Voyage 1 Limited

30 Broad Lane

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 was an unannounced inspection which took place on 13 November 2017.

30 Broad Lane is a residential care home for a maximum of six people with learning disabilities and associated needs. Some people within the home had difficulties that included mobility issues. At the point of inspection, the service had five female residents. The service is provided to people across two floors, with a lift to enable people to access both floors.

At the last inspection of September 2015, the service was rated Good. At this inspection the rating remained Good.

Why the service is rated Good

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

The service remained safe. Sufficient staff were deployed to manage people's needs, and enable them to engage in activities of their choice, through appropriate risk management. Staff knew how to safeguard people from abuse and were aware of the protocols to follow should they have concerns. Staff reported that they would not hesitate to whistle-blow if the need arose. Medicines were managed safely. Staff were competency checked annually and medicines audits were completed monthly to ensure people received their medicines as prescribed.

The service remained effective. Support was delivered by a highly trained staff team, who were able to respond appropriately to people's changing needs. Staff were supervised and supported by an effective manager, who ensured health professionals were engaged as required. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The service remained caring. Staff were polite, respectful and ensured they maintained people's dignity when supporting them. They encouraged open communication and worked on motivating people to increase their independence.

The service continued to be well-led. The registered manager was proactive, approachable and transparent in her practice. She welcomed comments and encouraged better practice. All audits were maintained, ensuring the registered manager had a full overview of the service.

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**

30 Broad Lane

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 took place on 13 November 2017 and was unannounced comprehensive inspection, completed by one inspector.

Prior to the inspection we referred to previous inspection reports, local authority reports and notifications. Notifications are sent to the Care Quality Commission by the provider to advise us of any significant events related to the service, which they are required to tell us about by law. As part of the inspection process we also look at the 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 had received the PIR for 30 Broad Lane and used this to help develop our inspection plan.

During the inspection we spoke with four members of staff, including the registered manager, one senior and two care staff. We spoke with two relatives of people who use the service. We completed observations during the course of the day, interacting with three people. In addition we spoke with three professionals from the local authority.

Records related to people's support were seen for three people. In addition, we looked at a sample of records relating to the management of the service. For example staff records, complaints, quality assurance assessments and policies and procedures. Staff recruitment and supervision records for three of the six regular staff team were reviewed.

Good

Our findings

The service continued to provide safe care and support to people.

Staff knew the protocol for reporting and acting on potential abuse. The procedure was available for staff to see within the office and discussed frequently within meetings. We were told by staff that they would "not hesitate" to whistle-blow if they had concerns. One member of staff said, "We have to keep residents safe, I wouldn't even think twice." Staff training in safeguarding was kept up to date and refreshed frequently, with staff attending the local authority course. Staff had also received training in the safe management of challenging behaviours. This focused on staff supporting people by using de-escalation and other support techniques rather than restraint. We saw work booklets to further support the training that staff completed as part of the assessment of competency.

People were protected from risks where possible. Staff continued to assess and document how to manage these within risk assessments and care plans. The risk assessments sought to minimise the risk whilst allowing people to take part in the activity. For example people were encouraged to access the community, use stairs within the home and access the kitchen. All people residing at the service had personalised evacuation plans in place, should an emergency occur. These documented what procedures staff were to follow and how to minimise the effect on people keeping them safe at all times.

There were sufficient staff deployed to keep people safe. The early shift consisted of four staff working with five people. Whereas the late shift had a minimum of three staff working. If additional staff were required this was authorised as needed. The registered manager recognised they relied on agency staff to maintain the staffing ratio. This was safely managed through consistent staff working alongside regular staff, who knew the people well. A recruitment drive was in place in an attempt to resolve this, however the rural location and lack of public transport was recognised as a contributing factor to the poor response. The service had a robust recruitment procedure that meant staff employed had been through vigorous checks prior to commencing employment.

People continued to receive support with their medicines from well trained and assessed staff. The service had a rigorous assessment protocol whereby staff were observed three times administering medicines prior to being signed off as competent. In addition any medicines requiring external administration (e.g. eye drops, nasal sprays) were further competency checked. Competency checks were reviewed annually to ensure staff practice remained safe . The registered manager completed monthly audits on all medicines to check whether these have been administered safely.

People were protected from the risk of infection. The premises were clean and tidy, with staff using separate equipment for all cleaning areas. Staff had been trained in infection control, and ensured that their practice was reflective of this. All chemicals were kept locked away.

The service had an IT system to monitor accidents and incidents. These would be sent to the appropriate professionals to gain further clarity on how to minimise further incidents. For example, the behaviour specialist would advise on any challenging behaviour.

Good

Our findings

The service continued to provide effective care.

