Voyage 1 Limited

Woodside

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
Woodside is a residential care home registered to provide personal care for up to 11 people with a learning disability and/or autism. The property is a large detached house with three adjoining self-contained flats. It provides long and short-term residential care. At the time we visited, nine people lived there, and one person was staying for a short respite stay.

People's experience of using this service and what we found
People, relatives and professionals all gave us positive feedback about the service. People were relaxed and felt safe with the staff who supported them. Relatives said; " [Name of person] is happy there," and "Staff look after their safety and well-being." A professional said: "Staff are very friendly, welcoming and knowledgeable" about people."

We were not fully assured the service were following safe infection prevention and control procedures to keep people safe with regard to the current COVID 19 pandemic. This was because the provider was not doing all that was reasonable possible to prevent cross infection when people were admitted to the service for respite stays.

People admitted to Woodside for a period of respite were not being COVID tested prior to their admission, so their COVID 19 status was not known until two or more days after admission. Also, they were not expected to self-isolate for 14 days after admission. This was not in accordance with government nor Voyage guidance on testing and self- isolation. Although we found no evidence that people had been harmed, these respite admission arrangements increased the risk of the spread of COVID 19 for the people living at Woodside and the staff caring for them.

We raised our concerns about these arrangements and explained the reasons why. In response, the provider made a voluntary undertaking to stop admissions for respite stays, whilst they reviewed their infection prevention and control arrangements.

People had been supported to understand the risks associated with the COVID 19 pandemic in ways that were meaningful to them. Staff used art and crafts to help people understand about 'germs' and reminded people to socially distance. Also, about the importance of keeping rooms well ventilated.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
• Model of care and setting maximises people's choice, control and Independence. Staff spoke about the ways they promoted people to be more independent. Three people lived in self- contained flats with staff support. One person enjoyed helping in the kitchen by washing up and emptying the dishwasher. People were encouraged to keep active by regular walks in the local area. Favourite community activities were being arranged in house during lockdown. For example, a weekly disco.

Right care:
• Care was person-centred and promotes people's dignity, privacy and human rights. People received personalised care by staff who knew them well. People were supported to keep in touch with family and friends by telephone and through video calls.

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff ensured people using services led confident, inclusive and empowered lives. The provider was committed to enabling people they supported to live fulfilling, meaningful and happy lives. People's care records focused on people's strengths, abilities and individual goals.

People's risk assessments and care plans provided staff with detailed, up to date information about how to safely care for each person. People received their prescribed medicines safely and on time.

Staff understood the signs of abuse and felt confident any safeguarding concerns reported were listened and responded to. Robust recruitment systems made sure suitable staff were employed.

Staff felt well supported by the registered manager and their deputy. They reported good team working and staff morale. Staff comments included; "Good teamwork," "We are one big happy family" and "Staff are lovely, they have a real passion for what they are doing." Effective quality monitoring systems were used effectively to oversee the quality of the service and make continuous improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good. (Report published March 2018).

Why we inspected
The inspection was prompted by anonymous concerns about leadership. Also, about differing COVID 19 arrangements for people who lived at Woodside compared with people admitted for respite stays. A decision was made for us to inspect and examine those risks. We reviewed the information we held about the service.

No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires improvement. This is based on the findings at 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. The provider has taken immediate action to mitigate these risks. You can see

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Woodside on our website at www.cqc.org.uk.

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Woodside

Detailed findings

Background to this inspection

The inspection
We carried out this focused 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.

Inspection team
One inspector visited Woodside.

Service and service type
Woodside is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service has a registered manager. Registered managers and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We announced the inspection before we visited to take account of the safety of people, staff and the inspector with reference to the COVID 19 pandemic. We visited the service on 28 January 2021.

What we did before the inspection
We reviewed information we had received from the provider and others since the last inspection. We sent the registered manager an inspection poster with our contact details to circulate to staff to seek their feedback. We requested information about infection control policies and procedures and the ongoing monitoring of safety and quality.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us 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 used all this information to plan our inspection.

During the inspection
We met nine people at Woodside. Four people were able to communicate briefly with us about their experiences of living at Woodside. We spoke by telephone with three relatives to get their feedback about quality of care provided. We observed staff interaction with other people in communal areas of the home. We looked at three people's care plans and at two medicine records.

