Staff also said they would not hesitate to use the home's whistle blowing policy.

Staff were visible in communal areas of the home and people received attention promptly. Standard staffing levels during the day were five care workers in the morning and four care workers in the afternoon / evening. During the night there were two care workers on duty; one 'waking' and one 'sleeping'. Rotas evidenced that these staffing levels were usually maintained, although there were occasions when they fell below the usual levels. Staff told us that on these occasions some tasks did not get completed, but people received the care and support they required. They also said the manager 'helped out' to ensure that people continued to receive appropriate care.

We checked the recruitment records for two members of staff. These evidenced that references and a Disclosure and Barring Service (DBS) check were in place prior to them commencing work. The DBS 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 helps to prevent unsuitable people from working with children and vulnerable adults.

The manager told us that all staff had to complete training on the administration of medicines as they might need to carry out this task when they took people out on activities. We saw that medicines were stored safely, obtained in a timely way so that the person did not run out of them, administered on time, recorded correctly and disposed of appropriately. Staff checked the amount of medicines in stock against medicines records three times a day to ensure no errors had occurred. We checked the records for one particular medicine that required regular reviews to be carried out; staff were able to describe the reviews that had

been carried out and the records confirmed this information.

Accidents and incidents were recorded, analysed each month and were audited to identify any patterns that might be emerging or improvements that needed to be made.

There was a contingency plan that provided advice for staff on how to deal with unexpected emergencies, and each person had a personal emergency evacuation plan (PEEP) in place that recorded the assistance they would need to evacuate the premises. Fire drills were undertaken to ensure people knew what action to take in the event of a fire.

We reviewed service certificates and these evidenced that equipment and systems had been appropriately maintained. This included mobility, ceiling and bath hoists, the electrical installation, portable electrical appliances, the fire alarm system, emergency lighting and gas safety. Weekly and monthly checks carried out by the home's maintenance person were clearly recorded.

Everyone who we spoke with told us that the home was maintained in a clean and hygienic condition and we observed this on the day of the inspection.

Good

Is the service effective?

Our findings

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the DoLS applications that had been submitted to the local authority for authorisation. The manager told us they had made enquiries about these applications but they were still waiting for them to be authorised.

Staff had received training in MCA and DoLS and we found that they had a good understanding about people's rights and the importance of obtaining people's consent to their care. It was clearly recorded when decisions had been made in the person's best interest when they did not have the capacity to make the decision themselves. Staff described to us how they helped people to make day to day decisions, such as using picture menus to help people choose meals, and holding up clothes so people could choose which outfit to wear. Care plans included a decision making profile that described how staff should communicate with people to aid decision making.

Staff confirmed that they had induction training when they were new in post on topics such as fire safety, allergen awareness, equality and diversity, first aid, health and safety and infection control. Induction training also included shadowing experienced care workers until the new member of staff felt confident enough to work as a full member of the staff team. Staff who were new to the caring profession were also required to complete the Care Certificate; this ensured that new staff received a standardised induction in line with national standards. Experienced staff were expected to complete the self-assessment tool to measure whether they need to revisit this training.

Training records showed staff had completed training on other topics considered essential by the home, including moving and handling, medicines management, MCA and DoLS, safeguarding adults from abuse, autism, MAPA, epilepsy and end of life care.

Staff signed a supervision agreement and we saw evidence to show that staff received regular supervision and an annual appraisal. This meant staff had the opportunity to meet with a manager to discuss any concerns and their development needs.

We saw that staff used verbal communication as well as Makaton and that they used touch with people to direct them and to comfort them. It was clear to us that, whatever form of communication people used, they were able to make staff understand them, and vice versa.

Details of a person's medical diagnosis were included in their care plan, and information had been obtained to provide a description of any medical conditions for staff. People were supported by GPs, community nurses and other health care professionals and all contacts were recorded. We saw any advice sought from health care professionals had been incorporated into care plans. One health care professional told us, "Any changes to medicines and management of [the person's] condition are discussed and the staff will contact

me for advice."

