Voyage 1 Limited

Voyage (DCA) (North East)

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?	Requires Improvement

Summary of findings

Overall summary

At the last inspection of this service in November 2015, we asked the provider to take action to make improvements. This was because safeguarding concerns had not always been reported or investigated. Risk assessments about people's individual needs were either inaccurate or not in place and health and safety shortfalls had not been addressed. Recruitment checks of new staff had not always been carried out so the provider had not made sure that staff were suitable to work with the people who lived there. Staff had not understood people's rights about their mental capacity to make their own decisions. People's individual care records were not accurate so people might not have received the right care. Also, the provider's quality monitoring processes were not effective in identifying or addressing these shortfalls.

After the inspection the provider wrote to us to say what they would do to meet legal requirements.

We carried out this comprehensive inspection on 11 and 12 May 2015 to check whether the provider had addressed these breaches. We found there had been improvements in all these areas.

Voyage (DCA) (North East) offers a supported living service to people within their own homes or shared houses. It offers personal care to people within the North East area. People who use the service have learning disabilities, autism and/or physical disabilities. They are supported with personal care, medicines, cooking, shopping, activities and other day to day tasks. At the time of this inspection 24 people were using the service.

Since the last inspection a registered manager had been appointed. 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.

People who were able to express a view told us they felt safe using the service. Some people said it was "better" than it had been at the last inspection. Staff told us, "It's a much happier place for people."

Since the last inspection we found that the provider had reported any safeguarding issues to the relevant local authorities and had notified CQC of these. Staff had training in safeguarding and there was a 'hotline' for them to use if they were concerned about any poor practice. Staff said they were confident about reporting issues.

There were enough staff on duty to support the people who lived there. The provider carried out checks to make sure only suitable staff were employed. Medicines were managed in a safer way for people and staff had had training in specific emergency medicines.

People and relatives we spoke with felt staff were competent to provide the right support. Staff felt well trained and supported in their roles. Staff now understood and worked within the principles of the Mental

Capacity Act 2005 (MCA). This meant safeguards were in place for people who did not have capacity to make some significant decisions. All the people were encouraged to make their own day to day choices.

Staff were knowledgeable about individual people and were able to spot any changes in their well-being. There were now personalised ways of supporting people with their individual behavioural needs. Staff liaised with other health agencies to support people with their healthcare needs.

Since the last inspection people were more involved in choosing, planning and shopping for their meals. People were also encouraged to have a healthy lifestyle to help their nutritional well-being.

The people we spoke with who were able to express a view said they were "happy" with the support they received. One person told us, "I get on well with the staff." Another said, "I like living here, it's good. The staff are nice."

Staff felt the service was a "much happier place" for people. One staff member told us, "They've all got a life now." One staff member commented, "It was very stressful through all the changes but the staff who stayed are really attached to people and that's why we stayed."

There had been improvements to people's care records and these were now up to date and personalised. All the support plans for people who used the service had been reviewed by the care staff members who knew the person best. People had been involved in planning their own support for the future.

In the past three months the provider had put into place a structured quality audit system to continuously monitor the quality and safety of the service. However it was too early to tell if this would be effective in driving sustained improvements.

Since the last inspection a new manager had registered with CQC. People said the registered manager was "absolutely champion" and "really great". They said she visited the different houses and asked if everything was alright. People now had the chance to discuss their views of the service at house meetings.

Staff said the registered manager was open and approachable. There were now regular staff meetings for staff to share ideas.

All the people, staff and visitors we spoke with said there had been significant improvements to the running of the service since the last inspection.

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.

Safeguarding incidents were now reported and addressed.

Risks to people were managed in a way that did not compromise their right to lead their own lifestyle. Medicines were managed in a safe way.

There were enough staff to meet people's needs. The provider checked potential new staff to make sure they were suitable.

Is the service effective?

Good

The service was effective.

Staff felt well trained and supported to care for the people who lived at the home.

People's capacity to make their own decisions was assessed.

People had good access to health care services and their well-being was kept under review.

Is the service caring?

Good

The service was caring.

People said they liked living there and staff were nice to them.

Staff talked about people in a valuing way that respected their individuality and abilities.

Staff helped people to communicate their choices and decisions about their daily lives.

Is the service responsive?

Good

The service was responsive.

Care was planned in a personalised and individual way for each

person.

People had support with their chosen activities, either in their homes or in the community.

