Voyage 1 Limited

Lavender House and Primrose Lodge

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This service offers accommodation across two separate houses which are located on the same site. They are registered to provide accommodation and personal care for up to 11 people with learning disabilities. This was the first inspection since changes in the registration of the provider. The inspection visit was unannounced and took place on 9 and 10 March 2016. At the time of our visit four people were living at Lavender House and five people were living at Primrose Lodge.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Support plans and risk assessments described the person's ability to manage aspects of their care for themselves and the assistance needed from the staff. However, some support guidance lacked a person centred approach. For example, daily routines did not state the person's preference for getting up and how staff were to deliver care in their preferred manner.

The people we spoke with said they felt safe living at the home. Some people named the staff while others said their relatives made them feel secure. Members of staff were aware of the safeguarding of vulnerable adults from abuse procedures. They knew the types of abuse and the expectations placed on them to report alleged abuse. The staff we asked were knowledgeable about whistleblowing procedures and their responsibility to report any form of abuse they may witness from other staff.

Risk management systems promoted people's safety and enabled people to take risk safely. Staff were aware of the actions they must take to minimise risk, including measures to support people in managing their care.

People said they had the attention they needed from the staff. Members of staff said where there were vacancies new staff were recruited to the vacant posts.

Medicine management systems were safe. Staff signed medication administration records (MAR) charts to show they had administered the medicines. Protocols were developed for administering "when required" medicines.

People said the staff knew how to care for them. The staff said the organisation provided essential training to ensure they had the skills needed to meet people's specific needs. The training matrix in place showed 92 percent of the 33 staff working at the home had attended essential training.

Staff benefited from one to one meetings with their line manager. They said at these meetings they discussed issues of concern and the people living at the service.

People's capacity to make specific decisions was assessed. Mental Capacity Act (MCA) assessments described the best interest decisions reached and who were the decision makers. Members of staff had a good understanding of the principles of the MCA 2005 and enabled people to make day to day decisions. These staff knew their role included helping people to develop skills and where the person had capacity, to assist them to become independent and leave the home without support from the staff.

People were supported with their ongoing health. People had annual health checks and regular check-ups with a dentist and optician. Referrals for specialists such as neurologists were made where people needed healthcare expertise input.

The people we spoke with said the staff were caring and by spending time with people the staff built relationships. One person said the staff showed them they mattered. Staff said support guidelines and relatives gave the additional information about people's preferences about their care.

We saw the staff support people to participate in community based activities. For example, hydrotherapy and shopping trips.

The staff said the team worked well together and the registered manager was approachable. Quality assurance systems were effective. Audits were in place to assess the standards and where shortfalls were found action plans were developed to meet the standards.

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.

Sufficient levels of staff were deployed to meet people's needs.

Safe systems of medicine management were in place. Staff signed medication administration charts to show they had administered the medicines. Protocols were developed for administering "when required" medicines.

The people we asked said they felt safe living at the service. Staff knew the procedures for the safeguarding of vulnerable adults from abuse.

Risks were assessed and staff showed a good understanding of the actions needed to minimise the risk to people.

Is the service effective?

Good

The service was effective.

People said they made some of their daily decisions. Best interest decisions were made for specific decisions where people lacked capacity to make them.

New staff said they received an induction to prepare them for their role and responsibilities. Staff said the training delivered increased their skills to meet people's changing needs. Members of staff benefited from one to one meetings with their line manager.

People's dietary requirements were catered for at the home.

Is the service caring?

Good

The service was caring.

People said the staff were caring. We observed good interaction between staff and people. Members of staff observed people's body language and were prompt to respond. For example, the staff offered refreshments when a person eye pointed towards drinks.

Members of staff were seen spending time with people in communal areas. We saw them discuss with people the tasks they were about to undertake.

Is the service responsive?

Good

Support plans and risk assessments were combined and reflected people's current needs which gave staff guidance on meeting people's needs. However, for some people their support plans lacked detail on how the staff were to deliver their care in a person centred manner.

People were helped to raise complaints. Complaints received were investigated and appropriate action taken to resolve them.

People attended college courses and participated in community activities

Is the service well-led?

Good

The service was well led.

Systems were in place to gather the views of people and their relatives. An action plan was developed to improve the service people received.

