Voyage 1 Limited

Rakelands

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 inspection was carried out on 25 and 26 July 2016 and was unannounced. At the last inspection on 9 January 2015 we found the provider had breached two regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We told the provider to take action and we received a report setting out the action they would take to meet the regulations. At this inspection we found that improvements had been made with regard to each of the breaches identified and the provider was now meeting the legal regulations.

Rakelands provides accommodation and nursing care for up to 16 people with a learning disability. At the time of our inspection there were 13 people living in the home.

Rakelands has a 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.

Staff had received safeguarding training and were able to describe sources and signs of abuse and potential harm. Staff were aware of the safeguarding policy which was easily accessible to them and knew how to report abuse.

Risk assessments were in place for each person based on their individual needs. People using the service were living with a learning disability, had complex needs and required nursing care. This meant that people were living with risks such as choking or at risk of suffering seizures. Risk assessments were detailed and demonstrated how these risks were managed to keep people safe.

The provider ensured staff were safely recruited to meet people's needs. Where staff performance issues had been identified the provider had taken appropriate action to ensure that fit and proper persons were employed to keep people safe.

There were enough staff on duty to meet people's needs. Everyone had their physical needs met, including their daily physiotherapy requirements and everyone was able to access and participate in activities. Some people visited a local activities centre a short distance away supported by staff.

Medicines were administered safely by staff who had been trained to do so. Medicines were administered by trained nurses, however all staff had undertaken training in medicines administration. Staff had also received epilepsy training in order to administer emergency medicines in relation to seizures.

Medicines were stored safely. Medicines storage temperatures were monitored on a daily basis to ensure medicines were kept at a safe temperature. Storage arrangements met the additional legal requirements for

the safe storage of controlled drugs.

Staff had received appropriate training to deliver the care and support for people living in the home. Records showed that training covered all essential areas such as infection control, food hygiene and fire safety. There was also training in relation to nutrition awareness and specific training around epilepsy awareness. Staff had regular supervision meetings and annual appraisals and said they felt supported.

People were asked for consent before care and support was provided. Communication support plans made it clear how people communicated so that staff understood when people were consenting. Most people were not able to communicate verbally and the communication support plans made it clear to staff, the ways in which people were able to communicate.

Where people lacked capacity to make specific decisions, the home acted in accordance with the principles of the Mental Capacity Act 2005 (MCA). 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Relevant applications had been submitted for people to ensure they were not being deprived without the appropriate legal authority.

People received sufficient nutrition and hydration in line with their requirements and were supported by staff to receive their nutrition if required. A large proportion of people received all or the majority of their nutritional intake through a percutaneous endoscopic gastrostomy (PEG). Staff were aware of each person's individual requirements which were clearly documented in their support plans. Some people received additional supplements through their PEG if they had insufficient oral intake to meet their nutritional and hydration needs People's weight was monitored on a monthly basis to ensure that appropriate action could be taken if they lost weight.

Health professionals were appropriately involved in people's care. People had complex conditions and needed support from a variety of health professionals. Each person had a health action plan which recorded the support required and the outcomes of any visits.

Staff were supportive and caring. Staff were observed to respond individually to people, enjoying fun and playful conversations appropriately. Relatives gave positive feedback about the quality of the care delivered in the home and one person told us they were happy and that staff were kind to them.

People were involved in day to day decisions about their care such as what to eat and what to wear. Staff knew people and understood their needs and preferences to offer appropriate choices and people chose using their individual method of communication.

Staff explained how they respected people's dignity by knocking on their bedroom doors before entering and ensuring doors were closed when personal care was being received. Staff treated people in a dignified and respectful way and addressed them with their preferred names.

People were supported to be as independent as possible. Where people were able to carry out activities such as holding a spoon or a flannel, they were supported by staff to be as independent as they were able.

Support plans were well evidenced, cross referenced with risk assessments, included details of decision making, displayed joint working and showed good involvement of multi-disciplinary team working. Plans were detailed, specific and individualised. People received personalised care that was responsive to their

needs and there had been co-ordination between different services when people moved to ensure a consistency of care.

People took part in a variety of activities and photographs of these activities were depicted throughout the home. Activities included golf (which was the activity on one of the days of the inspection), music, creative art, life skills, Indian head massage and storytelling. People also took regular holidays which included taking part in a variety of external activities.

