Voyage 1 Limited

Waterbeach

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

This inspection took place 18 and 23 February 2018. It was announced, we gave very short notice to make sure there would be a staff member present when we visited.

Waterbeach is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Waterbeach accommodates four people in one adapted, single storey building.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Why the service is rated good.

There was a registered manager at the service, although they were not available at our visit due to long term leave. Another manager was overseeing the home and intended to submit an application to register as manager for Waterbeach. 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.

Staff knew how to respond to possible harm and how to reduce risks to people. Lessons were learnt about accidents and incidents and these were shared with staff members to ensure changes were made to staff practise or the environment, to reduce further occurrences. There were enough staff who had been recruited properly to make sure they were suitable to work with people. Medicines were stored and administered safely. Regular cleaning made sure that infection control was maintained.

People were cared for by staff who had received the appropriate training and had the skills and support to carry out their roles. Staff members understood and complied with the principles of the Mental Capacity Act 2005 (MCA). People were supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People received a choice of meals, which they liked, and staff supported them to eat and drink. They were referred to health care professionals as needed and staff followed the advice professionals gave them. Adaptations were made to ensure people were safe and able to move around their home as independently as possible.

Staff were caring, kind and treated people with respect. People were listened to and were involved in their

care and what they did on a day to day basis. People's right to privacy was maintained by the actions and care given by staff members.

People's personal and health care needs were met and care records guided staff in how to do this. There were activities for people to do and take part in and people were able to spend time with their peers and take part in cultural and religious activities. A complaints system was in place and there was information in alternative formats so people knew who to speak with if they had concerns.

Staff worked well together and felt supported by the management team, which promoted a culture for staff to provide person centred care. The provider's monitoring process looked at systems throughout the service, identified issues and staff took the appropriate action to resolve these. People's views were sought and changes made if this was needed.

Further information is in the detailed findings below

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.

Staff assessed risks and acted to protect people from harm. Staff knew what actions to take if they had concerns about people's safety.

There were enough staff available to meet people's care needs. Checks for new staff members were undertaken before they started work to ensure they were safe to work within care.

Staff received the support they needed to help people with their medicines if required.

Infection control practices were in place and staff followed these to maintain a clean, hygienic home.

Effective systems were in place to learn lessons from accidents/ incidents and reduce risks to people.

Is the service effective?

Good

The service was effective.

Systems were in place to make sure people's care and support was provided in line with good practice guidance.

Staff members received enough training to provide people with the care they required.

People were supported to prepare meals and drinks as independently as possible.

Information was available to support people if they moved services. Staff worked with health care professionals to ensure people's health care needs were met.

Adaptations were made so that people could be as independent as possible.

Staff supported people to continue making decisions for

themselves.

Is the service caring?

Good

The service was caring.

Staff members developed good relationships with people using the service and their relatives, which ensured people received the care they needed in the way they preferred.

Staff supported people to be as independent as possible.

Staff treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People had their individual care needs properly planned for and staff were knowledgeable about the care people required to meet all aspects of their needs.

People had information if they wished to complain and there were procedures to investigate and respond to these.

Information was available about people's end of life wishes if this was appropriate.

Is the service well-led?

Good

The service was well led.

Staff members and the manager worked well with each other so that people received a good service.

Good leadership was in place and the home was well run.

The quality and safety of the care provided was regularly monitored to drive improvement.

People's views were obtained about changes to their home and what they would like to happen.

Staff contacted other organisations appropriately to report issues and provide joined-up care to people.

Waterbeach

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 18 and 23 January 2018 and was announced. We gave the service very short (less than 24 hours) notice of the inspection visit because it is small and we needed to be sure that people would be in.

The inspection was carried out by one inspector.

As part of the inspection, we reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Before this inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection, we observed how staff interacted with people to help us understand the experience of people who could not talk with us due to complex health needs.

We spoke with people living at the home although none of them were able to answer our questions. We spoke with two members of care staff, the manager, a manager from another service with the same provider and the operations manager. We checked three people's care records and medicines administration records (MARs). We checked records relating to how the service is run and monitored, such as audits, staff recruitment, training and health and safety records.

Good

Is the service safe?

Our findings

In the Provider Information Return sent before our visit the provider told us there were processes in place to protect people from abuse or harm, and these contributed to people's safety. Staff knew how to protect people from harm, they told us they had received training, they understood what to look for and who to report to. Information was available for staff, with contact numbers for the local authority safeguarding team, should they need to make a referral out of normal working hours. The manager told us that safeguarding was discussed with staff in meetings and individual supervisions.