We spoke with the registered manager and with six members of care staff and received written feedback from one member of staff. We arranged a virtual meeting with the Operations Manager South West and the Quality Assurance lead. We looked at one staff recruitment file. We reviewed a range of quality monitoring records, such as audits, regular checks, policies and procedures as well as servicing and maintenance records for Woodside. We sought feedback from local health and social care professionals and received a response from two of them.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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.

Preventing and controlling infection

● We followed up anonymous concerns raised with CQC about the arrangements for admitting people to Woodside from the community for respite stays. We found the arrangements were not in accordance with the providers own admission guidance nor with government COVID 19 guidance about admissions to care homes. [UK government Coronavirus (COVID-19): admission and care of people in care homes, December 2020. Voyage Home / Service Case Management - Infection Prevention and Control - COVID-19, 25 January 2021].

● The providers guidance showed people admitted to the home were supposed to be COVID 19 tested two days prior to admission and undergo a period of 14 days isolation. However, staff did not follow this at Woodside when people were admitted from the community for respite stays.

● People admitted from the community for respite stays were not COVID 19 tested prior to admission. Instead, they were tested on the day of admission. This meant their COVID status was not known when they were admitted. In addition, they were not self-isolating for 14 days. This put people living at Woodside and staff at increased of cross infection risk from COVID 19.

● Staff took some steps, prior to admission, to identify and reduce the risk of transmission from Covid 19. They completed a Covid 19 General Risk Assessment Form and a Covid 19 Respite Pre-Admission, Admission Health Check and Discharge Form. These showed that, for example, staff checked the person's temperature and whether they or family members or others they were in contact with prior to admission had symptoms of COVID 19. However, the failure to test and self- isolate people admitted for respite increased the risks of asymptomatic transmission of COVID 19. This was of concern due to the highly infectious strain of virus prevalent in the community at the time of the inspection.

● Woodside was closed to visitors at the time of the inspection due the national lockdown measures in place. This meant people living there were also unable to visit their family. Staff said one person got upset when people admitted for respite came in and went home again, which they weren't allowed to do.

● Four staff expressed concerns about the arrangements for people being admitted for respite stays. Staff comments included, "I find [respite arrangements] contradictory," "Allowing respite stays are putting residents and staff at risk" and "It feels better if people are tested."

● On 3 February 2021 when we raised our concerns the Director of Operations and the Quality development manager, who explained they were trying to balance the need to offer a respite service to people in the community, alongside meeting the needs of people living at the home.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised our concerns with the provider about these arrangements and explained the reasons why. In response, the provider made a voluntary undertaking to stop admissions for respite stays, whilst they took advice and reviewed their current infection prevention and control arrangements.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people living at the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We have also signposted the provider to resources to develop their approach.

Assessing risk, safety monitoring and management
● People's individual risk assessments were detailed with clear support plans in place to guide staff how to minimise risks for people.
● Environmental risks were well managed with good health and safety systems and an ongoing programme of servicing and repairs.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Staff had undertaken training and were aware of signs of abuse. They knew how to raise concerns and were confident they were responded to. One staff said, "If I had any worries, I would feel happy to raise. I've raised an issue in the past and [staff concerned] learnt from that. The person's care plan was made clearer and it was put in the communication book."
● The registered manager recognised and reported signs of abuse. They had recently reported to the local authority safeguarding team and Care Quality Commission a concern about potential abuse. They worked with health and social care professionals to develop a support plan for the person and to protect others.
● Accidents and incidents were reported by staff and monitored by the registered manager with further actions taken to mitigate risks.
●The service had recently experienced a period where a person's mental wellbeing had deteriorated with increased episodes of behaviours that challenged staff and others. Individual staff debriefing was underway, and a staff meeting planned to review and identify lessons learnt and areas for improvement. This enabled staff to reflect on incidents and share learning.

Staffing and recruitment
● Woodside had enough staff to make sure people's care and support needs were met. People were supported by a small team of staff they knew and trusted.
● There were systems in place to assess people's individual support needs, with flexibility to change staffing levels as people's needs changed.
● There had been some staffing challenges due to staff sickness and staff needing to self - isolate. However, contingency plans were in place to replace staff and to ensure a minimum level of staffing was adhered to. This included existing staff working extra hours and on call arrangements, so additional staff cover was available at short notice.
● Risks to people were minimised because the provider had a robust recruitment procedure which made sure all new staff were thoroughly checked and vetted before starting work. An induction and probation period were used to check new staff had right skills and attitudes.