The provider listened and responded to feedback about people's experiences, concerns and complaints. People, staff and relatives had all been given the chance to provide feedback and the provider had responded appropriately taking action to improve the quality of the service people received.

There was an open and transparent culture within the home. Staff were able to raise any issues or concerns with the manager and relatives told us they had a good relationship with the registered manager.

The registered manager submitted relevant notifications to the Care Quality Commission (CQC) in a timely way. A notification is an important event which the provider is required to tell us about. The registered manager was aware of the provider's vision and values, which included passion for care and positive energy. She said she wanted to make sure the home looked homely and encouraged parents and relatives to be part of life in the home.

Checks were undertaken to ensure the quality of the service. A health and safety monitoring tool ensured that window restrictors were checked weekly. Other checks carried out included hot water temperature, fire system, weekly inspection of bath chairs and wheelchairs to ensure they remained suitable for use.

Checks in relation to the overall running of the home had been undertaken such as a fire safety audit and an environment audit. A quarterly audit was carried out by the operations manager. An annual audit was undertaken by the provider's in house audit team. These ensured that the quality of care was monitored and actions taken to make improvements where appropriate.

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.

Staff knew how to keep people safe from harm and protect them from suffering abuse.

People's individual risks had been recorded and actions taken to manage them.

There were enough staff deployed to meet people's assessed needs.

Medicines were administered safely by staff who had been trained to do so and were subject to annual competency checks to ensure their suitability to continue this role.

Is the service effective?

Good

The service was effective.

People received care and support from staff who had been appropriately trained and who had a detailed knowledge about people's needs.

People were supported to make their own decisions and where they did not have capacity the provider had complied with the requirements of the Mental Capacity Act 2005.

Appropriate applications had been made to ensure that people were not being deprived of their liberty without lawful authority.

People were supported to have enough to eat and maintain a balanced diet.

Health professionals were appropriately involved in people's care.

Is the service caring?

Good

The service was caring.

People were supported in a stable and caring environment.

The staff promoted an atmosphere which was kind and friendly.

People were treated with respect and dignity and independence was promoted wherever possible.

Is the service responsive?

Good

The service was responsive.

The service was responsive.

Care was personalised and responsive to people's needs.

People were supported to take part in activities of their choice enabling them to live full and meaningful lives

The provider sought feedback from people and responded appropriately to ensure that the quality of the service was improved where possible.

Is the service well-led?

Good

The service was well led.

We found the home had an open and transparent culture.

The registered manager provided visible and positive leadership to the home, motivating staff to strive for improvements.

Effective quality assurance systems were in place to ensure the quality of the service was maintained.

Rakelands

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 inspection was carried out on 25 and 26 July 2016 and was unannounced. The inspection was carried out by an inspector and a specialist advisor. A specialist advisor is someone who has specific clinical experience and knowledge. In this case their skills and knowledge were in relation to learning disability nursing.

Before the inspection, we reviewed all the information we held about the home including the previous inspection reports and notifications received by the Care Quality commission. A notification is information about important events which the provider is required to tell us about by law. We used this information to help us decide what areas to focus on during our 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 reviewed the information included in the PIR along with information we held about the service.

During our inspection we observed and interacted with six people using the service. We spoke with three of their relatives. We also spoke with the registered manager, the operations manager, a nurse, the chef, the administrator and three support staff. We reviewed records relating to the management of the home, such as audits, and reviewed two staff records. We also reviewed records relating to six people's care and support such as their support plans, risk assessments and medicines administration records.

Where people were unable to tell us about their experiences due to their complex needs, we used other methods to help us understand their experiences, including observation.

We previously inspected the home in January 2015 and found two breaches of regulations.

Good

Is the service safe?

Our findings

People's relatives told us that their family members felt safe. One relative, when asked if their relative felt safe, said "(they) always look really well. I'd say (they) felt very secure." Another relative said "I feel (they) are very happy." People behaved in a way which showed they felt safe. They smiled and interacted with staff.

