

# Voyage 1 Limited

# London Road

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

### About the service

London Road is a residential care home specialising in care for people with traumatic brain injury. This care home provides care to up to 10 people of varying ages in one adapted building. At the time of our inspection, the service was providing personal care to eight people.

### People's experience of using this service and what we found

We received mixed feedback from staff, relatives and professionals about management and oversight of the service. The provider told us about ongoing issues with recruiting senior staff to support the registered manager to make the improvements needed at the service. We found shortfalls identified by the provider had not been always been addressed in a timely way to ensure the quality and safety of the service remained good. This meant people had not always been protected from the risk of harm. At the time of the inspection, the provider had committed resources to making the improvements needed. Work was progressing at pace to ensure people's needs and risks were assessed and managed safely.

People were positive about the service they received. Their comments included, "I love it" and "It is a good place to live, I am quite happy". People told us they felt safe and respected and they had enough to eat and drink. People described staff as "kind", "polite and respectful". One person said they valued being able to have as much independence as possible, staff only supported them with things they wanted support with.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However, we found the policies and systems in place had not always been followed to ensure legal requirements relating to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards were met.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection

The last rating for this service was Good. (Published 4 April 2020).

### Why we inspected

We received concerns in relation to the management of people's money, neglect of people's needs, poor staff culture and cleanliness at the service. As a result, we undertook a focused inspection to review the key questions of Safe and Well-Led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We also looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that

the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the Safe and Well-Led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

#### Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, safeguarding and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

#### Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

**Requires Improvement** ●

# London Road

## Detailed findings

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services. We also asked the provider about any staffing pressures the service was experiencing and whether this was having an impact on the service.

#### Inspection team

The inspection was completed by one inspector.

#### Service and service type

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At time of the inspection the registered manager was no longer employed by the provider but was still registered with CQC.

#### Notice of inspection

This inspection was unannounced.

Inspection activity started 22 February 2022 and ended on 7 March 2022. We visited the service on 23 and 24 February 2022.

### What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

### During the inspection

We spoke with seven people who used the service and one person's relative about their experience of the care provided. We spoke with 15 members of staff including the regional operations manager, regional support manager, a member of the provider's quality team, two managers from another of the provider's services, deputy manager, one senior and eight support workers. We spoke with one visiting health care professional.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at eight staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including daily, weekly and monthly checks and some policies and procedures were reviewed.

### After the inspection

We spoke with six people's relatives about their experience of the care provided. We received feedback from three professionals who work with the service. We sought further evidence from the provider to enable us to review their oversight of the service and action taken by them in relation to improvements needed. We attended a local authority large scale Safeguarding enquiry meeting. We sought clarification from the provider to validate evidence found. We looked at training data and quality assurance records.



# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- In 2021, two people developed pressure ulcers which healed after support from district nurses was requested by staff. Despite these injuries and the complexity of people's support needs, people's risk of developing pressure ulcers had not been reviewed regularly to ensure the risk to them continued to be managed safely.
- People's risk assessments related to malnutrition and choking were either not in place or had not been reviewed, despite relevant changes in people's physical needs and risks.
- The provider had not ensured staff had the competence and skills to carry out their roles safely. Staff training, supervision and competency checks had not been maintained in line with the provider's requirements. Records showed three (out of 21) staff's competency in giving medicines had been checked in the year before our inspection and only three staff could administer rescue medicines for seizures. Staff told us the latter had impacted people's opportunities to do activities outside of the service.

The provider had failed to assess the risks to people's health and safety, to do all that was reasonably practicable to manage risks and to ensure staff had the competence and skills to provide care safely. This was a breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities).

The provider had identified that people's risk assessments and support plans had not been reviewed and updated since 2019 and 2020 and was taking action to address this. We found the impact on people was limited as staff knew people well and sought advice from health care professionals when they identified new issues people were experiencing, for example, in relation to reddened pressure areas and new choking risks.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was not always working within the principles of the MCA. MCA assessments had not always been carried out where people's capacity to consent to specific aspects of their care was in question. Appropriate legal authorisation had not been sought to deprive one person of their liberty.

The provider had deprived a person of their liberty for the purpose of receiving care without lawful authority. This was a breach of regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities).

Following our inspection, the provider told us they had taken action to seek legal authorisation to deprive this person of their liberty.

#### Systems and processes to safeguard people from the risk of abuse

- People spoke positively about the service and their relationships with staff and were confident any safety concerns would be addressed with immediate effect.
- The provider was strengthening their oversight of systems to protect people from financial abuse. People's financial risk assessments were updated during the inspection. Time was needed for this oversight to become established under the new management to reduce the likelihood of financial abuse occurring.
- Staff recognised incidents and reported them appropriately. They knew how to raise any safeguarding concerns and were committed to keeping people safe.
- Staff told us managers took their concerns seriously. They were confident swift action would be taken with other agencies to protect people from abuse if needed.