People received care from a staff team that received a rolling training programme, ensuring that courses were refreshed as required to promote effective practice in meeting people's needs. The home was operating at 94% fully trained with the remaining 6% training booked. In addition specialist training was provided and sourced. For example, the registered manager had liaised with the local authority and arranged for staff to receive training in Makaton (This is a form of communication used for people who find verbal language difficult. It consists of using gestures and hand signals to represent words). This enabled effective communication with people within the services, who required additional communication aids. Staff reported that they would approach the registered manager with training ideas they felt could assist them with their job. We received feedback from people's relatives stating, "Staff are well trained". We saw evidence of staff having been through a comprehensive induction process which met the requirements of the care certificate framework. In addition staff received supervision on a bimonthly basis. One staff reported "I find these very useful, however I can approach [name] at any time to seek clarification on things." In addition monthly house meetings were completed. Minutes showed that operational issues, as well as those related to the people were discussed within these meetings. Any actions were completed as required, if targets were not met, an explanation was provided.

Care plans provided sufficient detail to ensure effective care was provided. These covered all aspects of support from night time routine, to the professionals involved in care. Documents were maintained to illustrate appointments and contact made with health professionals. Any information was cross referenced and updated in the care plan. We saw evidence of how a recent appointment and the feedback received, was being incorporated into the care plan for the person. This was then communicated to staff in handover and within the communication book, prompting staff to read the updated care plan. We were told by family members that the service would contact professionals as required for people's health needs. This was clearly evidenced in the health folders seen. We saw that GP's had been contacted when people had been observed to be off their food, or had a high fever. Medicine reviews were prompted for people where the continued need for medicines was questioned. This led to one person having a thorough review of their health needs, resulting in medicine doses being changed. As a result the person was able to do more, and was happier.

People were involved in devising the menus, and were offered an alternative if they did not wish to eat what was available. We completed an observation over lunchtime and saw staff showed people the different

puddings available. People were able to make an informed choice of what they would like to eat. As required dieticians or speech and language therapists were consulted with in relation to how meals needed to be prepared. Information was retained within the kitchen as reminders for staff during meal preparation, and within each individual care file.

People's rights to make their own decisions were protected. We observed staff seeking consent prior to assisting with a task; this was further well documented within each person's care plan. The document reinforced the need to seek consent prior to supporting. Details of how consent was to be sought was identified, for each person. This was documented within both the communication section and each relevant section of the care plan, to reinforce the importance of consent. Staff had received training in the Mental Capacity Act 2005 (MCA) and were able to clearly illustrate how this applied to their practice. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that the service had made all the necessary applications for DoLS to the local authority.

People were cared for in line with Equality Diversity and Human Rights (EDHR). People were provided support that ensured they were all not discriminated against. For example, people with disability were able to access the property safely,. For example, a lift was fitted to the service to enable people with mobility to access both floors. A wet room had been created to ensure the needs of people could be met when delivering personal care. These adaptations contributed to people being enabled to live a fulfilling life.

Good

Our findings

The service continued to deliver good caring practice.

People were supported by a consistent staff team as far as possible, to ensure people knew them well and were aware of how they wished to be supported. The high staffing ratios allowed staff to develop relationships with people, which in turn enabled good engagement. Staff communicated with people in the way they preferred. For example one person preferred to use Makaton, whilst another used picture symbol cards. Another person had developed their own version of Makaton. Staff spent time observing and recording the adapted signs so that they could communicate with the person, in their preferred way. We observed people smiling when staff interacted with them. A social care professional we spoke with said, "We have no concerns regarding the service. People are really cared for". Another professional said, "This is the most [name] has been cared for. The staff are wonderful and are doing a great job."

People were encouraged to be involved with the development of their care plans. With information being sought from people on their likes, dislikes, how they wished to be supported. We completed an observation over lunch, where two people were being assisted with their food. We saw staff spoke with people in a caring manner, asking them questions and laughing with them. They spent time with the people and assisted them as they chose. One person who was being assisted was encouraged to eat independently with staff support and prompting. We saw the person listened to staff, and ate slower, minimising the risk of choking. This was consistent with the person's care plan.

People's religious and cultural preferences were promoted and developed within the service. If a person wished to practice their faith, they were supported to attend the relevant place of worship. Care plans showed staff accompanied people. Similarly, people's diverse needs were supported appropriately. Some people required additional support related to their disability. This was developed and promoted within care plans.

People had their privacy and dignity maintained at all times. Staff were able to advise how they would support with personal care, ensuring people were covered as required. Doors and curtains were closed before personal care was commenced. Care plans clearly advised staff to talk people through what they were going to do, and if people declined support, to respect their wishes.