At our last inspection on 9 January 2015, we found that epilepsy guidance had not been transferred to support plans, that there was no clear system for stock control of medicines and that nurses' competency to administer medicines had not been appropriately assessed. During this inspection we found that people had comprehensive epilepsy support plans in place, a clear system of stock control and rotation was in place for medicines and that nurse's competencies in medicines administration was regularly assessed.

Staff had received safeguarding training and were able to describe sources and signs of abuse and potential harm. They also knew how to report abuse. Staff were aware of the safeguarding policy and had easy access to it. As a result they knew where to find relevant telephone numbers and procedures in relation to reporting a safeguarding concern. Staff were aware of how to protect people from abuse. One member of staff said "If you see bad practice you should address it." The registered manager ensured that staff knew about the safeguarding and whistleblowing policies. Whistleblowing is where staff can anonymously raise concerns regarding wrongdoing in their workplace. A card was displayed on the notice board entitled 'See something, say something.' This was to encourage staff to feel comfortable about reporting concerns and gave them a way of reporting which did not involve speaking with their line manager if they felt unable to do so. Staff said they would feel able to whistle blow, if necessary, without fear of reprisal. One member of staff said "Anything to me that looks out of the ordinary, I will not ignore."

There was evidence that the provider investigated incidents and ensured that staff acquired learning from incidents by holding 'lessons learnt' sessions. Staff told us they had learnt from incidents and this had helped them to ensure people were safe. The registered manager told us staff always completed body maps where this was necessary to ensure there was a clear record of any concerns. Body maps are documentation completed by staff when they notice marks or changes in people's skin and show where and when these were identified. Staff at all levels benefitted from learning from incidents.

Risk assessments, referred to by the provider as support guidelines, were in place for each person and based on their individual needs. People using the service were living with a learning disability, had complex needs and required nursing care. This meant that people were living with risks such as choking or were at risk of seizures. As a result of people's medical conditions everyday activities also carried an element of potential risk to people's wellbeing. The support guidelines described how people were involved in developing the guidelines to keep them safe and the skills they could display to contribute to this risk management. Risk rating definitions were categorised as 'Stop', 'Think', 'Go' where a categorisation of 'Stop' required a risk consideration meeting with the wider support team and a 'Think' required a risk consideration meeting with the immediate support team. Support guidelines clearly described to staff how the risk should be mitigated to keep people safe and included a summary of critical information. This meant that new or agency staff would be quickly aware of how to keep people safe. The critical information summary advised staff what to

always do, what not to do and what to never do. Staff were clear about risks to people and what actions they needed to take to manage those risks. For example one staff member explained how one person was at risk of choking on saliva when cleaning their teeth. They described how they kept the person safe when carrying out this activity by ensuring they stayed upright and had a limited amount of toothpaste limiting the amount of foam generated and therefore saliva produced. People were protected from risks, staff had been provided with appropriate guidance which was known and actions had been taken to prevent potential harm.

There was a thorough recruitment policy in place. Disclosure and Barring (DBS) checks were carried out before anyone could be recruited. These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Potential staff had to provide two references and a full employment history. The provider ensured staff were safely recruited to meet people's needs. Where staff performance issues had been identified, for example, in relation to infection control, the provider had taken appropriate action to ensure that fit and proper persons were employed to keep people safe.

The registered manager explained how staffing was allocated based on the funded assessed needs of people. For example some people were funded for one to one support for certain times of the day and night. In addition to this the registered manager told us she ensured that two members of staff were available for each person, as they all needed support to be hoisted into their wheelchair. On the days of the inspection there were seven support workers and one nurse working in the home. We observed there were enough staff on duty to meet people's needs. Everyone had their physical needs met, including their daily physiotherapy and everyone was able to access activities. There were also sufficient staffing levels to enable people to visit a local activities centre a short distance away. Staff told us there were enough staff on duty to meet people's needs apart from when staff called in sick at the last minute and it was too late to cover the shift. The registered manager told us that incidents of sickness had recently reduced and that she had recently rearranged shifts to ensure that extra staff were on duty at key times such as when people wanted to get up or go to bed. There were sufficient staff on duty to meet people's needs and keep them safe.