People said they knew how to raise any concerns and would be confident about doing this.

Is the service well-led?

Requires Improvement

The service was not fully well led. The provider had carried out quality checks of the service but it was too early to tell if these would lead to sustained, continuous improvement.

There was a registered manager in place. People and staff said the registered manager was approachable and supportive.

People were asked for their views about the service.

Voyage (DCA) (North East)

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.

The provider was given 24 hours' notice because the location provides a supported living service for younger adults who are often out during the day; we needed to be sure that someone would be in.

This inspection took place on 11 and 12 May 2016. The inspection was carried out by two adult social care inspectors on the first day and one adult social care inspector on the second day.

Before the 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 any improvements they plan to make. Before our visit, we reviewed the information included in the PIR along with other information about any incidents we held about the service. We contacted the commissioners and safeguarding adults officers of the local authority to gain their views of this service.

During the inspection we visited three shared houses and spent time with the people who lived there. We spoke with the registered manager, operations manager, four team leaders and five support workers. We also viewed a range of records about people's care and how the service was managed. These included the care records of five people, the recruitment records of four staff, training records and quality monitoring records.

Good

Is the service safe?

Our findings

At the last inspection of this service in November 2015 we found the service was not safe for the people who used it. This was because safeguarding concerns had not always been reported or investigated. We issued a Warning Notice about this.

At the last inspection we also found that risk assessments about people's individual risks, such as cooking or going out, were either inaccurate or not in place. Risk to people's health and safety due to the poor cleanliness of the premises had not been addressed. People's medicines had not always been managed in the right way. Recruitment checks of new staff had not always been carried out so the provider had not made sure that staff were suitable to work with the people who lived there.

During this inspection we found improvements had been made.

Since the last inspection we found that the provider had reported any safeguarding issues to the relevant local authorities and had notified CQC of these. The provider had worked with the local authorities to make sure that safeguarding matters were investigated by the right agencies, including the police where necessary. The provider had made sure that action was taken to protect people whilst investigations were carried out.

We found that staff had had further training in safeguarding adults and were now clear about how to report any concerns. One staff commented, "I feel more confident with safeguarding and whistleblowing now."

Staff told us that if they felt any concerns were not dealt with by the local management of the service they would be confident to take those concerns further, for example to senior management, to local authorities and to CQC. Staff told us the provider had a 'hotline' telephone number to report any concerns or poor practice. One staff member told us, "It definitely feels safer, for people and for staff. It's not overcrowded anymore."

Most safeguarding incidents related to altercations between people who lived in the shared houses. Since the last inspection a behavioural therapist who was employed by the provider was now involved in supporting people to manage their behavioural needs. It was anticipated this would help to reduce the number of safeguarding incidents. The registered manager had looked at compatibility within the houses and supported people to move to a different area of their house which had reduced some of the incidents. For one person staff had worked with them to discuss how their actions made other people feel and this had reduced the incidents. Another person now had one-to one support so they always had a member of staff to assist them and the behavioural therapist was also monitoring their well-being.

People who were able to express a view said they felt safe at the service and with the staff who supported them. One person said, "The staff are very good, they look after me." Another person commented, "It's better now."

Risk assessments were now in place for each person which reflected their individual and specific areas of risk and how these would be best managed. For example, there were assessments about people's physical, emotional and behavioural needs. These included strategies and control measures to minimise the risks. Risk assessments were up to date and kept under review.

Accidents and incidents were recorded on a computer system and in written format. The computer system automatically notified the registered manager when an accident or incident was recorded, so they could check the right actions had been taken. Accidents and incidents had been recorded accurately and dealt with appropriately. For example a person who had several falls was referred to the falls clinic, and a person who displayed behaviour that might challenge others was referred to the community learning disabilities team.

At the last inspection people in one shared house had not been supported with the cleanliness of their accommodation. For example, waste bins were overflowing and bedrooms were in an unhygienic state. Since then the house had been redecorated and was kept clean. One staff member commented, "It's easier for people to keep it clean because it's been decorated and got new flooring. It's a much nicer place for people to live now."

We found improvements to the way medicines were managed. At the last inspection we found staff were not trained in a rescue medicine that was prescribed for people with epilepsy. At this inspection we found 24 staff were now trained to administer this. Staff confirmed they would now know how to support people with this rescue medicine.

All staff had completed training in medicines management and then were observed three times to check their practice. Staff had competency checks of medicines administration every six months.

