# Voyage 1 Limited

# Maple Way

## Inspection report

14 Maple Way
Headley Down
Hampshire
GU35 8AY
Tel: 01428 717565
Website: www.voyagecare.com

Date of inspection visit: 25 and 28 September 2015
Date of publication: 20/11/2015

## 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? | Requires improvement |

## Overall summary

This inspection took place over two days on 25 and 28 September 2015 and was unannounced.

Maple Way provides accommodation and personal care for up to two people who have learning disabilities. The people living in the home had complex needs and sometimes demonstrated behaviour which staff may find challenging. At the time of our inspection there was one person living in the home. One person was in hospital supported by staff from the home. The home is located in a residential area in Headley Down, approximately four miles from the centre of Liphook. The home is semi detached and has a small garden.

Maple Way did not have a registered manager in post at the time of the inspection. The previous registered manager left in March 2015 and a new manager had been recently recruited but was not yet registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

# Summary of findings

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. They understood how to recognise the signs of abuse and knew how to report their concerns if they had any. There was a safeguarding policy in place and relevant telephone numbers were available.

Risks had been appropriately identified and addressed both in relation to people's specific needs and in relation to the service as a whole. Staff were aware of people's individual risk assessments and knew how to mitigate the risks. There was constant monitoring and reassessment of risks which ensured that staff took actions to protect people.

There were enough staff on duty at all times to meet people's needs as staff were rostered in accordance with people's assessed needs.

Medicines were administered safely by staff who had been trained and were competent to do so. There were procedures in place to ensure the safe handling and administration of medication. Staff knew how to administer emergency medicines for people.

People were asked for their consent before care or support was provided and where people did not have the capacity to consent, the provider acted in accordance with the legal requirements of the Mental Capacity Act 2005. People's mental capacity was assessed and decisions were made in their best interests, involving the relevant people.

The service worked well with health professionals to ensure the best and most effective care was provided for people. A psychiatrist and learning disability nurse had worked with the service.

People's relatives were happy with the care. Staff knew how to meet people's needs and this showed through their caring actions and their interactions with people using the service. People behaved in a way which showed they felt comfortable with staff. Independence was encouraged whenever possible and people responded positively to this.

Support plans were reviewed on a monthly basis and people were involved in these reviews through keyworker meetings and through staff observation of their behaviour when carrying out activities. Relatives and professionals were involved in regular reviews. Support plans were regularly updated with key information about people's support and their individual preferences.

There was no registered manager at the time of the inspection. A manager had been recently recruited who was yet to registered with CQC.

A robust system of quality assurance ensured the continuity of the level of service.

# Summary of findings

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

We always ask the following five questions of services.

**Is the service safe?**
The service was safe.

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

There were enough staff on duty to meet people's needs at all times. Recruitment methods were safe and ensured only suitable staff were recruited.

Medicines were administered safely by staff who were competent and had been trained to do so. Staff had received training to administer people's emergency medicine.

Good

**Is the service effective?**
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. Support plans were written in response to people's individual needs and behaviours.

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

Appropriate applications had been made under the Deprivation of Liberty Safeguards.

Health professionals provided advice and support where necessary and this improved people's care.

Good

**Is the service caring?**
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. Staff supported people to undertake activities they enjoyed.

Staff maintained regular contact with people's family members.

Good

**Is the service responsive?**
The service was responsive.

People's preferences, likes and dislikes had been recorded and responded to staff who understood and knew people well.

People were supported to use public transport to improve their independence. Support was also given for people to be as independent as possible.

Good

# Summary of findings

Relatives knew how to complain and feedback from people was sought and responded to by the provider.

**Is the service well-led?**

**Requires improvement**

The service was not always well led.

The home did not have a registered manager in post. A manager had been recruited who had not yet registered with the Care Quality Commission.

The manager post had been vacant for six months.

Not all relatives were happy with the management of the home.

People and staff were involved in developing the service through regular feedback.

Robust quality assurance systems were in place to ensure the quality of the service provided.

# Maple Way

**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 completed over two days on 25 and 28 September 2015 and was unannounced. The inspection was carried out by an adult social care inspector.

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 service is required to tell us about by law. Before the 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 used this information to help us decide what areas to focus on during our inspection.

During our inspection we spoke with two relatives. We also spoke with the manager, the deputy manager and two 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 one person'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.

Following the inspection we spoke with a learning disability professional to obtain their views on the home and the quality of care people received.

We last inspected the home in November 2013 and found no concerns.