Medicines were administered safely by staff who had been trained to do so. Medicines were administered by trained nurses, however all staff had undertaken training in medicines administration. Staff had also received epilepsy training in order to enable them to administer emergency medicines in relation to seizures. Nurses were assessed annually in relation to their competency to administer medicines. Nurses then checked the competency of support workers in relation to the administration of emergency medicines. These checks were also carried out annually. We reviewed records in relation to medicines. Medication Administration Records (MAR) were kept for each person. These were all signed appropriately with no gaps which would indicate that people may not have received their medicines as prescribed. Medication stock levels were recorded as a running total on the MAR charts and regularly checked back to actual stock levels. During our visit we observed a medicines administration round. The round was timed to match mealtimes to maximise people's compliance with taking their medicines. There was a robust system in place to ensure people took their medicines when away from the service.

Medicines were stored safely in a locked cabinet and locked cabinet secured to the wall. Temperatures were monitored on a daily basis to ensure medicines were kept at a safe temperature for storage. Storage arrangements also met the additional legal requirements for the storage of controlled drugs. Controlled drugs are medicines which require a higher level of security. Key information in relation to medicine administration was kept for each person. This included their photograph, how the person preferred to take their medicine, their diagnosis, any allergies and protocols for the administration of medicines which were given 'when required.'

Good

Is the service effective?

Our findings

Relatives told us they were very pleased with their family member's care and support. One relative said "They couldn't do more for him. He looks well." Observations within the home showed that staff were delivering support according to people's individual support plans and that people looked happy and responded positively to staff. We saw that staff communicated effectively with people, in accordance with their individual plans, in order to provide support and care.

Staff had received appropriate training to deliver the care and support for people living in the home. Records showed that training covered all essential areas such as infection control, food hygiene and fire safety. There was also training in relation to nutrition awareness and specific training around epilepsy awareness. Staff had regular supervision meetings and annual appraisals and said they felt supported by their colleagues and the registered manager.

People were asked for their consent before care and support was provided. Communication support plans made it clear how people communicated so that staff understood when people were consenting. Most people were not able to communicate verbally and therefore it was important that staff were familiar with the ways in which people communicated. One member of staff gave an example of how they supported someone with personal care. They explained they approached a person and offered personal care and if the person smiled that meant they were happy to receive the care. Another staff member told us that resistance was a clear indication the person did not want to receive care at that time and they would leave the person alone and offer the care again later. A relative said when asked about their family member's consent "Yes, I've heard them ask." Support plans included a decision making profile. The profile described how the person liked to be given information, the best way to present choices, ways to help the person understand the information, the best time for them to make a decision and when would be a bad time for them to make a decision.

Where people lacked capacity to make specific decisions, the home acted in accordance with the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the 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. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Mental capacity assessments had been completed which were decision specific. Where people were deemed to lack capacity, appropriate consultation had been undertaken with relevant people such as relatives to ensure that decisions were being made in a person's best interests. For example there were mental capacity assessments and best interest decisions for one person around the insertion of a percutaneous endoscopic gastrostomy (PEG) which is a tube placed into a person's stomach which allows them to receive nutrition, fluids and medications directly and their decision to have an influenza vaccination. There was also a best interest decision for the person to have their medicine placed in their food with their knowledge.

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 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. We found that the registered manager understood when an application should be made. Relevant applications had been submitted for people to ensure that any deprivations were subject to the appropriate legal authority.

We spoke with staff who had a good detailed knowledge of people's needs, their preferences, likes and dislikes. Support plans were in place which recorded people's support requirements. These matched what staff told us and our observations. For example support plans gave detailed descriptions under the headings 'What's important to me' and 'How to support me well.'

A choice of two main meals was offered with a dessert and a hot tea. On one day of the inspection the choice was venison meatballs or seabass. Small portions of the main choices were prepared each morning and shown to people in order to choose what they would like to eat for lunch. People indicated in different ways, for example by looking at the dish they would prefer. A relative told us "He gets a choice of two dishes. He chooses with his eyes." One person was eating meatballs for their lunch and staff told us the person had chosen this by smiling at the food they preferred.