There were daily checks of each person's medicines by staff in each house. At the end of every day a count of remaining medicines was recorded on the medicines administration records (MARs). Another count was made at each dosage time and this was recorded separately.

Where people were able, they had been involved in assessing how much support they needed with their medicines. Some people were able to manage some of their medicines themselves. Some people needed full support because of their complex disabilities. For other people they needed physical support because of their physical disabilities but were fully involved in written agreements about their support. People's medicines were kept in their own bedrooms, unless they chose not to have the cabinets in their rooms and this was respected.

Since the last inspection protocols about how to manage 'as and when required' medicines had been put into place. Also, there were now protocols and guidelines for staff about medicines that were liable to misuse. During this inspection we found a minor inconsistency when recording codes for non-administration of a prescribed cream when the person had declined it. This did not impact on the safety of the person. We pointed this out to the team leader and registered manager who agreed to ensure staff were fully aware of the correct code to use.

We found improvements to the way new staff were recruited to make sure they were suitable to work with vulnerable people. We viewed recruitment files for four staff members who had been employed since the last inspection. There were thorough recruitment and selection procedures in place to check new staff were suitable. Proof of identification had been provided, gaps in people's employment history were accounted for and references were received from previous employers. A Disclosure and Barring Service (DBS) check had

also been carried out before staff started work. These checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. The registered manager told us these checks were to be updated every three years which was good practice.

Three people who used the service had been involved in interviewing potential new staff. The three people involved proudly told us about this and how the interviews had taken place in people's apartments. One of the people said, "When we interviewed new staff I told them about the keyworker role."

People who were able to express a view said there were enough staff to support them individually with their day. Staff also felt staffing arrangements had improved, and some people now had one-to one support at most times. One staff member told us, "It's safe now. There's always someone with people to make sure they are ok."

Arrangements were still being finalised with the funding authorities about the number of support hours for each person. In the meantime we found there were sufficient staff to support people with their daily lives. In one house most people currently had one-to one support. In another house people shared the support workers' time. In all the houses we found there was enough support for people to lead a fulfilled lifestyle. The people we spoke with felt they were supported with activities outside and inside their homes. One staff member commented, "There seems to be enough staff because we get people out and about all the time."

Good

Is the service effective?

Our findings

At the last inspection we found the service did not make sure people's rights under the Mental Capacity Act 2005 (MCA) were upheld. (MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'). Staff had been unclear about MCA. They felt some people did not have capacity but this had not always been effectively assessed. For example, people had been expected to make some complex decisions about financial matters, regardless of whether they had capacity to do so.

During this inspection we found improvements had been made.

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.

We checked whether the service was working within the principles of the MCA. The records we viewed showed that, where appropriate, people's capacity had been assessed for specific, significant decisions. Where people were assessed as not having capacity to make a specific decision, such as managing money, a 'best interest' meeting had taken place. The best interest record included what the best outcome was for the person's safety. For example, one person had a best interest decision relating to medicines. This person had capacity to make decisions in other areas of their life but occasionally refused medicines which could impact on their health and well-being. The best interest decision was to encourage them to take their medicines as prescribed, but if they refused to contact their GP.

Some people who used the service had been assessed for court of protection arrangements. This meant they were protected by the court which had appointed key people to safeguard people's interests, such as managing their finances. Other people had appointees that were arranged through their relevant local authority. Staff told us and records confirmed they had received training in MCA and DoLS since the last inspection. Staff had also attended focused supervisions on the MCA and DoLS and were clear about how this applied to individual people using the service.

Some people had behaviours that could challenge the service and other people. At the last inspection we found there were no personalised ways of supporting people with their individual behavioural needs. At that time staff felt they were not effective in supporting people to manage their own behaviours. Although staff had had training they had lost confidence in supporting people when they were agitated or angry.

We found there had been improvements since the last inspection. The behavioural therapist had met every person who used the service. With the support of the person and with staff who were familiar with them individual behavioural plans had been developed. These were detailed guidelines that set out the potential triggers that might lead to specific behaviours. They also included clear strategies for the person and for

staff to support them, such as re-direction to another task. Staff had also received additional training in managing potential and actual aggression (MAPA) and said they felt more confident in supporting people now.

There had been a number of improvements to help staff be competent in their roles. The registered manager told us, "We have more team meetings, we've got a supervision and appraisal plan in place and staff on probation have probation review meetings. We've given staff more responsibility but more training as well, such as in finances, medicines and care planning reviews."