The manager was aware of their responsibility to report issues relating to safeguarding to the local authority and the CQC. A root cause analysis (detailed investigation) was completed to identify whether additional actions could further reduce the risk of reoccurrence. Information received before our inspection showed that incidents had been reported as required, and staff had taken appropriate action to protect people and reduce risks to them.

Staff assessed individual risks to people and kept updated records to show how the risks had been reduced. They told us they were aware of people's individual risks and our observations showed that they put the actions into place. Risk assessments contained enough information and detail to show how risks had been reduced. These included everyday risks, such as for showering or bathing, and for more less likely risks, such as for the possibility of exploitation. Assessments had also been completed for the individual use of equipment, such as wheelchairs and bed rails and identified risks such as entrapment. We found that staff had checked bed rails to ensure gaps were within the required measurements. Assessments were also available to advise and guide staff on the risk to each person in the event of a fire and how they should be assisted to evacuate the building if needed.

We found that environmental checks in such areas as fire safety and equipment used by people had also been completed. Staff completed fire safety checks on a daily, weekly or monthly basis as required. As well as checks to equipment used by people, such as hoists and bed rails, staff also completed weekly checks to vehicles used by people for transport. Vehicles also received servicing and MOT to ensure people were able to continue to use the vehicle.

There were enough staff to care for people, although neither of the two staff that we spoke with thought there were enough permanent staff. Both staff members told us that this meant people were sometimes unable to do the things they wanted to do. They explained that one person occasionally wanted to go out in the evening. However, this was not always possible if there were only two staff members on duty. They went on to tell us that the manager tried as much as possible to use staff working between Waterbeach and another home, rather than agency staff. Where agency staff were used, they were regular staff who usually knew people. This helped ensure that these staff knew people's care needs and were familiar with how they wanted to be cared for.

There were systems in place to determine staffing numbers, which was based on the number of hours each person received funding for from the local authority. This allowed for two staff members at all times, plus an

additional staff member at some other times. The staff rota showed that an additional staff member was also available at other times of the day and at weekends. The manager told us that they had also started to introduce an extra staff member for some evenings so that people could go out then if they wished. They also said that they would continue to monitor staffing levels to see if changing shift patterns would improve people's opportunities to do things at different times of the day. During our visit we saw that staff members were available for people when they were needed. They worked in a calm way; we saw that one person was supported to make themselves a drink and something to eat. Another person was able to eat lunch at a time that suited them and staff were able to spend time talking with people while they were relaxing.

We looked at a staff recruitment file and saw that satisfactory checks had been returned before the staff member worked with people. These included criminal records checks (DBS), identification and a health declaration to ensure that new staff were safe to work. New staff completed induction training and shadowed more experienced staff so that they had an understanding of how to keep people safe while providing care and support.

People who needed support with their medicines received this from staff who were competent to provide this. Staff members told us about the training they had received to be able to give medicines. This included training in giving medicines through a tube into a person's stomach (PEG) and emergency medicines for people who had epilepsy. We saw that people received their medicines in a safe way when staff gave these in tablet form or in liquid form through a PEG tube. Each person was given their medicines at the time prescribed for them. Medicines were stored securely in people's rooms or in a central area.

Records to show that medicines were administered were completed appropriately. We saw that medicines had been recorded as given and that this information tallied with medicines remaining in stock. Information, such as identification, specific instructions, allergies and contact details for each person's GP and pharmacy, was also available. This made sure that it was clear who the specific medicines were prescribed for. There were instructions for medicines that required specific consideration for when they were given or in regard to the side effects these may have. One person received their medicine in a drink and staff had clear guidance about letting the person know they had medicine in their drink so that it was not given covertly.

We looked at the cleanliness of the home and how staff reduced the risk of cross infection. We saw that the home was clean and there were no offensive odours. We saw that staff used personal protective equipment, such as aprons and gloves. There was also different cleaning equipment for different areas in the home. Training records showed that staff had received food hygiene and infection control training. We saw that staff had taken this knowledge on board and identified possible issues with cross infection at meal times. They took action to allow people to continue preparing for and eating their meals, while reducing any risk of cross infection by providing separate cutlery for one person. This showed us that processes were in place to reduce the risk of infection and cross contamination.

