Voyage 1 Limited

Redmond 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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This unannounced inspection took place on the 16 December 2014.

Redmond House provides accommodation for people requiring personal care. The service can accommodate up to 12 people. At the time of our inspection there were 12 people using the service. Redmond House provides care to younger people with a learning disability and some people have physical health needs.

There was a registered manager in post at the time of the inspection. 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.

There were not enough staff working at the service and this impacted on the care provided to people.

Medication procedures had been implemented to improve the management of medicines.

Summary of findings

There were safeguarding systems in place to protect people from the risk of abuse.

The provider had a recruitment system in place and staff had received a Disclosure and Barring service (DBS) check. The DBS helps an employer make safer recruitment decisions and prevents unsuitable people from being employed.

There was a system of staff training and development in place; however this did not always ensure staff were suitably trained to meet people's needs.

The registered manager and staff were aware of their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The registered manager was in the process of submitting DoLS applications to the local authority for people who needed these safeguards.

People received a range of food and drinks. However relatives were concerned diets were not always well-balanced.

People had access to a range of health and social care services. However, sometimes there was a delay in making arrangements for medical appointments.

People's privacy and dignity was not always respected.

People were not always supported to access the community or undertake activities of their choice.

The provider had a complaints system in place; however relative's concerns were not always recorded to ensure complaints were dealt with appropriately.

The provider's system of quality monitoring did not always identify concerns about the service.

There was a lack of formal systems to allow people and their relative's to feedback about the service.

The management of the home had been through a period of instability and there had been a lack of leadership to ensure good care was provided at the service.

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

The service was not always safe.

There were not enough staff on duty to meet people's individual needs.

Medication procedures had been implemented to improve the management of medicines.

There were systems in place to safeguard people from the risk of abuse. However, people were not always safeguarded from people's behaviours that challenged the service.

There were safe recruitment systems in place to check staff were of good character before they started work.

Is the service effective?

Requires Improvement

The service was not always effective.

There was a system of staff training; however, this did not always equip staff to meet people's complex needs.

Staff did not receive supervision with their manager to check standards in providing care were maintained.

The registered manager was aware of their responsibilities in regards to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and was in the process of submitting DoLS applications to the local authority where people required them.

People were supported with choices of food and drinks. Staff did not always prepare the food choices which were specified on the menu.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always respected.

People and their relatives were not always involved in the planning of care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always supported to do activities to meet their social needs.

The provider's complaints system did not ensure that relatives' complaints were recorded and dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Summary of findings

The provider system of quality assurance did not always identify failings in the service.

The provider had a lack of systems in place to enable people and their relatives to feedback about the service.

Redmond 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 was in response to concerning information received and to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 16 December 2014. The visit was unannounced. The inspection team consisted of three inspectors.

Before the inspection, we reviewed the information we held about the provider. We also spoke to health and social care professionals and commissioners. They provided us with information about recent monitoring visits to the service and safeguarding investigations.

During this inspection we spoke to the registered manager, a senior manager who worked for the provider and nine care workers. Many of the people living at Redmond House had a learning disability and were unable to communicate with us verbally. We therefore spoke to five of their relatives to obtain feedback about the service.

We undertook general observations in communal areas and during mealtimes. We used the Short Observation Framework for Inspection (SOFI) during lunchtime in the main dining area. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care records of five people who used the service and four staff recruitment files. We also reviewed records relating to the management and quality assurance of the service.

Requires Improvement

Is the service safe?

Our findings

Relatives told us that staff were unable to meet people's individual needs due to staff shortages. One relative said "The staff cannot provide one to one care; they are always doing other things and they are not able to interact with people in the living area". Another relative said "[relative's name] is supposed to have one to one care, but I don't think they have ever had it. The staff say they don't have time and have to cook and clean". During our inspection, we observed that staff had additional tasks to undertake and this took them away from providing people's care. We saw that the provider had calculated staffing levels based upon people's need for care; however they had failed to calculate the time staff needed to take to undertake tasks such as cooking, cleaning and administering people's medicines and the impact this had in providing one to one care.

