Care Quality Commission

Voyage 1 Limited

Grange House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on Friday 7 November 2014 and we gave the provider 24 hours' notice because the location was a small care home and we needed to be sure that people using the service and managers would be in.

Grange House is a care home for up to five people with a learning disability. When we inspected, two people were using the service. The home had a registered manager who had been in post since July 2014. 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 found staff knew the people they supported well and understood their care needs and how they communicated. Staff treated people with respect, offered them choices about aspects of their daily lives and allowed them time to make decisions about the care and

Summary of findings

support they received. Where people could not make decisions for themselves, staff worked with their relatives and others to agree decisions in the person's best interests.

People received the medicines they needed and staff followed clear procedures for the management of people's medicines. Staff referred people to health care services and supported them to attend appointments.

Since our last inspection, the provider had reviewed the home's complaints procedure and referred people using the service to a local independent advocacy service for support with making decisions about their care and treatment.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Managers and staff in the home were not responding to incidents affecting people's safety and welfare in line with the provider's policies and procedures.

The provider had not reviewed and updated people's risk assessments in line with their policy and there were not enough staff on duty at times to support people safely outside the home.

Records of the use of restraint lacked detail and we could not be sure restraint was used appropriately or safely.

The meals planned and provided did not always meet people's nutritional needs.

People using the service were not always able to take part in appropriate activities.

The provider did not inform the local authority or the Care Quality Commission of incidents that affected the welfare and safety of people using the service.

You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires Improvement

Some aspects of the service were not safe.

The provider had not made arrangements to ensure people using the service were safeguarded against the risk of abuse. Incidents were not referred to the local authority safeguarding team for investigation.

The provider had not taken proper steps to protect people against the risks of unsafe or inappropriate care. Risk assessments were not reviewed regularly and sufficient numbers of staff were not always available to support people.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider did not have suitable arrangements in place to protect people against the risks of restraint being unlawful or excessive. The recording of the use of restraint did not include enough detail to assure people were cared for safely.

Where people could not make decisions for themselves, staff worked with their relatives and others to agree decisions in the person's best interests.

The provider did not ensure people were protected from the risks of inadequate nutrition. Records showed people experienced gaps of 24 hours between hot meals.

Is the service caring?

Good

The service was caring.

Staff knew the people they supported well and understood their care needs and how they communicated.

Staff treated people with respect. They offered people choices about aspects of their daily lives and allowed them time to make decisions about the care and support they received.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People did not have access to appropriate activities. Staffing levels meant people were not able to take part in activities in the evenings and there was little evidence of activities outside the home after 5:30 pm.

The provider's care planning systems looked at people's individual needs.

The provider had reviewed the way they responded to complaints and a satisfactory record of complaints was kept.

Summary of findings

Is the service well-led?

Some aspects of the service were not well led.

The provider had not notified the local authority or the Care Quality Commission of significant incidents affecting people using the service.

The provider had a clear vision and values that included respecting and trusting people using the service.

The provider worked with other agencies to make sure people's health care needs were met.

Requires Improvement

Grange House

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.

The inspection took place on Friday 7 November 2014 and we gave the provider 24 hours' notice because the location was a small care home and we needed to be sure that people using the service and managers would be in.

The inspection team consisted of one Care Quality Commission Inspector.

Before the inspection, we looked at the report written following our last inspection on 1 April 2014. At that inspection we found the service was breaching a number of Regulations involving the management of risks to people using the service, the use of restraint, the procedures for managing complaints, care planning, staff recruitment and staff training. The provider sent us an action plan on 1 October 2014 and said the service would be compliant with the Regulations by 31 October 2014.

As part of our planning for this inspection, we also looked to see if the provider had sent us any notifications of significant events affecting people using the service. We found the provider had not sent any notifications since 26 January 2012 and we discussed this with the provider's operations manager during our visit.

During the inspection, we observed staff working with people using the service. We met both people but they were not able to communicate their views verbally. We saw people had good relationships with staff who treated them in a caring, professional manner throughout the day. We also looked at the support and health care plans for both people using the service, the training and recruitment records for two members of staff, the provider's safeguarding and whistle blowing policies and procedures, medicines records and staff rotas. We also spoke with the manager, deputy manager, two members of staff and the provider's operations manager.