Staff we spoke with said they had received more training since the last inspection and they felt more supported. One staff member said, "Things have really changed for the better. We've had lots more training. It's so much better now." Another staff member told us, "We've done more training which was really useful."

Staff told us, and records confirmed, they had regular supervision sessions and an annual appraisal with their managers. Supervisions are regular meetings between a staff member and their manager to discuss the needs of people who use the service and areas for development, and to offer support. Records showed staff received supervisions every three months as a minimum. The records of supervisions and appraisals were detailed and meaningful.

Where staff performance was not what the registered manager expected, 'significant discussions' were held with the staff member. Records of 'significant discussions' were clear about what was expected of staff in certain situations and how staff could improve their performance, such as maintaining accurate records after an incident.

Since the last inspection people had been supported to be more involved in arranging their meals, including menu planning, shopping and preparing meals. People had also been supported to understand the impact of a healthy lifestyle on their nutritional well-being. People described how they planned their menus and some people used picture menus to show their preferences. They used the menu plan as a guide to go grocery shopping.

Staff were knowledgeable about people's individual dietary needs. For example one person needed food to be prepared in bite-size pieces to prevent choking and another person was on supplements drinks to help them gain weight. Another person had diabetes and managed this themselves. Staff cooked meals for people in the shared houses but it was people's individual choice whether they ate in the dining rooms or in their apartments.

People were now weighed regularly and have their body mass index (BMI) calculated. The service was trying to develop health eating initiatives as some of the people who used the service were classed as obese when these were initially done. The registered manager had organised for someone from the local authority to come to one shared house to run a healthy eating cookery class. The registered manager had also suggested a vegetable patch at one shared house as people may be more likely to eat the vegetables they had grown. In one shared house two people had lost weight since these initiatives.

People were supported where necessary to access community health service such as GPs and dentists. Since the last inspection people had had a review of their health and medicines by their GP. The health records we viewed had been updated and information from healthcare professionals was included.

In a recent satisfaction survey a relative said, 'I was really grateful that staff were on the ball about [family

member's] health last year. They have supported her so well.'

It was also clear from discussions with people that they had been supported to access specialist health care services where appropriate. For example some people had input from dietitians, speech and language therapists and occupational therapists.

Good

Is the service caring?

Our findings

The people we spoke with who were able to express a view said they were "happy" with the support they received. One person told us, "I get on well with the staff." Another said, "I like living here, it's good. The staff are nice."

Another person commented, "I like living here. I like to have a laugh and we have a laugh here. I enjoy my one to one time with staff."

Feedback from people who used the service in a recent satisfaction survey included comments such as, 'The best thing is being able to spend time in my apartment and have my own space. I go to work twice a week with staff support'; 'I like the help I get off staff. I like living here as it is my home', and 'I can go out when I want with or without staff support'.

Staff felt the service was a "much happier place" for people. One staff member told us, "They've all got a life now." One staff member commented, "It was very stressful through all the changes but the staff who stayed are really attached to people and that's why we stayed."

In discussions with people it was clear they made their own choices about their daily lifestyle such as what to do and where to go each day. In one shared house one person had begun to choose which staff member they wanted to support them for one day a week. It was expected that this would become usual practice for other people in the house in the future. One staff member commented, "It's much better now – we're asking people what they want to do and where they want to go."

For day to day decisions each person now had a 'decision-making profile' that outlined the best time and way to allow them to make their decisions. These were personalised and detailed. For example, one person's decision-making profile stated that the person was fully involved in weekly menu planning but 'can change their mind daily so there should always be an alternative available for them'. Another person's decision-making profile stated, '[Name] likes to be given information verbally and this is to be backed up with pictures/symbols. The best time for [Name] to make decisions is when they are happy and calm and around lunchtime'.

One staff member told us, "People like to do their own thing which is fine, it's their choice. They live their life the way they want to, which is how it should be."

People who needed physical assistance said this was carried out the way they wanted and that staff supported their privacy and their personal hygiene. One person commented, "Staff help me have a shower every day."

Feedback from relatives in a recent satisfaction survey included comments such as, 'I think [family member] receives good care and support. They have more choice with meals now', 'I am satisfied with the top class care and support package', and 'care and support from the staff is excellent'.