Good

# Is the service safe?

## Our findings

A relative told us that their family member felt safe. We observed the person in the home on the day of the inspection behaving in a manner which demonstrated they felt safe and comfortable with staff, interacting and responding to staff.

Staff had received safeguarding training and were able to describe the types and signs of abuse and potential harm. They also knew how to report abuse. The relevant telephone numbers were displayed on the noticeboard in the manager's office. Staff were aware of how to protect people from abuse. Safeguarding was discussed regularly during staff meetings and supervisions.

Risk assessments, referred to by the provider as support guidelines, were in place for each person on an individual basis. People using the service were living with a learning disability and were at risk from a large number of everyday activities. For example, we saw support guidelines for one person in relation to access to toiletries, using public transport, having access to cash and having time alone. People within the service had very complex needs, their behaviours could challenge staff and put them in danger. From observations of people's support, it was clear that staff had detailed knowledge of these identified risks, making sure people were appropriately supported in the kitchen for example. Staff told us about key risks in relation to people they supported and explained how they were constantly reassessing risks to keep people safe. Such as, recognising signs which may lead to behaviour which may challenge staff, and taking appropriate steps to support the person and diffuse the situation. Staff had the ability to recognise when people felt unsafe. Support plans evidenced that the support guidelines were regularly reviewed.

If a person was undertaking a new activity, then they would risk assess as much as possible before the activity. Risks were then constantly evaluated throughout the activity, using appropriate forms, to monitor any on-going risks and whether new risks were emerging. This demonstrated that staff had an understanding of the need to keep people safe. They were aware of each person's individual needs, the associated risks and appropriate actions to mitigate any identified risk.

There were risk assessments in place to protect staff, people and visitors to the home. The documentation showed risks had been considered in respect of such areas as clinical waste disposal, infection control, maintenance of water, bathrooms and wet rooms and food preparation. There were seasonal risk assessments in place such as in the case of cold weather or a heat wave.

There were arrangements in place to address any foreseeable emergency. There was a fire evacuation plan in place which had been regularly practised. Personal evacuation plans reflected everyone's individual needs and were in everyone's support plan.

Incidents and accidents were thoroughly and robustly investigated where necessary. The provider had commissioned an external health and safety company to investigate a recent incident and had responded appropriately to recommendations. For example, it was recommended that staff receive first aid training and records showed this had been booked. Lessons learned were to be shared at a clinical governance forum held by the provider.

The provider used a Health and Safety monitoring tool to maintain safety within the home. This ensured that relevant policies were in place such as infection control and that safety checks were carried out and where relevant actions taken. For example six monthly testing of the fire alarm and emergency lighting and annual checks in respect of gas safety, fire extinguishers and electrical testing was monitored.

Staffing was allocated based on people's assessed need. Both people required one to one support in the day and one person required two to one support if accessing the community. Staff were rostered appropriately to meet their assessed need.

The provider considered people's individual needs when recruiting staff; matching skills to people's specific needs and ensuring people were an active part of the recruitment process. Emergencies such as sickness were mostly covered by staff picking up extra shifts. Sometimes cover was provided by staff from other homes run by the same provider. Wherever possible the use of agency staff was avoided as it affected the consistency of care provided for people with very specific needs, which the staff knew well.

There was a recruitment policy in place. Disclosure and Barring (DBS) checks were carried out before anyone could

Good

# Is the service safe?

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.

Medicines were administered safely by staff who had been trained to do so. Staff had received medicines training and epilepsy training in order to administer emergency medicines. Each person had a personal profile sheet and a sheet explaining how and when ad hoc medicines (known as 'as required') were to be administered. Staff told us about people's 'as required' medicines and this matched descriptions in people's files. There was also a hospital grab sheet for each person, in case of admission to hospital. Medication Administration Records (MAR) were kept for each person. These were all signed appropriately with no gaps. Medicine stock levels were monitored and checked weekly by the deputy manager. Monthly medicine audits were completed by the deputy manager; this included the checking of storage, labels, documentation and returns in relation to medicines.

Good

# Is the service effective?

## Our findings

People's relatives told us they were very pleased with their relative's care and support. One relative said "When (they) went through a bad patch (they) had two staff with (them) all the time – we were very happy with that."

Staff had received appropriate training to deliver the care and support for people living in the home. Records showed training covered all essential areas plus additional areas specific to people's needs such as autism training. The training records were monitored on a monthly basis to ensure staff regularly updated their training.

People were asked for their consent before care and support was provided. Communication passports within support plans made it clear how people communicated so that staff understood when people were consenting. Staff understood when a person was saying or indicating 'no' and they respected people's wishes. 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. There were systems in place to ensure people were given the best chance of being able to make a decision for themselves.