Following the inspection, we also spoke with a relative of one person using the service and a social care professional responsible for monitoring placements in the home to get their views on the care and support provided to people.

Requires Improvement

Is the service safe?

Our findings

The home's manager told us there had been no recent safeguarding incidents. However, when we looked at daily care records completed by support staff and records of accidents and incidents, we found a number of incidents that should have been referred to the local authority's safeguarding adults team. For example, records showed two incidents of unexplained bruising in February and July 2014 that should have resulted in referrals to the safeguarding team. Records also showed two incidents in September and October 2014 where a person using the service had physically assaulted staff. We discussed these incidents with the provider's operations manager and they confirmed the provider had failed to notify the local authority safeguarding team of these incidents.

People using the service may have been at risk of unsafe care as the provider had not regularly reviewed and updated people's risk assessments. At our last inspection in April 2014, we found the manager had identified gaps in people's risk assessments. During this inspection we reviewed the risk assessments for both people living in the home and saw these were last updated in October 2013. We discussed this with the provider's operations manager who said staff in the service were not following the provider's policy to review risk assessments when needed or every six months.

The risk assessments we saw covered mobility, support in the local community, personal care and support with nutrition. The provider had assessed that both people using the service needed support from two members of staff when they were outside the home. This was reflected in people's care plans and risk assessments. However, during the inspection, two members of staff took both people to a local park. The failure to provide sufficient numbers of staff to support people outside the home meant people could have been at risk.

We looked at staff rotas and these showed a minimum of two support staff on duty between 7:00 am and 9:00 pm. In addition, the manager or deputy manager also worked shifts in the home. After 9:00 pm, one member of staff slept in the home and was available to support people during the night, if required. During the inspection, we saw the staff rotas accurately recorded the number of staff on duty each day.

People's assessed care needs were not always met, as they were not always able to access community activities. The Deputy Manager and support staff told us additional staff were provided if activities or appointments were planned and we saw this was reflected in some of the rotas we looked at. However, this level of staff support did not always allow people to take part in activities outside the home as assessments showed both people needed 2:1 support. It also meant people could not take part in activities in the evening, as only one member of staff was available from 9:00 pm. The daily care records we looked at showed very few activities outside the home after 5:30 pm.

These were breaches of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a safeguarding adults policy and this was reviewed and updated in October 2014. Staff working in the home had signed to show they had read the updated policy. The provider also had a confidential whistle blowing procedure to enable staff and visitors to raise concerns and we saw this was displayed in the front hallway.

Staff we spoke with told us they had completed safeguarding adults training and they were able to tell us what action they would take if they had concerns about a person using the service. They told us they would alert the home's manager or a senior manager within the organisation and they would make sure they investigated their concerns.

We saw the manager and deputy manager carried out regular audits in the home, including a health and safety audit. Where issues were identified, action plans were in place to resolve these. For example, at our last inspection we noted smoke seals on doors had been painted over and this issue had been addressed and resolved at the time of this inspection.

We checked the home's arrangements for ordering, storing and managing the medicines people needed. We found people's medicines were managed so they received them safely. We looked at the medication administration records (MAR) for both people living in the home. These showed all required medicines were in stock and people had received

Requires Improvement

Is the service safe?

their medicines as prescribed. Both of the people using the service had their prescribed medicines reviewed by their GP in June 2014 and the manager kept a record of these reviews in the home.

At our last inspection we noted the medicines records did not record whether people had allergies. The deputy manager confirmed staff had checked with people's GP's and the MAR sheets we saw showed no known allergies for either person.

All medicines were held securely in a lockable cabinet or fridge. Medicines were supplied pre-packed by the pharmacy. This minimised the risk of dispensing errors by staff. Staff who administered medicines were appropriately trained.

Requires Improvement

Is the service effective?

Our findings

The manager told us on occasion one person using the service exhibited behaviours that challenged. Staff training records showed all staff had completed training in Non-Violent Crisis Intervention to enable them to manage these behaviours and reduce risks to the person concerned and others. The daily support records we saw showed that staff sometimes used restraint as part of their interventions to make sure people were safe. However, the records of the use of restraint lacked detail and we could not be sure restraint was used appropriately or safely.

For example, the records we saw did not include the type of restraint used, when it was used, the reasons why it was used, how long the restraint lasted, who was involved and the condition of the person before and after they were restrained.