The arrangements for staffing the home had become unstable due to several staff leaving the service. There was also an unfilled vacancy for a team leader to provide staff with leadership and support in providing care. The provider was bridging the gap in staffing by using agency staff and this created a variable level of care. One relative said "The agency staff are not very good and [Relative's name] looked messy and dirty the other day". Another relative said "There are a lot of agency staff, some are very good, and others sit around a lot". We observed that agency staff lacked the skill and knowledge to care for one person and this resulted in them using behaviours that challenged the service. They became physically aggressive and tried to throw objects and furniture around in an office area of the home. The member of staff was unable to intervene and the person was allowed to continue with behaviours that challenged the service. This situation put people and staff at risk of harm.

The staffing levels had become difficult to manage due to some agency staff being unreliable and not turning up for work. Staff told us this put them under considerable pressure and made it difficult to spend time with people interacting or going out into the community for social activities. We also saw information which confirmed that agency staff did not always turn up for their shifts. The provider and the registered manager were taking immediate action to resolve this situation and were in the process of recruiting permanent staff.

This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010.

Improvements had been made to the management of medicines, however relatives were concerned medicines were not always managed safely. For example, there had been a number of medication errors which included giving people the wrong medicine and failing to store medicines in a safe way. Relatives told us they were concerned that medication errors put people at risk of unsafe care. However, we found that the new registered manager had made several improvements to the management of medicines. This included re-training all the staff and introducing new medication procedures and medicine storage facilities. We saw that a daily medication audit had also been implemented and this enabled staff to identify medication errors quickly. The registered manager acknowledged that more work was required to improve the management of people's medicines and this included developing a set of formal procedures for managing medicines required as and when needed (PRN) and improving the storage facilities for one person's medicine.

People were not always protected from the risk of abuse. For example, one relative told us their family member was "fearful" of other people living at the home. They told us staff did not always prevent people from being hurt when other people had behaviours that challenged the service. Staff confirmed that several staff did not always follow procedures as they thought they "knew better". However, staff had been reluctant to report their concerns for fear of reprisals from other staff. They told us that previous managers had not always listened to their safeguarding concerns and had done little to address this situation. We raised this with the registered manager and they told us staff had been briefed about how to reduce the risk of people being harmed and to manage people's challenging behaviours. They also told us they had implemented an 'open door policy' to assist staff in raising safeguarding concerns and some staff had reported potential safeguarding concerns to them. We saw that the registered manager had promptly reported these concerns to the local safeguarding authority and the Care Quality Commission (CQC) and was working closely with all agencies to safeguard people using the service.

A range of risk assessments were in place designed to minimise the risk of unsafe care. However, relatives raised concerns that risks of going out into the community and

Requires Improvement

Is the service safe?

undertaking activities were not fully explored. Staff told us they were aware of risks to people's health and safety and were able to manage conditions such as epilepsy. For example one staff member explained the actions taken to manage a seizure such as taking medication and ensuring the person was in a safe recovery position. Another staff said "We use distraction techniques when out in the community and we find [person's name] is well behaved". We saw that staff had recently updated some risk assessments to account for any new risks to people's safety such as risk of seizure, risk of fall and risk of undertaking activities. However, some people's risk assessments had not been reviewed recently. For example, one person was at risk of losing weight and they had not received a re-assessment of this risk for seven months. We also found that they had not been recently weighed which also increased the risk of losing weight. The registered manager informed us that they had planned a review of each person care and this involved identifying any risks of providing their care. They also told us that appropriate referrals were being made to health and social care professionals where additional intervention to manage risks was required.

There were recruitment processes in place to ensure staff were of good character and able to work with people. Staff confirmed that they had been through the provider's recruitment process which included completing an application form and having an interview to check suitability. We saw that the provider had obtained references from the staff's previous employers and that staff had received a Disclosure and Barring Service check (DBS). This check helps employers make safer recruitment decisions and prevents unsuitable people from being employed.

Requires Improvement

Is the service effective?