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 is a law that protects and supports people who do not have the ability to make decisions for themselves. Staff had received training in the MCA 2005 and were able describe the principles. Mental capacity assessments had been completed as appropriate. Where people were deemed to lack capacity, appropriate consultation had been undertaken with relevant people to ensure that decisions were being made in a person's best interests.

The Care Quality Commission (CQC) monitors the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Relevant applications had been submitted for people and reviewed and updated when necessary.

Staff 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.'

Relevant professionals were involved to ensure people were supported to have healthy well balanced diets that met their specific needs. A speech and language therapist had carried out an assessment following a choking incident and a learning disability nurse regularly visited the service to support one person. People had regularly visited the dentist and the GP. Notes about the advice given were kept on people's support plans. Menus were chosen by people on a weekly basis by pointing at pictures of different kinds of food. Staff managed the food pictures to ensure that the overall weekly menu was healthy and balanced, and reflected people's individual choices. Staff had received nutritional training to enable then to do this appropriately.

Good

# Is the service caring?

## Our findings

People's relatives were pleased with the care provided by staff in the home. One relative told us "They do look after (the person). (They) had some time in hospital – someone was with (them) 24/7 and I think that's absolutely brilliant – top notch."

Staff were supportive and caring. Staff showed they were able to communicate with people and understood their needs. They interacted in a meaningful way which people enjoyed and responded to. Staff spoke enthusiastically about people's likes and dislikes. They demonstrated they knew people really well and what was important to them. One member of staff said "I spend a lot of time doing (the person's) hair and make up. She loves pink lipstick."

Staff respected people's dignity by knocking on their bedroom doors before entering and giving people personal time alone in their bedroom whilst monitoring them from a distance. Offering people choices and ensuring they looked nice was an important part of maintaining people's dignity. Staff supported other people to undertake activities they enjoyed such as long walks and cooking. Staff knew that walking was an important technique to calm one person down and was also an activity they really enjoyed. Walks were planned regularly and taken on an ad hoc basis.

Independence was encouraged as far as possible. One person was able to make their own cup of tea and staff just gave verbal prompts to the person to ensure their safety was maintained. The person had clearly carried out this activity often and knew exactly what they were doing, ensuring that the used tea bag was put in the bin, they used a cloth to wipe up any mess and washing their cup up after they had finished their tea. The person had also been encouraged to learn how to iron and there was a detailed description of this in their support plan, describing how staff had demonstrated without the iron plugged in initially and then at a very low setting until the person was confident.

Staff maintained regular contact with family members and recognised the importance of this. One person was supported to visit their family regularly and maintain telephone contact. The home had purchased a equipment which would promote contact through social media, and this was being tested and set up. One relative said "The care staff are second to none."

Staff demonstrated that they knew people well and were familiar with their preferences, likes and dislikes. One person liked drinking cups of tea often and was able to make their own cup of tea. They knew that one person needed minimal support with personal care and how to ensure they were able to provide prompts without impacting the person's independence. The person took pride in her appearance keeping up with the latest fashion, and during the inspection was taken by staff to buy new jewellery. We saw her room was personalised with family photos and there was a large array of perfume and clothing accessories, which corresponded with their support plan. Staff were respectful of choices and when one person chose to stay in bed in the morning, this was respected. One member of staff said "We treat (people) how we would like to be treated."

Good

# Is the service responsive?

## Our findings

People's relatives had been involved in their support plans, were kept regularly updated and were involved in regular reviews. Reviews included professionals involved in the people's care, which meant that support plans included all feedback and advice in a timely way. The staff had worked with people through observation, preferred methods of communication, such as using pictures or objects of reference, and regular evaluation to ensure support plans were tailored to people's individual preferences. Objects of reference are objects which have meaning assigned to them, for example a cup might represent a drink. Monthly meetings were held between people and their key support worker to review the previous month and plan activities and special events for the following month.

The service had one bus, and to ensure everyone did not have to do the same activity or wait while others had their activity, the service had looked at alternative methods of transport which would give people greater independence. Alternatives such as the local bus service was explored and tested for one person. The person had the freedom to use the local bus whenever they wanted.

People had a person centred planning (PCP) meeting every six months which looked at their goals and aspirations and how these could be achieved. One person's PCP review included being more independent and horse riding. These had all been achieved and new goals needed to be set to ensure the home continually strived for the best outcome for the person.