People using the service had very specific requirements in terms of the consistency of the food they required. For example some people required a pureed diet. The chef had records of these in the kitchen which matched with the requirements recorded in people's support plans. We saw that the appropriate type of food was then provided for people to eat. Most people needed support to eat their meal and staff provided this in line with people's needs. For example one person's support plan said they should eat their lunch sat at the table in a 90 degree upright position. We observed the person being supported to eat their lunch in this way. People's eating and nutritional requirements were clear to staff because each person had a 'meal mat' in place. These were place mats brought out each meal time detailing people's requirements. For example one person's meal mat stated they required fork mashable food, to be supported by staff sat in front of them and could drink fluids which were normal to grade one. Grade one is fluid which is very mildly thickened. We could see that the guidance provided was being followed by staff. People were supported to have enough to eat and maintain a balanced diet.

A large proportion of people received all or the majority of their nutritional intake through a PEG. Staff were aware of each person's requirements which were clearly documented in their support plan. Some people received additional supplements through their PEG if they had insufficient oral intake. Staff monitored what people ate in order to determine whether additional supplements were needed. A dietician was closely involved with people's care in relation to their PEG input. They visited the home every three months to ensure people's individual prescriptions for their PEG feed were sufficient to meet their needs. People's weight was monitored on a monthly basis to ensure that appropriate action could be taken if anyone lost weight. People were supported to receive sufficient nutritional intake.

Health professionals were appropriately involved in people's care. People had complex conditions and needed support from a variety of health professionals. Each person had a health action plan which recorded the support required and the outcomes of any visits. There was evidence that the health actions plans were reviewed monthly ensuring that people's health needs were kept up to date. Records included, for example, visits to a neurologist, visits to the dentist and reviews by dieticians and epilepsy nurses. People had access to onsite physiotherapy which they received daily. People were unable to tell staff if they felt unwell. Support plans clearly documented how people behaved when they were unwell so that staff could take appropriate action. For example one person's support plan stated 'I won't tell you if I am feeling unwell but I will become

grumpy, emotional and want to be left in my room.' This meant staff were able to respond to people when they became unwell to ensure they received the right treatment.

Good

Is the service caring?

Our findings

Relatives told us that their family members were happy living in the home. One relative said "We have always been satisfied that (our relative) has been well looked after. Whenever we have seen (our relative) he has been very happy." Another person's relative said "They know him well. Last week, we went to visit him, a lady care worker that he likes was talking to him, he really smiled at her."

Staff were supportive and caring. Staff were observed to respond individually to people, enjoying fun and light-hearted conversations appropriately. For example one person enjoyed watching soap operas and a member of staff told us they teased them by pretending to put the news on. This was a standing joke between the two. Staff knew people individually and explained that people trusted them. One member of staff said "I talk to him on his level. He trusts us and it reflects in his happiness." Staff knew how to comfort and support people at times of anxiety. For example one person was anxious about going to the doctors for a blood test. A member of staff told us that they bought a magazine which included pictures of houses and puppies for the person and this had minimised their anxiety. The staff member said "That's good care to me." Another member of staff said "I have worked here a long time so I have really got to know people."

We observed one person being supported to eat. The member of staff was engaging with the person maintaining conversation and interaction throughout explaining what they were doing. They made sure the person maintained their dignity by ensuring their mouth was clean after eating. Another person's lunch was interrupted by the person having a coughing fit. Staff calmly supported the person throughout and explained clearly the actions they were going to take. The actions taken were as described in the person's care plan showing staff knew the person's individual and specific care needs.

People's rooms were decorated in a personalised way. One person had cushions with photographs of their family on them in their room. People had family photos in their room and access to music and television. One relative told us "(my relative) loves opera and classical music. They put it on for him in the evening." This helped people to feel that this was their home and their wants and preferences were important and respected.

We spoke with one person using their method of communication. They told us they were happy and they liked living at Rakelands. They also said that staff were kind and made them laugh. We observed all these things throughout our inspection. During lunch one person became upset because their handbag and teddy bear had been left in their room. A member of staff immediately fetched the person's bag and bear and placed them where the person could see them. This reassured them while they ate their lunch. Staff knew people very well and ensured their care was tailored to their individual preferences.

People were supported to maintain close relationships with their family and friends. One relative described the home like a family. They said "We went to the Christmas party; everyone was in the lounge together. It was like they all knew they were there with each other and were glad to be home. They were talking to each other with little noises." Another person's relative said "Whenever we go and see (our relative) they (staff) are always able to tell you about him and how he's been. They give him a tickle and make him smile. He

definitely seems to know and like them."