We saw that incidents were responded to appropriately at an individual level and information about these fed into broader analysis. For example, analysis of one person's wish to carry out meal time preparation identified potential risks to other people living at the home. The action taken as a result of this meant that the person was able to continue preparing their own dining area, while staff prepared the area for other people. The registered manager confirmed that any learning as a result of accidents or incidents was discussed by the staff directly involved with the care of the person.

Good

Is the service effective?

Our findings

Needs assessments were completed for people living at the home periodically, even though they had all lived there for a long time. (The home was previously registered with a different provider and all four people lived there then.) The needs assessments were completed following guidance from the organisation's quality and governance team. This team looked at all new legislation and guidance so that they could update policies and procedures and cascade changes to staff caring for people. The provider organisation was also a member of several organisations, such as Skills for Care and the British Institute for Learning Disabilities, that promoted learning and current good practice in caring for people.

We saw that people living at the home had varying levels of cognitive ability and that staff worked effectively to manage all of their needs. People were provided with the level of support appropriate to their needs. This included equipment, to help people walk independently, and the use of technology to monitor health needs. For example, where people had epilepsy and suffered from seizures, sensor equipment was in place. This alerted staff so that they could provide support only when needed and people were able to spend time in their rooms without being disturbed.

Staff told us that they received enough training to give them the skills to carry out their roles. One staff member commented that they had "so much" training. They went on to describe how epilepsy training had been interesting and provided them with clear information about the different types of epilepsy. Both staff members also commented that they would be able to ask for additional training if they felt the need. Staff training records show that staff members had received training and when updates were next due. Our observations showed that staff assisted people appropriately and where required, used equipment in the correct way. We were therefore satisfied that staff members followed the training they had received.

Staff members had differing views about the amount of support they received. One staff member explained that they could discuss issues with the management team and this allowed them to discuss any concerns they had. The other staff member did not feel as well supported and said they felt this was due to other staff who did not always have the required skills to care for people. We found that staff had the required training and skills and that this was an isolated incident.

We observed that refreshments were available throughout the day and people were offered drinks when they returned from being out. Staff talked about meals that were available with people and showed them the available meals so that they could choose what they would like. We saw one staff member do this and then watch the person's body language to determine whether they were happy with the meal offered. When the person ate only a small amount of the meal, they were offered an alternative. We saw that people were properly supported with eating and drinking.

Staff monitored people to make sure people received enough nutrition to meet their daily requirements. For example, those people who staff provided meals to in alternative ways, through a tube into their stomach (PEG). This was A staff member described how they had contacted the dietician when they had become concerned about one person's weight loss. This resulted in a change to the person's diet and a gradual

increase in their weight.

Staff told us that they worked with health and social care professionals that people had been referred to. 'Hospital passports' (a document with details about the person) and health care plans were completed to help staff in other health or care settings support the person in the way they wanted. The manager told us that staff were able to contact the specialist learning disability nurse at the local NHS hospital if a person needed to attend as an inpatient. This helped provide support for the person and ward staff, although staff from the home who knew the person would also stay with the person if needed.

People's care plans showed that they had access to the advice and treatment of a range of health care professionals. These plans provided enough information needed to support each person with their health needs, including detailed descriptions of the changes people had been advised to make. Two people had received advice about their diets from Speech and Language Therapists and we saw that staff supported people to make the required changes to their diets.

The home is an adapted single storey domestic bungalow. Our observations and conversations with staff showed that people were able to access all areas of the home if they wished. Adaptations had taken place to provide overhead ceiling tracking for hoists, which helped one person transfer from their bed to their wheelchair easily and comfortably. Work was being carried out during our visit to adapt a bathroom so that everyone living at the home could use the room.

People who lack mental capacity to consent to arrangements for necessary care can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The service was good at ensuring people were able to make their own decisions. Staff showed us that they had a good understanding of the MCA and worked within its principles when providing people with care. They told us that people had the right to make their own decisions as much as possible and they presumed people were able to do this unless assessed as otherwise. One staff member told us how they did identified what people wanted for those who found it difficult to verbally communicate, which made sure assumptions were not made for people. We saw that people were able to spend time where they wanted. One person returned to their room after their meal and went back to bed, while other people spent time in communal areas and with staff. We saw that staff made sure people were happy where they were and regularly checked if the person wanted to move. Staff completed mental capacity assessments and could access guidance to show the help people needed to make sure they were able to continue making decisions.

Good

Is the service caring?