Members of staff worked well together to provide a person centred approach to meeting people's needs.

Quality assurance systems to monitor and assess the quality of care were in place and protected from unsafe care and treatment.

Lavender House and Primrose Lodge

Detailed findings

Background to this inspection

'We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 and 10 March 2016 and was unannounced.

The inspection was completed by one inspector. 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 improvements they plan to make.' We also reviewed information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with three people, three staff and the registered manager. 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 spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for two people. We also looked at records about the management of the service

Good

Is the service safe?

Our findings

The people we spoke with said they felt safe. They were able to describe how this was achieved for example, the staff and having adequate staffing levels made people feel secure. Members of staff showed a good understanding of safeguarding of adult's abuse procedures. They knew the types of abuse and the actions they must take. These staff were aware of the duty placed on them to report concerns of abuse by other staff. One member of staff said they would report to their line manager poor practice they may witness from other staff. They were confident that their concerns would be investigated.

Staff were aware of potential risks to people's health and wellbeing and the action needed to minimise the risks. They told us risk assessments and support guidance were in place for people at risk of malnutrition, for people with mobility needs and for people who experienced epilepsy. A member of staff said risk assessments for people who were underweight directed staff to monitor food and fluid intake and to serve enriched diets which helped the person to maintain a healthy weight. Another member of staff said staff checked on people who experienced seizures, there were audio monitors in their bedrooms and training in epilepsy was attended.

Risk assessments and support plans were combined. A traffic light system was used to identify the level of risk and support guidance was developed where further action was needed for people to be able to take risk safely and on how their care and treatment was to be delivered. For example, the risk assessment and support plan for percutaneous endoscopic gastrostomy (PEG) tube included the regimes for the care of the site, training that staff must undertake medicines to be administered and nutrition. PEG feeding is used when people are unable to swallow or to eat enough. The mobility risk assessment and support guidance for another person described when support from staff was needed, the number of staff required, the equipment used and the level of risk.

People said there was enough staff to help them. One person said "normally there is enough staff." Another person said "the staff care" for them. A member of staff said "we are really good, we cover shifts. We make sure all the shifts are covered."

The staffing structure was one registered manager working across both houses with a deputy assigned to each house. The staffing rota was arranged to cover shifts in both houses. Three staff were on duty in Lavender House and four staff in Primrose Lodge. A member of staff said in Primrose Lodge there were more staff to support people with moving and handling and personal care needs.

Safe systems of medicine management in place were safe. Medication administration files had a photograph of the person to ensure their identification and included information on the person's preference for taking their medicine. Medication administration records were signed by the staff to show the medicines administered. Protocols for when required medicines were in place which detailed the purpose, administration directions and the maximum dose to be taken in 24 hours. Visits from the pharmacist were annual to check medicine systems and at the most recent visit all standards checked were met. A member of staff said medicine systems were checked twice daily when shift changes occurred. They said this was to

ensure safe medicine systems.

Good

Is the service effective?

Our findings

People received care and treatment from staff that were skilled and well supported. A member of staff said they were registered onto the care certificate and their induction included shadowing more experienced staff for two weeks.

Training that increased staff's skills and increased their knowledge of people's needs was provided. A member of staff said online training was provided. Staff said training to meet people's specialist needs was provided by the organisation. For example, epilepsy and moving and handling. The analysis of training attended showed 92 percent of staff had attended the training the provider had set for the staff to attend which included infection control, fire safety and moving and handling.

One to one meetings with a line manager were regular. A member of staff said their one to one meetings were with their line manager and were eight weekly or six per year. They said at the one to one meetings they discussed areas of improvement, training needs and issues of concerns. Another member of staff said at their one to one meetings they discussed issues of concern and the people at the service.

People told us they made some daily decisions. One person said they made decisions about menu choices, activities, what they wore and about their routine. Another person gave us an example on how staff helped them make informed decisions. They said "I don't like swimming. The staff say it's good for you but if you don't have to if you don't want to".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The people living at Lavender House and Primrose Lodge were subject to continuous supervision. Therefore appropriate DoLS authorisations were in place.