Redecoration of one shared house meant those people now lived in an environment that upheld their dignity. Previously this house had been dark, unclean and cramped. This was now bright, well decorated and had additional lounge space for people to spend quiet time away from other people if they wanted. One person told us, "It's much better now. I can use one of the lounges or the dining room to meet with visitors, not just my bedroom which is private."

One person had chosen and ordered new bedroom furniture and this had arrived on the day of inspection. The person was very excited and proud of their furniture. Staff celebrated this with the person, making complimentary remarks about their new furniture and treating them with respect.

People and staff described ways that people were more involved in using their independent living skills, such as preparing meals or even just drying dishes and this was an on-going goal for people. Staff told us they had purchased new, light-weight hoovers for people who used wheelchairs so they could be more involved in cleaning.

One person told us, "I can cook my own scrambled egg now in the microwave. I can hoover, dust and polish now. I even clean the kitchen. I know what my tablets are for and how often to take them but I like staff to watch me just in case." Another person said, "I do my jobs on an afternoon such as cleaning my room and the house."

People support plans included details of how to support people to maximise their independent living skills. One person's records stated, staff should "not deskill [name] by doing task for them that they can do themselves" and to "encourage [name] to do as much for themselves as they possible can".

Some people had keys to their bedroom or apartment doors and made good use of these when they were out. However they did not have the code for their front door and the registered manager agreed to look at this.

Some people told us they could ask relatives to help them be involved in decisions. Arrangements were being made through a local authority for an advocacy services to provide other people with impartial support when making decisions.

Good

Is the service responsive?

Our findings

At the last inspection in November 2015 we found the provider had not been responsive to people's care needs. This was because the provider had not made sure people received personalised care. People's individual care records had not accurately reflected their needs or were incomplete. This meant that it had not been possible to be clear if a person was supported in the right way or in the way they preferred.

During this inspection we found there had been improvements to people's care records and these were now up to date and personalised. All the support plans for people who used the service had been reviewed by the care staff members who knew the person best. These were then rewritten and were being reviewed each month at key worker meetings with the person (if they chose to attend). Where able, people had been involved in discussions about their own support plans so that their preferred way of being supported was included in their plans. For example, one person had been asked how they would like to be supported if they were feeling upset. The person said they would prefer to be left to have some quiet time in the privacy of their bedroom and this was written into their support plan with their agreement.

The support plans were personalised and respected people's abilities as well as their needs. For example, one person's plan instructed to staff to 'be consistent around me so I know where I stand and what is expected of me' and 'always listen to what I am saying and acknowledge what I'm saying'. The support plans were detailed and specific to each person, for example about their individual health needs and communication. For instance, one person's communication plan stated, 'If [name] says they have a bad head whilst out it means they want to come home'.

People described how they had been involved in planning the support they wanted to achieve their personal goals. One person commented, "I had a meeting with the registered manager and talked about what I wanted to do and where I wanted to be. I feel I can talk with them and my keyworkers." We saw examples where other people had been involved in setting their own goals and agreeing their support plans such as medicines, behaviour and mobility. One person's goal was to go to New York and they were being supported by staff to achieve this.

In discussions with staff it was clear they were very aware of people's individual ways and could recognise any changes in their well-being. Their knowledge of people had been used to develop detailed and specific support plans about people's behavioural needs. For example, one person's support plans indicated that if the person put their finger to the left side of their nose and looked away it meant they were anxious and were likely to become agitated. One staff told us, "We know people inside out. We know even the slightest change in them and if something is wrong."

The behavioural therapist told us, "Staff are so familiar with people's individual behaviours, even what they look like if they are about to become disengaged, so I was able to write the plans with them so clearly. Support plans are much more tailored to individual people. Report writing is much better and is still improving."

People said they got support with activities they enjoyed. For example they were supported to access the local community for shopping and social activities, such as walks, going to a local pub or trips out. Some people had planned day time placements at day centres and workshops and some people did voluntary work at a charity shop. Other people were independently able to spend their day as they wished.

During this inspection three people at one shared house had decided to go on a picnic and had been involved in preparing the food to take. At another shared house a few people and staff decided on the spur of the moment that because it was a nice evening they would go to the local pub. At another house one person described how the support they had to go shopping, for meals out, walks along the seafront and for a head massage.

The behavioural therapist told us, "Everybody is out much more and even doing more things inside like baking and this has had a positive impact on them."