The staff responded well to people's mental health needs. One person had Seasonal affective disorder (SAD) and detailed support plans had been written around the person's needs at this time and the support they required. For example, staff described the need to keep the person safe and to use distraction techniques. They also demonstrated a knowledge of how to support them by using an ultra violet light and using cushions in between the person's legs to manage the risk of them self-harming. It was recorded that the person was less able to make choices at this time and staff needed to manage this by ensuring they did not confuse the person, when they were distressed. There was a need to limit choices at this time. The home had also considered that the person's ability to maintain adequate nutrition at this time was reduced and staff knew to offer food little and often and to ensure they were offered plenty to drink. There were also detailed plans around the use of 'as required' medicine so that staff knew at what stage, the person needed medicine.

People chose activities which they enjoyed and were supported by staff to attend these. Staff monitored to ensure the person was still enjoying and benefitting from the activity so that alternative choices could be made if necessary. One relative told us "(the person) goes out a great deal."

Where necessary, action was taken, in response to people's health needs. A psychiatrist and learning disability nurse were regularly involved and a speech and language therapist had carried out an assessment because the person had choked on some spaghetti. Spaghetti was a food the person liked and enjoyed, so advice had been sought to ensure the person could continue to eat this food in a safe way.

Relatives knew how to complain. People had communication passports which showed the ways in which they communicated. Staff were very knowledgeable about people's communication methods. This meant they understood when a person was indicating how they were feeling and why this might be. People also had monthly opportunities to discuss their care and support with their keyworker.

Staff used shift handovers to discuss and share how each person had been, including any changes or concerns about their wellbeing. This demonstrated they were able to offer consistent care.

The home had good links with the local community, people regularly visited local discos, the library, used local transport and shops.

Requires improvement

# Is the service well-led?

## Our findings

The home did not have a registered manager in post. The previous registered manager had left in March 2015 and a new manager had been recruited in September 2015. They were not yet registered with the Care Quality Commission (CQC). Between March and September 2015 the deputy manager had been managing the home. He was liked and respected by staff. Staff knew and understood people well.

There was mixed feedback from relatives, of the two people using the service, about the management of the home. There was some concern from relatives about the way a significant incident had been dealt with by management , particularly in respect of their communication and liaison with relatives.One relative was unhappy about the way a serious incident had been dealt with. They said "I cannot fault the level of care which as been given by care staff, but the management…we haven't been approached properly. As an organisation they're very lacking –lacking on human approach." The other relative was happy with management.

Staff said they were able to raise any issues or concerns with the manager or deputy manager. They felt they were listened to. Staff were happy and worked well together ensuring a happy atmosphere, which was reflected in people's care. The staff knew about whistle blowing and that there was a policy. They all said they would whistle blow if necessary but had not had cause to do so.

A team building event had been held for staff which included a quiz. Monthly meetings between people using the service and their keyworker reflected feedback from new activities, to ensure people had input into how the service was run.

Feedback from people and staff was sought on a regular basis. We saw evidence of home meetings, staff meetings, team building exercises and keyworker meetings. We observed that people were listened to and offered choices. Photographs displayed around the home, in people's support plans and the daily diaries demonstrated that feedback from people was important and taken into account when developing the service.

Staff had written their own support plans as a learning process of demonstrating to themselves, the things that they would want in their own support plan. This gave them a much better view in respect of the important things in people's lives which should be reflected in their support plans and demonstrated that staff respected people's individual views.

Staff were aware of their responsibilities both within the home and to people they supported. This was reflected in their job roles, through supervision and appraisal. Duty of care, safeguarding and Deprivation of Liberty Safeguards (DoLS) were discussed at team meetings.

Robust systems for quality assurance were in place, such as, legionella risk assessment, asbestos management plan, electrical equipment testing, emergency lighting, fire alarm testing, medication and infection control audits, reviews of the environment and a health and safety monitoring tool. All these checks were carried out at regular intervals and there was evidence to support this. Provider audits were carried out quarterly and based around the five domains CQC inspect under. The last one had been carried out in September 2015 and no actions were required.

The provider held manager's meetings alternate months. These included other managers from homes in the local area run by the same provider. Minutes of the last meeting showed that vacancies, training and CQC reports had been discussed. This ensured that managers were able to discuss issues at a more strategic level and also to access peer support.

Incidents and accidents were recorded and responded to appropriately. Records showed that incidents were followed up and investigated where necessary. Actions which needed to be taken as a result were cascaded to staff in team meetings and where necessary support plans and other records were updated. There was also an online system maintained by the provider which meant that incidents could be analysed for trends on a provider basis and that senior management were informed in a timely way in order to take any actions which may be required provider wide.