Voyage 1 Limited

Walker 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

Located in a residential area and close to local community facilities, Walker Lodge is registered to provide specialist care for up to eight people with an acquired brain injury. The home also provides transitional rehabilitation for people who want to move into the community in supported tenancies. The home is a purpose built facility with accommodation located over two floors. A passenger lift is available for access between the floors and the building has been designed to ensure full access for wheelchair users. There are a number of car parking spaces adjacent to the home. Eight people were living at the home at the time of our inspection.

At the last inspection, the service was rated Good. At this inspection, the service remained Good.

Our observations showed there were plenty of staff around the home to help people with their day to day needs. There were systems and processes in place to ensure that people who lived at the home were safeguarded from abuse. This included training for staff which highlighted the different types of abuse and how to raise concerns within the infrastructure of the home. Staff we spoke with confirmed they knew how to raise concerns. Medication was well manager and only administered by staff who had the correct training to enable them to do this. There was a process for analysing incidents, accidents and general near misses to determine what could be improved within the service provision. There was personal protective equipment (PPE) available within the home, and staff wore appropriate protective clothing when competing person care tasks or serving meals. Risk assessments were detailed and specific, and contained a good descriptive account for staff to follow to enable them to minimise the risk of harm occurring to people who lived at the home, these were specifically tailored to support people with brain injuries.

Menus were varied, people told us they had input into the menus and were supported to make some smaller meals themselves. Staff were suitably trained, specifically to support people with acquired brain injury. Additionally, staff were regularly supervised and appraised to enable them to provide good care to people who lived at the home. Staff told us they were well supported through the induction process, regular supervision and appraisal. Staff said they were up-to-date with the training they were required by the organisation to undertake for the job and training records confirmed this. Training was a mixture of e learning and face to face courses. Consent was also sought and clearly documented in line with legislation and guidance. The service was operating in accordance with the principles of the Mental Capacity Act 2005, and best interest processes were documented for people who required support with decision making. People had access to other medical professionals who often visited the home and were involved with people from a clinical point of view. The service was able to demonstrate good relationships with external healthcare professionals and case managers. All bedrooms were spacious and home was adapted to encourage and support peoples rehabilitation needs.

People were included in their care and support as much as possible, and there was evidence to suggest that person centred plans had been discussed with people and their relatives People were treated as individuals, and their choices and preferences were respected by staff. This was evident throughout our observations

around the home, and the information recorded in people's care plans. Staff also described how the ensured they protected people's dignity when providing personal care. Staff spoke with people and about them with warmth and sensitivity, and told us they enjoyed helping people to rehabilitate.

There was a process to listen to and respond to complaints which was clearly displayed for people in the home and any visitors if they wished to raise a formal complaint. Staff were trained to support people who were on an end of life pathway, and we saw that training was taking place for this and on going. n addition, people were supported to cope with death and grieving, and had been supported to access funeral plans if they required. We saw examples throughout our inspection which showed that the organisation was operating in a way which was person centred. Person centred means support based on the individual needs and preferences of the person and not to suit the organisation. In addition, information was made available and presented to people in which supported their understanding.

The vision of the organisation was person centred and the staff we spoke with told us they liked working for the company. Quality assurance system were robust and sampled a wide range of service provision. We saw that were issues had been identified they had been subject to an action plan which was reviewed regularly and updated with the latest action points. The service worked in partnership with the local community, and hosted various events in schools and colleges.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Walker 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a comprehensive inspection.

This inspection took place on 19 December 2017 and was unannounced.

The inspection team consisted of an adult social care inspector.

Before our inspection visit, we reviewed the information we held about Walker Lodge. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people who used the service. We viewed the provider information return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We spoke with two people who used the service, four relatives and 12 staff. We also spoke to the registered manager of the home, and the deputy manager. We spoke with three visiting healthcare professionals. We looked at the care plans for three people and the recruitment files for two staff. We also looked at other documentation associated to the running of the service.

Good

Is the service safe?

Our findings

We asked people if they felt safe at the home. Comments included, "Yes, it's great" and "No reason not to." We spoke to relatives of people who lived at the home, and they said, "I feel really reassured knowing that [family member] is there", "They are remarkable, I am very impressed indeed with the home." Professionals we spoke with also confirmed that they felt the home was safe.

We saw that the recruitment and selection of staff remained safe, and DBS checks continued to be completed for all staff who worked at the home. Our discussions with staff indicated that they were able to explain the course of action that they would take if they felt someone was being harmed or abused, this was reflected in the organisation's safeguarding policy. Staff spoken with also said they would whistle blow to external organisations such as the Care Quality Commission (CQC) if they felt they needed to. There was information made available around the home for people to access if they felt needed raise concerns, and this was also documented in the 'service user guide.'