People who were able to express a view told us they would feel able to make a complaint or raise any concerns. One person told us, "I get on with most staff but I tell the others if I don't like them. If I was unhappy I would tell them." Other people told us, "I can talk to [operations manager]" and "[registered manager] asks me if everything is alright – I would tell her if it wasn't happy".

Since the last inspection people told us they had house meetings to give their views. We saw from minutes that people were encouraged to raise any issues. There was information for people in easy read format about how to make comments if they were unhappy with the service (although some people did not have immediate access to this).

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in November 2015 we found the service had not been well led. This was because the provider's quality monitoring processes were not effective in managing risk or making sure people received a safe or quality service. The provider had identified some of the shortfalls earlier last year but no remedial action had been taken. We issued a Warning Notice about this.

Following the last inspection a team of senior managers had compiled a comprehensive action plan to address the previous shortfalls. Quality assurance systems had been put in place to check the progress of the action plan and whether improvements were being made. The significant areas of safety concerns had all been acted upon, for example safeguarding, medicines and risk assessments and support plans. Some actions had longer timescales, for example person-centred reviews were scheduled to be completed by September 2016.

Structured checks of the service included a check of all accidents and incidents by the registered manager, which were analysed for any trends. Monthly key worker reviews between support staff and people were sent to the registered manager every month for their oversight.

Quality audits were carried out in three monthly cycles. On the first month the registered manager carried out a quality audit and set an action plan with timescales for any areas that required improvement. The following month the registered manager checked the progress of the action plan. On the third month the operations manager checked that the audit and actions had been completed. On the fourth month the audit process started again. At the most recent audit the service had scored 88%.

During this inspection we found improvements had recently been made to the way the provider checked the quality and safety of the service. However it was too early to assess whether this would be effective in driving sustained improvement.

Since the last inspection the provider had submitted notifications about incidents to Care Quality Commission (CQC) in line with legal requirements and in a timely way.

In one shared house we also found that people did not have immediate access to information about what they should expect from the service (called a service user guide). This information was kept in care folders in the staff sleep-in room which was not accessible by people. The registered manager agreed that this information should be kept in a way that people could access easily.

Also the minutes of house meetings held by people at the same shared house were immediately sent to the 'head office' in another area rather than kept at the house for people to refer to. Although we were told this was due to a storage issue, at least some months' copies could be kept at the house so that people could check back on previous agreements and actions during their next meeting.

Conversely, in another shared house, people were offered an information folder to keep in their bedrooms if

they wished (two people had chosen not to). The folder contained relevant information for them including a service user guide, minutes of house meetings and a summary of the previous CQC report. The registered manager agreed that people in all shared houses should be offered this information.

After the last inspection report was published the provider sent letters to people who used their service and their relatives which stated the issues identified were not typical of the Voyage organisation and how they wanted to improve this service in all areas. People and relatives were invited to discuss any concerns with the operations manager of the organisation. This indicated that the provider was open about the previous failings.

The provider had recently used satisfaction surveys to get a sense of people's and relatives current views of the service. The responses from people and relatives were positive. Feedback from relatives included comments such as, 'I think [family member] receives good care and support. He has more choice with meals now', 'I am satisfied with the top class care and support package', and 'care and support from the staff is excellent.'

After the last inspection a new manager was appointed and has been registered with the CQC. The registered manager was described by people as "absolutely champion" and "really great". Staff said she was "approachable" and "supportive". Every week the registered manager spent some time in each of the shared houses so people had a chance to speak with her. We saw people were pleased to see the registered manager during her visits and there was a good interaction between them.

People and staff told us they felt they could discuss any matters with the registered manager and the operations manager. One person commented, "I can talk to them. They come round and ask if everything is ok."

A staff member commented, "[The registered manager] is in and out all the time. She comes round and makes sure everyone is alright. [The operations manager] also pops in and always talks to all the people and staff." A healthcare professional told us, "The new manager is open, approachable and has a good rapport with the staff group. She's very hands-on."

Staff felt the organisation management of the service had improved since the last inspection. For example, one staff member commented, "It's definitely better run now than six months ago. We have staff meetings every month and we had a combined one with staff from [another house] in a community centre. We have the chance to give our views now and share ideas."

Staff spoke positively about changes at the service since the last inspection. One staff member said, "It's really changed for the best. I'm happy coming to work now as we've really gone forward. We've got a good management team now." Another staff member told us, "The management team are great, very friendly and helpful. They know what they're doing."