Members of staff were knowledgeable about principles of the Mental Capacity Act 2005. Staff helped people make daily decisions. One member of staff said people made decisions about what to wear and activities. They said "we guide them" for example, we suggest a "sparkly" outfit for parties. It was also explained that pictures of food items were used to help people understand the menu choices available.

Some people used alternative methods of communication such as body language and vocal sounds to express their decisions and wishes. The communication care plans in place described the person's method of communication which included how staff were to interpret behaviours and vocal sounds and the most appropriate response. For example, one person used a high pitched voice when they were hungry and staff were to offer snacks. For another person staff were instructed to avoid "jargon" and to show the choices available.

People's capacity to make decisions was assessed and where people lacked capacity best interest decisions were made for specific decisions. For example, flu vaccines, health screening and administration of medicines. Relatives and healthcare professionals were consulted to ensure the best decisions for the person were made.

Staff said there were people whose behaviour at times became challenging. A member of staff said they helped people to become calm and "praise" was given when they regained control of their behaviour. Another member of staff said some people refused personal care and once staff explained to the person the consequences of their decision they would agree to staff assistance.

Behaviour management support plans described the behaviour staff found difficult to manage. Support plans described the triggers that the behaviour was escalating and when the person had become calm. For example, step by step guidance was in place for staff to reduce one person's anxiety during community based activities. Staff were directed to explain the task and included was the number of staff needed to undertake community activity and how to interpret their agreement to participate in the activity. One person said "I don't like it when I am in a mood. The staff don't like it and I don't like it." Another person said "the staff say go to your room and they make sure I am safe [in the bedroom]". People told us after challenging incidents the staff discussed the incidents with them.

People's dietary requirements were met. The menus were devised from people's suggestions. We saw people had a choice of cereals and toast for breakfast, lunch was a light meal and the main meal was served in the evening. A good range of fresh, frozen and tinned foods were available at the home. The day's menus were on display in the kitchen.

People were supported with their ongoing health care needs. Health Action Plans were developed from the GP's annual health check-up and included the input from other healthcare professionals such as dentists and dieticians. The dates of appointments and reports of their visits formed part of the health action plan. Support plans were then developed to ensure people's healthcare needs were met for example pain management. Hospital passports detailed personal and essential information to assist medical staff in the event of an admission to hospital.

Good

Is the service caring?

Our findings

People said the staff were caring. One person said "the staff at times make me feel that I matter." Another person said the staff always used their preferred first name. One page profiles gave information on what was important to the person for example, maintaining contact with family and how the staff were to support them with the things that were important to them.

A member of staff said "people's care is good. They have a choice." They said the staff had a good understanding of people's preferences and there was "banter". Another member of staff said there were conversations with people about their likes and the support plans gave them guidance on how people wanted their care delivered.

We saw good interaction from staff with people. The staff observed people's body language and were prompt to respond when required. For example one person was eye pointing for refreshments and staff were prompt to offer a choice of drinks. We saw staff sit with people in communal areas and helped people with the activity they were undertaking. During the inspection we saw people going out with staff to participate in community activities.

The environment was purpose built for people using a wheelchair which allowed people to move around the home with ease. Within the site there were two separate houses each offering accommodation for people with mobility impairments. There was level access into both homes with shared space on the ground floor and bedrooms on the ground and first floor which can be accessed by the lift.

People said they were asked for their views about the service. One person said "you get pampered here".

Records in place gave staff guidance on how people liked their care and treatment to be provided. A typical day support plan described the person's routine, the aspects of care this person was able to manage for themselves and how staff were to assist them with this daily routine. For some people the plans were written in the staff's perception of past experience and from observations of the person's preferences. Family relationships, leisure activities and any authorised restrictions formed part of the "typical day" support plan.

The staff respected people's rights. People said the staff respected them because their visits from friends and family took place in bedrooms for additional privacy. Another person said the staff knocked on their bedroom doors before they entered. The staff we spoke with gave us examples on to demonstrate that people's rights were respected. One member of staff said they respected people's privacy and dignity when they made sure personal care was done in bedrooms with doors and curtains closed. Another member of staff said they always asked to enter bedrooms.

Good

Is the service responsive?