Our findings

We saw that staff were kind and thoughtful in the way they spoke with and approached people. They put people at ease and we saw that staff achieved this by considering their actions first. They faced people, spoke directly towards them and when people were sitting at a different level, staff lowered themselves so they were not standing above the person. In turn, we saw that people usually responded to this attention in a positive way.

We found that staff knew people well and that they were able to anticipate people's needs because of this. They knew what people would do, although they continued to make sure people were able to make their own decisions. People were able to get up when they wanted and one person often chose to stay in bed later. Staff were available when the person did get up and supported the person to then do what they wanted. We watched as the person was offered a choice of activities and food to eat, although they were not interested in these and ultimately returned to bed.

We saw that staff members told people what they were going to do before doing it, which meant that people were not suddenly surprised. They were able to indicate if they were not happy for staff to continue, for example by their body movements. We also saw that people were made aware of those close by so that they were not startled if people were not in their direct eye line. Staff also knew people well and for those people who were less able to verbally tell staff what they needed or wanted this support had a positive effect. We saw that staff watched people's movements and offered closed questions so that the person could quickly indicate what they wanted. Staff described the circumstances under which they would ask people if they wanted support. We saw that staff had enough time to spend with people.

There was information about advocacy services at the home, so that people or their relatives could contact these organisations if they wanted to. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Staff respected people's right to privacy and to be treated respectfully. This was evident in the way both the manager and staff spoke and interacted with people. We saw this in practice when people were helped from one area of the home to another. Staff checked to make sure people's clothing was straight and suggested quietly to people when and if they needed to have personal care. Staff members received training in key areas that supported people's right to respect and dignity. This included specific training in 'understanding their role' and 'working in a person centred way'. We also saw that care records were written in a way that advised staff to consider people's right to privacy and dignity whenever they provided care and support. For example, in advice about caring for one person's specific needs around continence, staff were told to monitored this regularly to reduce the risk of offensive smells occurring.

People could have visitors whenever they wished, although staff told us only one person had a regular visitor. Staff respected people's confidentiality by keeping records about them safely stored away, where they were not on display for people coming into the home.

Good

Is the service responsive?

Our findings

Staff had a good knowledge of people's needs and could clearly explain how they provided support that was individual to each person. Staff were able to explain people's preferences, such as those relating to health and social care needs, personal preferences and leisure pastimes. One staff member told us, "The care records contain enough information."

We looked at people's care plans and other associated records. The manager explained that staff were in the process of transferring records to an electronic system. Until this was complete and for a short while afterwards, paper records would also be kept. This meant that information could be in different locations, however staff we spoke with knew exactly where to find each document as they had helped write them. One staff member told us that they felt some records were not written in enough detail and the transfer to an electronic system had given them the opportunity to change this.

All files contained details about people's life history, their likes and dislikes, what was important to each person and how staff should support them. Plans were written in detail, which provided clear guidance for staff members care practice. Information about people's lives provided detailed histories that were set into sections of their day; an overview, night time routine, 'at home' and 'support hours'. This provided staff with a chronological order of when people usually did things and included cross references to other plans or documents within the person's care records. Additional information was available that described what people's movements and verbal sounds may be interpreted as meaning. This enabled staff who may not know people as well to have some understanding of what each person was telling them or experiencing.

Plans for the care of more individual needs, such as for giving liquid food or medicines through a tube into the stomach (PEG), were written in detail. These provided clear guidance regarding the care of the tube, the insertion site through the skin and what staff should be seeing. For example, the appearance of the insertion site if all was well. There was also extremely clear and well detailed information to guide staff in what to do if people suffered from epilepsy. One person's support plan provided information about the warning that person had, what staff should do and what happened during a seizure. The support plan went on to explain what medicines staff should give and when, what happened after the seizure and when to call for medical or emergency help. Staff we spoke with had a very good understanding of people's needs in this area. We saw the care plans were reviewed on a regular basis and if new areas of support were identified, or changes had occurred. Daily records provided evidence to show people had received care and support in line with their support plan.

People had access to a variety of activities that staff supported them to take part in. Most people visited day services regularly throughout the week and staff had also listed what each person liked to do in their spare time. We saw that one person attended church on Sundays and spent time there following the service helping out. There were staff members constantly present in communal areas of the home and this helped people to do what they wanted and choose where to spend their time.

The provider told us before our inspection that staff at the home used assistive technology to help people

maintain their independence. One person had a motorised wheelchair that enabled them to easily move between different areas in the home and outside between the building and the transport.