Relatives and friends we spoke with, were overwhelmingly positive about the care and support their family member received. One relative said "The staff have empathy." Another relative told us "He never minds going back there when he's been home. That tells me he is happy there." Two people had a book which included their life story in pictures. This included pictures of their parents (who were deceased), their early life and previous places they had lived in. These books were important to them and they regularly looked at them with staff.

Due to their complex needs people were not able to actively participate in creating their support plan. The level of involvement in support plans was recorded in people's individual plans but was mostly in relation to observing the person and their reactions. Relatives confirmed they had been actively involved in developing and reviewing the person's plan of care and support. People were involved in day to day decisions about their care such as what to eat and what to wear. Staff knew people well enough to offer appropriate choices and people chose using their individual method of communication.

Staff explained how they respected people's dignity by knocking on their bedroom doors before entering and ensuring doors were closed when personal care was being received. Staff treated people in a dignified and respectful way and addressed them with their preferred names. People were spoken to and about with affection. People were dressed smartly and were clean with nicely combed hair. This ensured their dignity was respected.

People were supported to be as independent as possible. Where people were able to carry out activities such as holding a spoon or a flannel, they were supported by staff to be as independent as they were able. One person was able to let staff know when they needed the toilet. This ensured they could be independent in terms of being supported to use the toilet and did not require continence care.

Good

Is the service responsive?

Our findings

Relatives told us they had been involved in creating the support plans, were kept regularly updated and were involved in regular reviews. We found that the home had worked with people through observation, preferred methods of communication and regular evaluation to ensure that support plans were tailored to people's individual preferences.

At our last inspection on 9 January 2015, we found that people did not always have access to meaningful activities. During this inspection we found that people had access to a variety of activities of their choice.

Support plans were personalised, responsive to needs, up to date and were aligned with best practice. They included a range of documents which included support plans and a health action file. Each support plan file contained personal details, a relationship map, a one page profile, an 'Important to me' and 'Important for me' page, a typical day, communication plan, decision making profile and decision making agreements, support guidelines and a social history.

Guidance on a 'typical day' included all support needs and wishes over a day and that included all aspects of personal care. The format of the communication plan made it clear for staff to recognise the most appropriate way to get to know someone. The format very simply guided staff to acknowledge and respond to communication. For example 'If the person does this or says this, it means this and we should do this.' People had individual communication books which were kept with them. For example one person's communication book stated 'I communicate through body language and facial expressions. I usually make eye contact.' Another person's communication book stated 'If I am pale, quiet and restless, this could mean I'm in pain. If I am frowning, it could mean I am hungry or thirsty.' This ensured staff, visitors and health professionals had immediate access to the person's communication needs. This would be especially important if the person was taken to hospital and were unable to verbally communicate their needs.

We found support plans to be well evidenced, cross referenced with risk assessments, including details of decision making, displaying joint working and good involvement of multi-disciplinary teams. Plans were detailed, specific and individualised. For example one person who was receiving their nutritional intake through a PEG was unable to eat food. Tasting different flavours was important to them and this had become a special activity undertaken with a relative where they were able to taste different foods. One person had been supported to attend school which had finished two days before the inspection. Support plans demonstrated good links between home, school and family and showed input from children's services and the school. A full plan was in place to address the person's adult needs now that they had left school. The person's epilepsy care plan had been written jointly with the epilepsy nurse. Support plans included pictorial evidence to guide staff showing correct positions for people, for example at night, and how to apply body braces. One person had been admitted for 28 days respite care. A full support plan was in place on the day of admission ensuring that staff had access to full information to meet the person's complex needs. Two days after admission, the person's PEG fell out. There was a clear care plan in place to address this emergency which staff followed. A 'holder' was put in place until a replacement could be sourced from the hospital. This ensured that no doses of medicine or food were missed. Staff responded appropriately to the

situation ensuring the person's support needs were met at all times. We found that people received personalised care that was responsive to their needs and that there had been co-ordination between different services to ensure a consistency of care.