Risk assessments were completed in a range of different areas and were all specifically tailored to the person's needs. For example, we saw that one person required support with their personal care, however, some of the task they could complete themselves. The task required them to make use moving and handling equipment to support safe transfers, and we saw this was safely risk assessed including informative instruction for the staff on how to support the person in a safe way, such as where to stand and what verbal prompts to use.

We discussed previous substantiated safeguarding's with the registered manager, as we wanted to be sure that recommendations had been implemented and lessons had been learnt from shortfalls in service provision. The registered manager discussed a particular incident, which had led to additional staff training, and a risk assessment review for the person involved.

We spent time with the senior member of staff and checked people's medication. Medication was well managed. We viewed some of the MAR (Medication Administration Records) charts for people and saw that they were filled out correctly. We spot checked the medications and saw that the balances of the stock corresponded to what was recorded on the MAR chart. Medication was only administered by senior staff who had undergone specific training which included annual assessments of their competency. Medication was stored in a temperature controlled room. The temperature of this room was recorded twice daily to ensure temperatures were within the correct range. Storing medications at inappropriate temperatures could affect their ability to work.

We checked the procedure for controlled drugs, (CD's). These are medications with additional safeguards placed on them. We saw the procedure for administered controlled drugs was in line with the provider's policy and national guidance. There were no controlled drugs at the home at the time of our inspection.

The home was clean and odour free and there were provision for hand sanitizer on the walls. Sluice rooms were kept locked when not in use. Staff wore personal protective equipment (PPE) when supporting people

with personal care.

Good

Is the service effective?

Our findings

People who lived at the home, relatives, and healthcare professionals all told us that they felt the staff were exceptionally skilled. One relative said, "The staff all know what they're doing, it's nice to see." A healthcare professional was also complementary about the skill set of the staff.

Staff spoken with discussed their training schedule and induction processes with us. We saw that all staff were required to complete an induction which was aligned to the principles of the Care Certificate, as well as the induction provided by Voyage. Staff said their training was good, and they felt well informed and skilled. One staff member said, "It is definitely good training, and its specific to the people we support." We saw training took place in topic areas such a manual handling, first aid, Mental Capacity and DoLS, and safeguarding. Additional training was completed by staff which focussed on how to specifically support someone with an acquired brain injury, as well other needs people had such as epilepsy and diabetes awareness. Staff confirmed and records showed that staff underwent regular formal supervision and had an annual appraisal. Records showed that supervisions took place every six – eight weeks. Staff said they could request supervision sooner if needed.

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

The registered manager demonstrated an understanding of the MCA and associated DoLS procedures. Discussion with the registered manager confirmed they understood the need for DoLS to be in place and when an application should be made and how to submit one. We saw that DoLS were applied for following a specific two-stage mental capacity assessment process which clearly documented the reasoning behind the DoLS needing to be in place. Consent was also gained in accordance with people's best interests, and we saw evidence of best interest meetings taking place regarding certain aspects of people's care. The person was involved as much as possible in these processes.

People told us they were supported to attend appointments. We saw that other medical professionals were involved in people's well-being. Their contact details were part of people's care plans if the staff ever needed to contact someone for assistance and support.

People were supported to eat if this was required. Additionally, people who required specialist support with eating and drink due to guidance in place by the speech and language team (SALT) had support plans and risk assessments in place around this. These plans included the sitting position the person should adopt to prevent them from choking. Other people were supported to cook their own meals and had access to an adapted kitchen. This was to help people to learn skills which would help them when they moved into the community.

Good

Is the service caring?

Our findings

We received the following comments with regards to the caring nature of the staff. "They are great", "Lovely, no issues at all", "They are just amazing" and "I would say the staff were fantastic."

We observed a vast amount of positive interaction on the day of our inspection. One of the staff members had arranged for a carol concert to take place in the home on the day of our inspection. All of the staff were encouraging people to become involved, and the whole event was very engaging.

Language used in support plans was respectful, and we saw they were written with the dignity and respect of the person at the forefront of the support plan. There was phrases such as, "I don't want you do everything for me, please encourage me." Also, our discussions with staff indicated they knew how to uphold dignity and champion respect when supporting people. Comments we received from staff included, "Speak to people with respect, and don't finish sentences for them." Staff were able to describe how some people can become distressed due to their cognitive abilities, and explained how this could be frustrating for people. One staff member said, "It is important to be patient with people."

We observed one staff member supporting a person who was becoming agitated. We saw they supported them appropriately in accordance with their support plan needs.