Staff confirmed they knew what action to take should someone in their care want to make a complaint and were confident the manager would deal with any given situation in an appropriate manner. There were copies of the home's complaints procedures in the staff office and staff were able to produce an easy read version. We saw that complaints had been investigated and records were kept to show the action that was taken to resolve these.

People had their end of life care wishes recorded as part of their support plan, where this had been identified as a need. For example, for people who were getting older or who had deteriorating health conditions. Information was recorded about preferences for such things as who was important to the person, where people wanted to be and what they wanted to happen after they died.

Good

Is the service well-led?

Our findings

There was a registered manager in post, although they were not available for our visit the Waterbeach, due to a period of long term leave. 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. The home was being supported by a registered manager from another of the provider's services. This manager told us that they intended to apply to be the registered manager at Waterbeach until the existing registered manager returned to work.

The manager was supported by an operations manager, senior care staff and care staff. We saw that people and staff knew who they were due to the visible presence they had around the home. A staff member explained, "I love [manager], she's very supportive, she's very approachable." They went on to say how the manager supported them, "She will do something to resolve issues. If we're short (of staff), she will help us out." We saw that staff liked working with people who lived at the home and that they had respect for the manager, who had taken action to make changes for the benefit of people.

Staff told us that they had a number of opportunities, such as regular staff meetings and handover meetings, to discuss the running of the home. One staff member told us how they had been supported to review and update risk assessments and support plans since working in a more senior staffing role. This had given them a great sense of achievement and ensured that detailed guidance was available for other staff. They were supported by senior staff and felt they could discuss any issues or concerns they had with them. Staff were further supported in supervision meetings, where they were able to discuss their performance.

A whistle blowing policy was available and staff told us they were confident that they could tell the registered manager something and it would be dealt with. They also confirmed that they had received training on whistle blowing. This meant that the organisation was open in their expectation that staff should use this system if they felt this was necessary.

Community links had been established when one person attended church services on a regular basis. They then began to attend a coffee morning at the church and this led to this person and other people living at Waterbeach getting to know other community services, such as local shops, hairdressers and the library. The manager told us that people living at the home visited the library to use their musical books section, which they really enjoyed.

We saw that the views of people was obtained through tenants meetings. During our visit people attended a meeting about the adaptation of a bathroom and the type and colour of the tiles they wanted in the bathroom. The manager told us that questionnaires had been sent to people, their relatives, staff and visiting health care professionals before our visit. They said that these would be looked at for any trends or themes and to see where improvements and learning could be made. However, staff members told us they were not aware of these questionnaires.

The manager used various ways to monitor the quality of the service. These included audits of the different systems around the home, such as medicines management and infection control. The audits identified issues and the action required to address them. We also saw that the operations manager carried out an audit, which also identified issues and presented them as a risk scorecard. A monthly report was developed from this. We saw that the service risk reduction report had identified a reduction in the amount of staff turnover and the number of agency staffing hours. A third level of auditing was completed by an internal (to the organisation) quality assurance team. In their most recent visit they found little of concern, but they found that there was no confirmation to show staff had received training in giving liquid food and medicines through a tube into the stomach. The staff members on duty had received this training and training certificates were made available the following day.

The manager monitored accidents and incidents and we could see that staff took appropriate actions to reduce reoccurrences. Despite this, the analysis identified that medicine errors may be an issue, and although no trends were identified, action had been taken to review staff competency in administering medicines. Trends and themes of safeguarding issues were looked at every three months and then passed on to the provider organisation's quality team and operations manager. This allowed for an organisation wide analysis of information to see what lessons could be learnt. This shows that auditing and analysis systems were effective in identifying issues and taking the appropriate actions to resolve them.

During the inspection the manager told us that they were aware of the CQC guidance of 'Registering the Right Support.' This is the CQC policy on the registration and variations to registration for providers supporting people with a learning disability. The provider's representative also confirmed that they were signed up for 'The Driving Quality Code.' This code was developed following the Winterbourne review that identified abuse of people with learning disabilities at Winterbourne View. The government and many other organisations that support people with learning disabilities are taking action to make sure that this never happens again.

Information available to us before this inspection showed that the staff worked in partnership with other organisations, such as the local authority safeguarding team. We saw that the registered manager contacted other organisations appropriately and in relation to safeguarding, investigated the issue and took action where this was required. We saw that information was shared with other agencies about people where their advice was required and in the best interests of the person.