People's special dietary requirements and their likes and dislikes were recorded in their care plan and we saw people had appropriate nutritional assessments and risk assessments in place. Staff were taking part in the nutrition mission, an initiative introduced by the NHS to reduce the risk of malnutrition for people who live in residential care. People's food and fluid intake was recorded when this had been identified as an area of concern. We spoke with staff about people's special dietary needs, such as textured food and thickened fluids. Staff clearly understood the recommendations of health care professionals and told us this information was held in the home's kitchen for all staff to follow.

The manager told us they attended a meeting arranged by the local authority to help them keep up to date with good practice guidance. Following one of these meetings, they had sourced oral hygiene training for staff as recommended.

We observed that people who could mobilise independently walked around the home without restriction and had no problem with finding their way around. Relatives told us they felt their family members were safe living at the home. One relative said, "The building is very suitable for [Name]."

Good

Is the service caring?

Our findings

We observed that staff were kind, caring and patient. A relative told us, "Yes, I do think they care" and a health care professional said, "The staff team seem to know the residents well and are obviously caring." Comments from staff included, "We are here because we want to give a bit back", "We put them first – 100%" and "We all have special bonds and soft spots for people."

Our observations of people who lived at the home indicated they were happy and comfortable in the presence of staff. The SOFI inspection we carried out showed that staff interacted with people appropriately and continually checked that they were happy and their needs were being met. They encouraged people to interact with books and made sure everyone was involved in conversations and activities.

People had been allocated a key worker. A key worker is someone who takes a special interest in the person and is their main link with the staff group. A member of staff told us, "Everyone has a key worker. We have a responsibility to be their voice." A health care professional told us, "All of the staff have recently been booked onto Intensive Interaction training, which [Name of manager] initiated herself and I am working with the keyworkers of one resident to implement this training in order to provide them with meaningful and enjoyable opportunities for interaction."

People were assisted with personal care in their own bedrooms and bathrooms, and staff told us that health care professionals saw people in their own room if they required any treatment. A relative told us that staff respected people's privacy and dignity. They said, "Staff are quick to act if they see any situations that might compromise a person's dignity."

Relatives told us that staff also promoted people's independence. We observed this on the day of the inspection; if people were able to carry out tasks for themselves, staff encouraged them to do so.

One relative said they felt communication between themselves and staff could improve, although they told us that they were always told if their family member was ill or had a seizure. Another relative said that they telephoned the home daily so they were always kept informed of their family member's well-being.

The manager told us that no-one at the home had required the involvement of an advocate. Advocacy services help vulnerable people access information and services, be involved in decisions about their lives and explore choices. The manager said that people were supported by family members with decision making and they would contact the person's social worker if additional support was required.

We saw that written and electronic information about people who lived at the home and staff was stored securely to protect confidentiality.

Good

Is the service responsive?

Our findings

A care plan had been developed from the person's initial assessment, information gained from relatives, and with the involvement of health and social care professionals. We checked the care plans for two people who lived at the home. We found they included information that described the person's personality, their individual care and support needs, their usual daily routines and their previous lifestyle in a 'one page profile'. A relationship map recorded the names of family and friends, and details of health and social care professionals involved in the person's care. This resulted in staff having an excellent understanding of people's social and cultural diversity and their values and beliefs.

A staff member said, "We get used to the way they communicate. They use body language, basic Makaton, gestures and facial expressions." We saw that care plans included details of people's actions and what these might indicate, such as being in pain or being anxious. One person had a 'life book' that had been produced by their parents. Staff told us this helped them get to know the person's preferences and enabled them to provide person-centred care.

One person who lived at the home had a serious skin disease. Over the years the manager and support staff had attended dermatology appointments with this person where consultants had changed the antibiotics and creams prescribed, but the condition had not cleared up. Through the determination of staff and the manager expressing that the condition was affecting this person's quality of life (as they appeared to be in pain) and researching the condition, a best interest decision was made and treatment which involved weekly injections was offered. Staff had specialist training from nurses to administer the treatment, and guidance was written on how to administer and the signs to look out for whilst the person was on the treatment. As a consequence, the person's skin condition improved and they had started to take part in social activities again that they used to enjoy. Staff reported that this person's whole quality of life had improved. The manager felt, if it had not been for the on-going perseverance and commitment from the staff team, this person would still be suffering from this condition.