Our findings

There was a basic system of staff training in place; however, relatives raised concern that staff did not understand people's complex needs. For example, one relative told us "The staff have no idea about Autism or how to meet [relative's] needs. We need the staff to have specialist training". Another relative said "Specialist training needs to be put in place, if [relative's name] was unwell, staff could not give them their medicine." The registered manager confirmed that staff were no longer able to administer one person's medicine due to staff needing specialist training, however, alternative arrangements had been made for a district nurse to administer the medicine as an interim measure. While we saw that a system of staff training was in place; this provided basic training such as health and safety, medications management and first aid. There was no formal training in place to help staff understand learning disabilities such as Autism. Staff were also concerned that their training did not fully prepare them to care for people. One member of staff said "I have been here for years, but I feel like I've only just started learning". The registered manager acknowledged the need to improve staff training to provide a more specialist level of care to people.

Staff had not received a recent supervision with their manager to check they were working to a required standard. One staff said "There are no staff supervisions at the moment. I'm not sure about some things I'm doing but I don't like to ask". Another member of staff said "We are supposed to have supervision, but have not had it yet". We saw that the registered manager had a plan in place to re-introduce the system of staff supervision; however, this had not been fully implemented at the time of our inspection.

The registered manager was aware of their responsibilities under the Mental Capacity Act 2005 and in relation to the Deprivation of Liberty Safeguards (DoLS). People who were unable to provide consent for their care had received or were in the process of receiving an assessment by the Local Authority to ensure the appropriate safeguards were in place.

We saw that when people's freedom needed to be restricted they had received an assessment by the local authority and care had been put in place in people's best interests. For example, one person was unable to consent to having constant one to one care and we saw that an appropriate application had been made to the Local Authority and safeguards were in place. Arrangements had also been made to support the person to make choices and a best interest decision had been made with their family and health and social care professionals involved in their care.

People received a choice of foods and drinks; however relatives were concerned that people's diet was not always healthy. For example one relative said "[relative's name] diet is terrible; the snacks are always chocolates and crisps". Another relative told us there were too many processed foods served at mealtimes and not enough access to healthy meal choices. Another relative told us "There are too many puddings served [relative's name] has put on weight since coming to live here". We observed that a menu was available which contained information about a variety of food choices and we saw that staff gave people alternative meal choices to suit their likes, dislikes and preferences. However, we also saw that the menu did contain a number of processed food choices. For example, we saw that hot dogs were often served at lunchtime. We also observed that staff did not prepare the 'sausage casserole' as described on the menu and instead served people with a 'tinned soup'. We raised our concerns about the food choices available with the new registered manager and they confirmed that they planned to improve the arrangements for food and drink at the service. We saw that people requiring assistance to eat their food were provided with staff support and people needing a soft diet due to swallowing difficulties had access to a soft or blended diet.

People accessed a range of health and social care services; however, relatives stated that these arrangements needed improving. For example, one relative said [relative's name] does go to the doctor but we have to remind staff of appointments, otherwise they don't go". Another relative also said "[relative's name] does go to the doctors and the dentist, but it is a bit hit and miss with staff arranging appointments". People's care records showed that people had accessed a range of health professionals such as the GP, dentist, optician, district nurse and the learning disability team. The registered manager had improved systems for accessing health care by maintaining a record of all medical appointments required.

Requires Improvement

Is the service caring?

Our findings

People did not always receive dignified care. Several relatives raised concerns about the arrangements to protect people's dignity. We also observed that one person was routinely cared for in a way that compromised their dignity and this was in view of people using the service, staff and visitors to the home. This situation did not contribute to an environment where all people living at the home were valued or respected. We also observed that the premises did not provide people with privacy. For example, we observed that people could be easily viewed from outside and there were few measures in place such as net curtains or blinds to protect people from public view. We immediately raised this with the provider and the local safeguarding authorities and the provider took immediate action to place frosting on the windows to provide people with an improved level of privacy at the home.