This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they knew people's likes and dislikes with regard to the food and drink people preferred. They told us they had a weekly house meeting and pictures were used to help people choose the meals they wanted each day. We saw the pictures were used on a menu chart in the dining room to show people the food planned for the day.

Staff also told us they served the main meal of the day at lunchtime with a snack meal in the evening. On the day we inspected people had meatballs and pasta at lunchtime. The evening meal was planned to be salmon fillets but when we checked the fridge we found two packets of smoked salmon and a small tub of coleslaw. The inspection took place on a very cold day and the meal staff planned to provide was not appropriate. We discussed this with the provider's operations manager who agreed and asked staff to provide a more appropriate meal. The staff prepared scrambled eggs with the smoked salmon, but they served the meal at 4:45 pm. The daily care records showed on most days people were given a yoghurt or mousse later in the evening. This meant there was a significant gap between meals being provided for people.

Staff told us they had completed a full induction training programme when they started working in the home. One member of staff said, "The induction was very useful and really helped me to get to know people living in the home."

The staff records we checked showed both staff had completed their induction training and training the provider considered essential to their role. This included infection control, medicines management, safeguarding adults and training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The training records we looked at showed all staff had either completed the training they required or were booked to attend refresher training in the near future.

Staff records also showed support workers had supervision with the home's manager or deputy manager. The records we saw showed staff had last received supervision either in August or September 2014. The Operations Manager also told us each member of staff would have an annual appraisal but these had not been completed when we carried out this inspection.

At our last inspection in April 2014 we noted some staff were unable to communicate easily with people using the service in English. The provider's action plan said individual training and development plans would be developed for all staff to make sure they had the skills necessary to support people using the service. The Operations Manager also told us that the provider's recruitment procedures included an assessment of applicants' written and spoken English. During the inspection we saw staff were able to communicate with people using the service both verbally and non-verbally.

Staff were able to tell us about their responsibilities under the Mental Capacity Act 2005 and DoLS. They told us some aspects of people's liberty were restricted for their safety. For example, the front door and kitchen door were locked because people would not be safe if they went out without staff support and they had been assessed as unable to use the kitchen without staff supervision. The manager told us they had applied to the local authority for authorisation of these restrictions, but no assessments had yet been carried out. The manager was aware of the need to inform the Care Quality Commission of the outcome of any DoLS applications.

The provider, manager and support staff understood their responsibilities and acted in line with legislation to make

Requires Improvement

Is the service effective?

sure people were involved in making decisions about their care and support, wherever possible. People's support plans included assessments of their capacity to make certain decisions about the care and support they received. We saw that one person's relative was involved in meetings to ensure decisions were made in the person's best interests. A local authority care manager was involved in meetings to agree best interest decisions for the second person.

Staff supported people to maintain good health and enabled them to access the health care services they needed. We looked at both people's health care records and saw staff supported them to visit their GP's, dentist and optician regularly. We also saw staff supported people to attend clinic and hospital appointments when necessary.

Good

Is the service caring?

Our findings

Staff understood the care and support needs of people using the service. The support staff we spoke with knew the people they worked with very well. They were able to tell us about their life history, significant people, daily routines and preferences. They were also able to tell us how each person communicated their needs.

We saw staff treated people with respect and in a caring, professional manner throughout our inspection. Staff spoke with people respectfully, gave them opportunities to make choices and decisions about their care and support and made sure they had sufficient time to make these decisions. When one person became anxious, support staff took time to reassure them and allowed them space to be on their own. When the person was less anxious, staff took time to explain what was happening for the rest of the day and made sure the person understood.

People using the service or their representatives were involved in reviewing the care and support they received.

The care plans we looked at included assessments of the person's health and social care needs, life history and information about their likes, dislikes, hobbies and interests. Staff told us the assessments and other information were used to develop a detailed care plan and risk assessments. One member of staff told us, "It's all about the people we work with, we need to know what they need."

Staff told us their training had included issues of privacy, dignity and respect and they were able to tell us how they included this in their work with people. For example, they told us they addressed people by their preferred name and always knocked on doors before entering people's rooms. We also saw people were able to spend time in their rooms when they wanted to be away from others and they could lock their bedroom door from the inside if they wanted more privacy.