Using medicines safely
● People received their medicines safely and on time. Staff were trained in medicines management and had

their competency assessed to make sure they had the knowledge and skills to administer medicines safely.
● Medicines were received, stored, administered and disposed of safely. Regular audits were carried out to identify and address any concerns and make improvements.

Requires Improvement

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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

- When people were admitted to Woodside for a respite stay, staff were not following the government or the providers Infection Prevention and Control guidance. People admitted to Woodside were supposed to have COVID 19 testing two days prior to admission and undergo a period of 14 days isolation following admission.
- The operations manager and governance lead were aware staff were not following the guidance. They explained they were trying to balance the need to offer a respite service to people in the community alongside meeting the needs of people living at the home. However, these arrangements did not sufficiently take account of the increased risks of COVID 19 cross infection for people living at Woodside or for staff.
- We followed up anonymous concerns raised with CQC that people were at increased risk because senior staff were not experienced, did not listen or respond to concerns. We found no evidence to substantiate this claim.
- The registered manager had a good understanding of their roles and responsibilities. They felt well supported in their role and their ongoing development was supported by the operations manager and other Voyage staff.
- Staff praised teamwork and the family atmosphere at the home and said they felt well supported by the registered manager and their deputy. Staff comments included; "They run the place really well," "They are doing their best" and "[Registered manager] supports the team well."
- Relatives and visiting professionals also expressed confidence in the leadership at the home and said it was well run. A relative said, "I know [person] is happy, if I had any concerns, I would feel happy to call them."
- The service had a range of other effective quality monitoring arrangements in place. For example, regular health and safety and infection control checks were completed. Audits of care records and medicines management were undertaken with continuous improvements made in response to findings.
- Senior managers and directors regularly visited the service to meet with people and staff. The provider received regular reports, so they could monitor quality and be aware of risks. For example, information about accidents/incidents, complaints, staff training and supervision.

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

- The registered manager was experienced and had worked at Woodside for several years, so knew people

and staff well. They led by example, liked to be "hands on" and had an "open door" approach to staff and people.
● People's care records prompted staff to adopt a positive approach for people they supported. For example, by focusing on people's strengths and abilities and promoting increased independence.

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
● Staff were encouraged to challenge any practice concerns in confidence through a "See something, say something" whistleblowing policy. Where any concerns about staff skills, performance attitudes or performance were identified, these were dealt with in accordance with the provider's policies and procedures.
● Where mistakes were made, the registered manager was open and honest with people and families and made improvements.
● The registered manager notified Care Quality Commission (CQC) of events which had occurred in line with their legal responsibilities.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were consulted and involved in day to day decisions about the running of the home. For example, about what they wanted to eat, how they spent their day and about personalising their room.
● A survey of relatives and professionals in December 2020 showed positive feedback about the care provided. One relative wanted more regular communication, so staff now rang them weekly to provide an update.
● Regular staff meetings were held where staff had opportunities to discuss people's care. They were encouraged to make suggestions and receive feedback.

Working in partnership with others; Continuous learning and improving care
● People lived in a home where staff worked in partnership with health and social care professionals, family members and advocates to make sure people received the care and support they needed. Professionals said; "The service seems to run very effectively and efficiently" and "The service appears organised and well run. When I visited, I observed positive interactions between residents and staff."
● Staff were continuously learning and improving through Voyage learning and development programme. For example, training in positive behaviour support, improving their non-verbal communication skills and how to meet people's individual health needs.
● Staff worked closely with the local learning disability and mental health professionals to review people's medicines as part of a national good practice project for stopping over medication of people with a learning disability, autism or both.
● The registered manager received updates about regulatory changes through monthly newsletters from Care Quality Commission. They kept up to date with best practice guidance through regular contact within Voyage managers. They received regular updates, supported one another and share good practice ideas.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Service users who lived at Woodside were not fully protected against the cross-infection risks associated with the COVID 19 pandemic. This was because the staff at were not following UK government or the providers guidance about COVID 19 testing or self–isolation when admitting service users for respite stays Regulation 12 (2) (h)