Care plans were reviewed each month by staff and more formal reviews were held with commissioners, health and social care professionals and relatives. This provided an agreed and up to date record of each person's care needs. When any areas for improvement had been identified in reviews, it was clear that staff had responded positively and had worked towards making these improvements. Care plans had been updated to reflect any changes made. Daily handover meetings also ensured staff were provided with up to date information.

People were supported to keep in touch with family and friends. The manager told us that she had contact with families on a weekly basis. She spoke with them when they visited the home, on routine visits and when they attended social events. Everyone had visits from family and friends and some people also spent time with their relatives at the family home.

Activities were carried out by care staff as part of their day to day duties. Each person had a weekly activity programme in place; activities included pamper sessions, crafts, music, trips out and books. One person

went swimming and horse-riding most weeks. It was clear that activities were based on people's individual abilities and interests. One relative told us they felt more activities would be beneficial and other people told us that sufficient activities were provided.

There were policies and procedures in place that informed people how to express concerns or make a complaint. We checked the complaints log and saw there had been no formal complaints during the previous year. We saw that complaints made prior to this time had been managed effectively. One relative told us they had raised numerous concerns and these had been dealt with effectively. They said they had not needed to make a formal complaint. One relative said that relatives meetings were infrequent. They also said they would not wait for a relative's meeting if they had concerns; they would speak to the manager straight away. Relatives felt that any concerns they raised would be addressed by the manager.

Staff told us they would know if someone was unhappy, as they knew them well. They said they would not hesitate to make a complaint on the person's behalf if they felt there were concerns.

Some compliments had been received at the home. One health care professional had commented, 'You are well organised and documents are always up to date'.

Good

Is the service well-led?

Our findings

There was a manager in post who was registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission 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.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service in the form of a 'notification'. We found that notifications had been submitted when required.

The provider is required to display their inspection rating following a CQC inspection. The rating for the inspection conducted in April 2015 was clearly displayed within the service and on the organisation's website.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely.

Staff told us they were happy with how the home was managed. Comments included, "[Name of manager] is always there and my colleagues are supportive" and "Senior managers are easy to talk to." A health care professional told us, "I find [Name of manager] responsive and keen to engage with professionals and follow advice given."

Surveys had been distributed to relatives and to staff. The responses had been collated and analysed. Comments from staff included, 'Brilliant – a very caring place to work' and comments from relatives included, 'A lovely service overall' and 'I have no concerns'. Some minor concerns had been raised and these had been recorded on an action plan, along with the name of the person responsible for taking the action. Staff also attended staff meetings, and told us their views were listened to. One member of staff said, "We are very vocal. We say what we think."

The manager carried out quality audits to monitor that systems at the home were working effectively and that people received appropriate care. These included audits on fire safety and accidents / incidents. The operations manager carried out a review of the audits completed by the manager, and there was an electronic system which fed the outcome of all audits and any other feedback received to the organisations head office for further analysis. This showed that there were systems in place to monitor the quality of the service provided, and make improvements in respect of any identified shortfalls.

The manager told us they were always looking for ways to improve. They had recognised that some people found external social clubs overwhelming. They had started a social club on the site of Bethia Cottage that also included a supported living house and a respite service. Some people had enjoyed this as they were more comfortable spending time with people who they knew. There had been a social club on the evening

before our visit and it was clear that people had enjoyed it.

The manager described the culture of the home as, "Passionate staff", "Caring", "Choice orientated" and "A good quality of life". A relative described the home as, "Happy and well-run" and staff described the culture as, "A welcoming home", "Happy" and "We care about each other."

Staff said that they received their rotas four weeks in advance which helped them to achieve a work / life balance. Staff received a voucher to reward long service, and had access to a benefits programme where they could save money on products and services. This showed that staff were appreciated by the organisation.