There was advocacy information available for people who wished to make use of this facility. This information was displayed in communal areas where it was easily accessible for people. We saw that there was a variety of information available in formats which people could understand. This ranged from communication using just words, or just pictures and no words. This supported some people's understanding and allowed them to make choices independently.

Support plans were either signed by the person themselves, if they had the capacity to do so, or via a best interest process which involved their family members. Support plans had been signed and dated when they had been subject to review.

Our conversations with people indicated that visitors were free to come to the home and see their family member when they wanted, and there was space in the home for people to visit in comfort either in the person's room, or in the communal areas.

Good

Is the service responsive?

Our findings

We received positive comments regarding the support people received which clearly indicated that people were being supported a way which was meaningful for them. Comments from family members included, "I know they [staff] will encourage [person] to do what they can themselves." Healthcare professionals told us that they thought the support was 'excellent' and one family said the support was 'tremendous' and really suited to their relative's needs.

We saw that support plans contained Goal Attainment Scaling paperwork, (GAS) which focused on what goals the person wanted to achieve and the support that they needed to reach their goals. This was specifically linked to their rehabilitation plan. For example we saw that one person was being supported by their key worker to make a 'cookbook' in a format they understood, complete with recipes that they had made in Walker Lodge and could make once they lived in the community with minimum support in place.

Another person received specific support to maintain relationships with their family members, specifically younger members of the family. For example, we saw a document which was designed specifically for one person's younger family member which was a question and answer book. The younger person had used the book to ask questions about their relative's acquired brain injury. The staff responded in the book and shared this with the family member.

Another person had been supported with their rehabilitation and now did not require the use of their walking aide. We spoke with this person and they told us how much the staff had supported them to set themselves personal goals, which included learning to walk independently with the help of the Occupational Therapist (OT). This showed that the organisation was ensuing they worked with other healthcare professionals so people received support which was responsive to their needs. This person was also hoping to move to a new home very shortly, and was looking forward to this.

We saw that people had access to a kitchen and were regularly encouraged by staff to make their own meals and snacks. This was encouraged daily for each person who wanted to live independently in the community. There was a therapies coordinator in place whose role was to work independently developing activities for people to help them plan their day.

We saw that there had been three complaints raised since the last inspection. We checked these complaints and saw that they had all been responded to in line with the organisations complaints process. People had information made available to them informing them how to raise a complaint if they felt they needed to.

Staff had undergone training to enable them to support people at the end stages of their life. In addition, we saw that staff supported people to cope with the grief and loss of family members. We saw that funeral plans had been arranged with some people, as this was their choice, and details of this were kept securely with a detailed plan of the person's wishes.

Good

Is the service well-led?

Our findings

There was registered manager 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.

The culture of the home was friendly and relaxed, and people commented positively about the service, some comments received included, "[Registered manager's name] is just amazing, she is so knowledgeable about people." And "We are very impressed with the level of leadership and skill the registered manager has."

Staff spoken with told us they enjoyed working at the home, and would not hesitate in approaching the registered manager if they had any concerns. Comments included, "[Registered manager's name] is just great, really approachable." Also, "Yes it is great working here, we work well together as part of a team."

The staff were able to fully demonstrate that they understood the culture and ethos of the home. Friendly, person focused, with a huge emphasis on supporting people to do as much for themselves as possible.

We saw how the registered manager engaged with the wider local community, such as schools and colleges, and often went to the local schools to teach an awareness of acquired brain injury. The service often had events at the home and tried to include the wider community to attend. The registered manager told us this was because they wanted people to meet and form relationships with the people living in Walker Lodge, due to them eventually becoming integrated into the community. This had worked well, and one person told us that they regularly accessed the community, and had made friends with people. They said, "Everyone knows me."

Quality assurance procedures were clear. We looked at the last quality assurance audit which took place at the home and saw that some improvements had been highlighted, these actions were clearly documented on a working action plan, which had clear timescales for completion and ownership of different tasks. Once the actions had been completed, they were signed off by the registered manager.

Team meetings took place every other month. We were able to view minutes of these meetings. A team meeting took place on the day of our inspection.

There were audits for the safety of the building, finances, care plans, medication and more regular checks like the water temperatures. We saw any recommendations were being followed up with a plan of action by the registered manager.

There were polices and procedure in place for staff to follow, the staff were aware of these and their roles with regards to these polices.

The registered manager was aware of their roles and responsibilities and had reported all notifiable incidents to the Care Quality Commission as required. The ratings from the last inspection were clearly displayed in the main part of the building. The rating for the last comprehensive inspection was also displayed on the provider's webpage