We saw all confidential information about people using the service was kept securely in the office.

Requires Improvement

Is the service responsive?

Our findings

A social care professional who worked with one person using the service told us they organised regular reviews of the person's care. They said the managers and staff from the home contributed well to each review. They said they felt people were well cared for but the provider could do more to promote people's independence and provide more appropriate activities.

The care records we looked at included weekly activity plans, daily care notes and a one-page summary of the person's care and support needs. This summary also included clear guidelines for staff on how the person should be supported.

People did not have access to appropriate activities. The activity plan we saw for one person was task based, including 'dusting, polishing and hoovering' their bedroom every morning. Other activities included going out for a drive in the home's vehicle, walks in the local area and ten-pin bowling once a week. The deputy manager told us staff had not followed up a suggestion made at a review meeting in August 2014 that the person might enjoy going to the gym.

We saw little evidence that staff supported people to take part in activities in the evenings. The daily care notes we looked at showed both people were usually in their night clothes by 8:30 pm at the latest and they spent time in their rooms or the lounge. We saw no evidence staff arranged evening activities outside the home as there was usually only one member of staff available after 9:00 pm and both people needed support from two staff when outside the home.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's care planning systems were centred on the individual. Support plans considered people's care and support needs, including those related to their age, disability, gender, race, religion or belief and sexual orientation. For example, one plan included information about the person's religious beliefs and how staff working in the service should respect these. Staff told us they supported this person to attend a local place of worship.

At our last inspection in April 2014 we found people using the service were not supported to raise concerns in line with the provider's policy. Following the inspection the manager told us they had referred both people using the service to a local advocacy service. During this inspection the deputy manager told us both people were still waiting for an advocate to be allocated. The operations manager told us the provider had reviewed the management of complaints in the home and since our last inspection the provider had received one complaint about the home. We saw the complaint was well recorded with details of the actions staff took to respond and address issues raised. The record showed the person who made the complaint was satisfied with the outcome of the provider's investigation.

Requires Improvement

Is the service well-led?

Our findings

As part of our planning for this inspection, we looked at the notifications sent to us by the manager and provider. It is a legal requirement that the provider notifies the CQC of certain significant events and incidents affecting people using the service. These notifications include any abuse or alleged abuse. We found the provider had not sent any notifications to CQC since 2012. During this inspection we identified a number of incidents that should have been referred to the local authority safeguarding adults team and notified to the CQC.

This was in breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We saw the provider had a clear statement of purpose that detailed their philosophy of care. This included quality support, respect and trust. Staff we spoke with told us they discussed the provider's philosophy of care as part of their induction training.

The Operations Manager showed us a quarterly audit of the services provided in the home that the manager had started to complete in October 2014. The audit covered all aspects of the care and support provided to people using the service, and included care planning, risk management, finances, medicines and the environment. Where the manager identified areas that required improvement, they developed an action plan to address the issues, although we saw this had not been done in all instances. The Operations Manager told us they visited the home monthly to review the audits and action plans with the manager.

The service learned lessons from events that affected people's welfare and safety. The deputy manager told us accidents and incidents would be discussed in a staff meeting to learn lessons and the staff we spoke with also confirmed this.

We saw evidence the home worked with other health and social care agencies to make sure people received the care, treatment and support they needed. The provider ensured people were supported to make and maintain contact with community healthcare services, including GP's, dentists, district nurses and community mental health services.

The home had a manager who registered with the Care Quality Commission (CQC) in July 2014. A registered manager is a person who has registered with the CQC 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 manager was also registered to manage two other small care homes for the provider. They told us they spent two days each week in the home and the deputy manager was responsible for the day-to-day running of the home at other times.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not taken proper steps to ensure that people were protected against the risks of care that is inappropriate or unsafe because they had not carried out assessments and did not always deliver care to ensure the welfare and safety of each person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had not made suitable arrangements to safeguard people against the risks of abuse because: 1. They had not taken appropriate steps to identify the possibility of abuse or respond to allegations of abuse. 2. They had not made suitable arrangements to protect people against the risks of excessive or inappropriate restraint.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person had not made suitable arrangements to provide appropriate opportunities, encouragement and support for people using the service to promote their autonomy, independence and community involvement.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had not notified the Care Quality Commission of allegations of abuse in relation to people who use the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.