#### Preventing and controlling infection

- We were somewhat assured the provider was preventing visitors from catching and spreading infections. Staff did not always carry out necessary checks before they allowed visitors to enter the service. Managers made improvements during the inspection; however, the process was not embedded.
- We were somewhat assured the provider was using PPE effectively and safely. We observed the deputy manager advising staff when PPE was used incorrectly. We saw two staff not wearing facemasks appropriately while in communal areas during the inspection.
- We were somewhat assured the provider was promoting safety through the layout and hygiene practices of the premises. Laundry was piled up and the backlog created a potential source of infection. New machines had been ordered to assist staff to deal with laundry promptly.

We have signposted the provider to resources to develop their approach.

- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

#### Visiting in care homes

- Relatives visiting was taking place in line with government guidance.

#### Staffing and recruitment

- The provider was struggling to recruit a senior staff team and we found this had delayed action being taken to address shortfalls identified by the provider.
- Appropriate care staff levels were in place to meet the needs of people in the service.



- Staff told us they felt there were enough staff to meet people's needs.
- People told us that they did not have to wait for support from staff. We observed staff assisting people and delivering care in a timely manner.
- Safe recruitment practices ensured staff were suitable to work with people using the service.

#### Using medicines safely

- The provider had carried out a medicines audit prior to our inspection. We saw improvements had been made or were underway. However, we found one medicine had not been stored safely. A risk assessment was carried out to manage risk until a medicines fridge was available.
- Records showed people had received their medicines as prescribed. People's medicines were reviewed regularly by health care professionals to ensure they remained appropriate.
- People were supported by staff to make their own decisions about medicines wherever possible.
- People's medicines were regularly reviewed to monitor the effects on their health and wellbeing.

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Continuous learning and improving care

- We found three breaches of regulation. These failings demonstrated the systems in place had failed to identify or act upon risks in order to provide a safe service to people. This meant people would have continued to be exposed to the risk of harm.
- The provider's systems to monitor and improve the safety and quality of the service had not always been operated effectively. The registered manager had not always carried out audits and stored information in-line with the provider's requirements. Consequently, not all relevant information was available to the provider to support effective oversight.
- A provider quality audit in August 2021 showed a significant drop in performance from their previous quality audit in 2019. The 2021 audit identified shortfalls in key areas including monitoring people's health and well-being, staff training and meeting requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). In-line with the provider's quality improvement process, this should have triggered close monitoring of improvements against an action plan. However, the audit process was not completed and managers did not have access to this audit and draft action plan at the time of our inspection. We found the shortfalls identified in August 2021 were still present.
- An audit carried out by the regional manager in December 2021 failed to reflect the extent of the issues/shortfalls at the service. An action plan with dates for completion was not available in the service during the inspection. When shared with us after the inspection, we saw completion dates for improvement actions had been missed.
- The provider described ongoing difficulty in recruiting and/or allocation of staff to support the registered manager in making required improvements.

All of the above demonstrates the failure to operate effective systems to monitor and improve the service which was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider carried out a quality audit on 14 and 15 February 2022, prior to our inspection. The service scored below expected standards at this audit (in draft at the time of the inspection). We saw the provider had committed extensive resources to improving the service and progress was being made at pace at the time of our inspection.

- A new registered manager had been appointed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Before our inspection, the provider had identified a need for improvement in the staff culture to ensure staff worked as expected. The provider had approved an 18 month staff support and training programme as one of several measures to address this.
- Staff told us about challenges they had experienced during the pandemic, including the loss of two people, which had impacted everyone at the service.
- We saw the provider had been open with staff about concerns raised about the service. Staff spoke openly with us providing context and balanced feedback to our questions.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Representatives from the provider were open and candid and were motivated to make improvements.
- The provider had appropriately notified agencies of all incidents.
- The provider was open and honest with people and informed relatives when accidents and incidents had occurred.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People told us they were involved in decisions that affected them. We saw meetings had been held to get people's feedback about the service.
- The service had worked with others in their local community to try to raise the profile of the service to aid recruitment of staff.
- Staff told us they felt more supported in the three months before the inspection and one told us they felt their feedback was now being responded to.

Working in partnership with others

- Opportunities for partnership working had been reduced during COVID-19 restrictions but good working relationships continued with local primary care teams such as GP's, district nurses and therapists. All we spoke with were positive about their experience of working with the registered manager and staff team. One health care professional said, "Staff have supported assessment's really appropriately and helpfully. Manager has been responsive."

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>There was a failure to assess the risks to the health and safety of service users and do all that was reasonably practicable to mitigate any such risks. 12(2)(a)(b)</p> <p>There was a failure to ensure staff had the skills and competence to provide care safely. 12(2)(c)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>There was a failure to ensure service users were not deprived of their liberty for the purpose of receiving care or treatment without lawful authority. 13(5)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>There was a failure to operate effective quality assurance systems to ensure compliance with governance requirements. 17(1)</p> <p>There was a failure to monitor and improve the quality and safety of the service provided and a failure to monitor and mitigate risks to the health, safety and welfare of people using the service. 17(2)(a)(b)</p>