Confidentiality was promoted within the service. Staff ensured they did not speak about people in front of others where possible. Records were maintained securely in the office. Information was circulated within the

staff team on a need to know basis.

Good

Our findings

The service continued to provide responsive care and support to people.

Since our last inspection two new people had moved into the home. We saw the service had completed thorough initial assessments prior to their admission. Staff, where possible visited the person in their home, and encouraged visits to the service. This allowed the person to become acquainted with residents and the staff. The visits and the initial assessment were used to help write the care plan and risk assessments. The registered manager referred to the care plan as a "working document", which required updating as and when necessary, to meet people's changing needs. We saw evidence that reviews took place every six months, where changes had not been made to any of the documents prior to this. Families and professionals were consulted in addition to people for further information to ensure people were cared for in a personalised manner.

People had individualised care plans that illustrated their personal preference. For example one care file contained information in both written and pictorial format, as this had been requested by the person. Each section of people's care plan contained information on how they wished to be supported. We were told that information gathered from other sources (e.g. previous placements) was never trusted wholly. Staff worked with people and documented people's responses for themselves. For example, one person reportedly disliked the TV and socialising with other people. However, the staff team found they were happiest when amongst others, feeling isolated if left alone. We witnessed the person sitting in the communal lounge smile, and communicate through body language that they were content, when asked. The person stroked staff's hand and smiled continuously whilst nodding. The care plan had subsequently been amended to reflect the person's observed preference. Key worker's were assigned to people so that one person could take responsibility of developing person centred packages. They met with the person monthly discussing their care needs and whether any changes were required. Meetings were minuted. People had individualised activities, which met their needs. On the morning of the inspection, two people went out for individual community activities, whilst three people remained at the service. In the afternoon, both in house group activities were offered as well as community activities. Each person had their own activity programme. This was presented in the format of their choice, and retained both in their files and in the bedrooms. If people did not want to engage in an activity this was respected.

The service had a complaints procedure which was presented in a user friendly format and provided to people within the handbook. It was recognised that people would need support to express a complaint or concern. Independent advocates were available to act on behalf of people, and promoted by the service.

The service had received a number of complaints by one member of the public, regarding a variety of issues, including people vocalising, activities on site, and multiple visitors to the home. These were appropriately logged and responded to as required. Where appropriate an investigation was completed and a report filed. The service had received a number of compliments from professionals and families involved with the service. One professional contacted CQC and said that "this was the happiest they had seen [name]".

Good

Our findings

The service remained well-led.

The service had a registered manager in place. 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. We were kept up to date with relevant notifications and events that by law the CQC are to be told of. The registered manager promoted confidentiality both in practice and record keeping, ensuring all documents were securely kept in the locked office. We found that in most cases records were kept up to date. For one person we found staff were not recording night-time checks on the correct paperwork. The registered manager assured us that night staff would be spoken with to ensure they use the correct paperwork.

The service continued to maintain accurate and up to date documents that reflected people's specific needs. The registered manager maintained an oversight of these. Staff were asked to sign they had read and understood any alterations made to the documents related to people. The key worker's were encouraged to take the lead in ensuring person centred packages were created for each person. Staff were encouraged to use their initiative. One member of staff reported, "She [manager] is a great mentor. She teaches us and allows us to try new things when working with people". Staff reported that the registered manager was open and transparent. She was approachable, and a good leader. Professionals spoke highly of the registered manager, and her drive to ensure that the service maintained a good relationship with all professionals. One professional said, "[Name] is very good. She knows how to manage the service well." Similarly relatives praised the manager and the staff stating, "They are a good bunch."

Annual quality assurance (AQA) reviews were completed taking into account the views of people, relatives / friends, stakeholders and the staff team. Questions around the home's practice, and what could be done better were asked. Where applicable action plans were generated to drive improvement within the home and the service. People's opinions were recorded within key worker sessions and used as required to further inform the AQA. Staff reported that the supervisions and team meetings were official avenues for them to raise any concerns or discussions. However, the registered manager encouraged them to speak to her or the regional director of any issues as and when they arose.

The service continued to complete comprehensive audits, to ensure a good service was provided to people. The registered manager completed monthly and quarterly audits. In addition the regional director would

then complete an audit every quarter looking at the outcome of the manager's audit, as well as their own comprehensive findings. These worked in line with the regulations and were therefore aimed at delivering care that was reflective of best practice. All health and safety checks were completed. Checks were appropriately completed by external professionals to ensure that equipment was safe to use. For example, fire equipment, the lift, moving and handling equipment, boilers, water checks etc. The service had an appropriate contingency plan that was to be implemented in the case of an emergency. This was kept up to date, and reviewed annually.