People took part in a variety of activities and photographs of these activities were depicted throughout the home. Activities included golf (which was the activity on one day of the inspection), music, creative art, life skills, Indian head massage and storytelling. People also took regular holidays which included taking part in a variety of activities. During our inspection some people visited a local activity centre, where they took part in activities such as cooking and music. During monthly meetings with their keyworker people were able to discuss activities they would like to do and plan special occasions and outings. A keyworker is someone a member of staff who has special responsibility for a person, ensuring they are happy in all aspects of their daily life.

The provider sought, listened and responded to feedback about people's experiences, concerns and complaints. There had been no written complaints received by the home since 2014. People's relatives told us they were able to raise issues with the registered manager if required. One relative said "I feel comfortable raising concerns with (the registered manager); she's a very honest person." Another relative said "If I tell (the registered manager), I know she will take notice, usually I don't have to say anything." Another relative told us that the registered manager was very responsive to issues. They told us that on one occasion they had mentioned to the registered manager that it was very difficult to find trousers to fit their relative and suggested that some trousers should be specially made. They were very impressed on their next visit to find that the registered manager had organised some trousers to be specially made for their relative. They were pleased he had some trousers which fitted him. The registered manager was responsive to feedback, ensuring that actions were taken to meet people's needs.

Feedback forms were sent to relatives, staff and people to gather feedback and information about where the service provided could improve. Feedback from relatives included positive feedback such as 'He is very well cared for, provided with stimulating activities and he is safe,' 'Staff have an understanding of profound needs and the care required to meet such.' Feedback from staff had included some suggestions for improved ways of working and an action plan had been put in place as a result of this feedback which included monitoring sickness and recording keyworker duties. Feedback was also sought through regular staff meetings and supervisions. One member of staff said "We do have meetings when we are encouraged to bring up issues, things that could be done better and things that are going well." Keyworker meetings were held monthly with people, this meant they were given an opportunity to feedback about their care and support.

Good

Is the service well-led?

Our findings

There was an open and transparent culture within the home. Staff were able to raise any issues or concerns with the registered manager who, they told us, always listened and responded. Relatives told us they had a good relationship with the registered manager whom they respected. One relative said "It's a very open sort of arrangement, feedback is taken on board."

Relatives were very positive about the registered manager and her leadership of the home. One relative said "(The registered manager) is firmly in the driving seat, she knows what's going on." Another relative said "I think she is a very good manager. I feel my son is safe with her there."

The provider held meetings for registered managers in the local area; this helped the registered manager to view the home more strategically and in the context of local themes and activities. There was also networking amongst local registered managers which allowed for information and good practice sharing which could be brought back to the home to improve the service provided.

The registered manager submitted relevant notifications to the Care Quality Commission (CQC) in a timely way. A notification is an important event which the provider is required to tell us about. The registered manager was aware of the provider's vision and values, which included passion for care and positive energy. She said she wanted to make sure the home looked homely and encourage parents and relatives to be part of life in the home. Relatives commented on how the home felt relaxed and how they felt part of life in the home, being invited to attend regular events. One relative said "It's very homely, it has a nice feel to it." Staff felt involved in contributing to the development of the service and this reflected in the care developed and the family feeling within the home. A potential relocation of the service had been considered and discussed with people, staff and relatives. A steering group had been set up which included representatives of people, relatives and staff. The steering group had contributed to how they would like the new building developed and designed. Staff had been asked to contribute to a wish list, which included medicine cupboards in each room and a cinema system.

A 'Working together' group had been set up by the provider for people supported by Voyage. Some people from Rakelands had attended. The initial meeting discussed how people would like to be involved and how they could contribute to the future of Voyage care. Minutes of the meeting were awaiting therefore actions identified as a result were not yet known.

Checks were undertaken to ensure the quality of the service provided. A health and safety monitoring tool ensured that window restrictors were checked weekly. Other checks carried out included hot water temperature, fire system, weekly inspection of bath chairs and wheelchair checks to ensure they remained suitable for safe use.

Checks in relation to the overall running of the home had been undertaken such as a fire safety audit and environment audit. A quarterly audit was carried out by the operations manager and was based around the five questions asked by CQC during inspection. An annual audit was undertaken by the provider's in house

audit team. Any actions derived from these two audits were added to the consolidated action plan. We tracked actions from the provider audits through to the consolidated action plan and confirmed they had been completed.