Our findings

People said their care was delivered in their preferred manner and they were aware support plans to meet their needs were developed by the staff. One person said "they write what you say." Staff said support plans were developed by the senior staff and the registered manager. They said there was an expectation they read support plans and sign documentation to indicate they had read and understood the plans. A member of staff said keyworker [member of staff assigned to specific people] meetings took place to discuss support plans. They said support plans were reviewed annually or biannually with the care manager. Internal reviews with the person and families were held annually.

The typical day plans described the aspects of care the person was able to manage without support and the assistance needed from the staff. The person's preferred routine and leisure activities were included in the support plan. However, some support guidance lacked a person centred approach. For example, daily routines did not say the person's preference for getting up and how staff were to deliver care in their preferred manner. We drew the range of the support plans in place to the registered manager.

Support plans with associated risk assessments were in place for assessed needs. We looked at support plans for people at risk of malnutrition, challenging behaviour and for people that experienced epileptic seizures and who required percutaneous endoscopic gastrostomy (PEG) tube. For example, the support plan for PEG tubes listed the medicines prescribed, how staff were to care for the PEG tube, regimes which included food and fluids to be administered through the tube.

The support plan for one person at risk of malnutrition instructed staff to provide high calorie diets and their weight was to be monitored twice weekly. The input from healthcare professionals which included assessing people who were losing weight by the use the malnutrition universal screening tool (MUST) score was included in the support plan.

Epilepsy support guidance instructed staff to maintain a record of seizures, gave staff guidance on the types of seizures the person may experience and when to contact emergency services.

Handovers were used to inform staff on people's current needs. A member of staff said there were handovers at the beginning of each shift. They said during the handovers the shift leader planned the shift which included assigning staff to support people on community activities. Another member of staff said there was a shift plan which they followed.

People participated in community based activities such as hydrotherapy, swimming, and attending college courses. One person said they attended college. Another person said they went to coffee shops and enjoyed watching action sci-fi films. On the day of the inspection activities were organised and we saw people going out with staff. For example, people went swimming.

People knew who to approach with their concerns and complaints. One person said the staff had helped them raise a complaint about a service they received.

The registered manager had received two complaints from members of the public since the last inspection. These complaints were resolved by the manager.

Good

Is the service well-led?

Our findings

The views of people, their relatives and from the staff were gathered annually. The registered manager said the annual service reviews (ASR) were pictorial and some people were able to complete the forms without keyworker support. There was an analysis of responses and 11 people, 22 staff and five relatives responded. An action plan was developed based on feedback received which included more activities. The staff's feedback was based on having better management presence in both houses and more staff meetings.

Staff said the team worked well together. A member of staff said "we are here for the guys [people]. We look after them." Another member of staff said the team was brilliant.

Team meetings were held to discuss issues and pass information about changes in procedures and policy. At the team meeting held in December 2015 the staff discussed the arrangements to celebrate Christmas.

The registered manager said the style of management depended on the situation. They said the management style was mainly open and friendly as well as a fair and approachable but if necessary a directive approach was used. The staff said the manager was approachable. A member of staff said the registered manager had a "good rapport with people. We have a laugh but we know when it's serious. The staff team respect him."

Recruitment of staff was a key challenge to the registered manager. The registered manager said there had been staff resignations but some had wanted to return. They said the staff had a good understanding of capacity and decision making which meant people had "greater choices."

Staff valued the people they cared for and were motivated to provide people with high quality care. The registered manager said a person centred approach was a value of the organisation. They said to ensure people were at the centre of their care, suitable staff were recruited and provided with the training needed to provide good quality care. Staff said there was a person centred approach used. A member of staff said people participated in a wide range of activities.

Quality assurance arrangements in place ensured people's safety and well-being. The registered manager conducted annual reviews of the service known as annual service reviews (ASR). The ASR for January to March identified shortfalls in the number of Deprivation of Liberty Safeguards (DoLS) applications submitted for authorisation and documented life stories and updated health action plans for people living at the service. Action plans were developed to meet the shortfalls. The member of staff assigned to achieve the action plan signed the record when the task was complete and the regional manager countersigned the plan to confirm the standard was met.

The registered manager said internal meetings with seniors were organised to discuss patterns and trends. They said people's health such as the number of seizures experienced, challenging behaviour incidents and supporting people to develop skills was discussed.