People and their relatives were not always involved in making decisions about their care. One relative said "We were not consulted when [relative's name] went to the doctor, they told us after the event and we did not know they had been put on medication". Another relative confirmed this situation and also told us their relative had been put on medication without their involvement. They also said "There is no feedback from staff when [relative's name] goes for appointments; we have to call the staff and some of them know nothing about [relative's name] care". While we saw that people had individualised care plans, there was a lack of evidence which showed how people or their families had been involved in the planning of care. The registered manager told us that they were trying to implement a new system of care planning to ensure people and their relatives were more fully involved in making decisions about people's care. However, we saw that people's care plans contained information about making choices about their daily lives such as whether to have a bath or shower and choosing the clothes they wanted to wear. We observed that staff gave people choices about their daily care. For example, we saw one person was asked where they wanted to go on an outing into the community. However, people who were unable to communicate verbally had limited ways communicating their choices or decisions about their care. For example, one person needed to use picture cards to communicate, however during the inspection visit the picture cards were not being used routinely by the staff. Relative's also expressed concern that alternative methods of communicating such as using picture cards where not consistently used to enable people to make choices.

People were treated with kindness and compassion and relatives told us the staff were of a caring nature. However, they also raised concerns that the number of agency staff working at the service did not enable people to build trusting relationships with staff. For example, one relative said "There are more agency staff working at the home and [relative's name] takes a long time to trust people; this makes it difficult as [relative's name] doesn't feel comfortable with unfamiliar faces". The registered manager told us that they were trying to use the same agency staff to provide a good continuity of care as they had recognised this as a concern. They were also recruiting permanent staff to make sure that this situation was addressed long term.

Other relatives told us there was a lack of staff interaction which also influenced the development of positive and caring relationships. For example one relative said "There is a lack of staff interaction and they leave people sitting around a lot. One person is always left sitting in a chair watching the traffic". Another relative said "[relative's name] is often left on their own in their room and they need to be stimulated all the time". However, we did observe that staff and people interacted in a positive way. For example, at lunch time we saw staff supported people to eat in a kind, patient and sensitive way. We also saw that staff made the lunch time meal a social occasion by talking and singing with people and making them laugh.

Requires Improvement

Is the service responsive?

Our findings

The system of complaints management needed improvement. Relatives told us that they had made several complaints concerning their family member's care which had not been dealt with. One relative said "I have made a complaint to the manager as [relative's name] looked scruffy and hair was a mess but nothing was done". Another relative told us "I made a complaint, but this was not fully investigated and they didn't answer my question". While we saw there was a complaints log in place, this had not captured relatives' verbal complaints about the care of people using the service. We did however, review one relative's complaint and saw that the provider was dealing with their concerns. This included responding to the complainant and informing them of their actions to investigate and propose a meeting to discuss their concerns.

People did not always receive care which was responsive to their needs. For example, relatives raised concern that staff did not plan people's activities around their needs. One relative said "It depends which staff are on duty as to whether [relative' name] goes out". Another relative said "the staff do things their way. They provide basic levels of care but the quality of life and going into the community is lacking". While we saw that each person had an activities schedule in place, staff told us they were not always able to keep to this schedule. For example, staff said that due to issues with staffing there were not always staff on duty to drive the minibus and this prevented people from accessing the community. The registered manager acknowledged these difficulties and told us they were trying to improve the service and people's access to the community. During the inspection visit, we observed that several people were supported to access the community and undertake activities of their choice.

People's needs had been assessed and care plans had been developed. However, relatives shared mixed feedback about how well staff understood people's needs. For example, one relative said "I have tried to explain to staff how [relative's name] likes to be dressed, however they continue to dress [relative's name] like a baby". Another relative reflected the improvements to the care planning system and said "There is a new key worker system in place and they have asked me lots of questions about [relative's name] needs. I've told them important information about [relative's name] medication, likes and dislikes and how to spot when [relative's name] is unwell". We saw that there was a system of care planning in place and people had individualised care plans in a range of subject areas such as personal care, moving and handling needs and to address physical health needs such as epilepsy and risk of seizures. The registered manager also told us that they were improving the system of care planning to ensure relatives were more involved in planning people's care.

Requires Improvement

Is the service well-led?

Our findings

Relatives were concerned that the service lacked stability due to the inconsistent management of the home. For example, one relative said "There have been six managers in six years and I have no faith in them making any improvements". Staff also confirmed this situation and told us that the service had been unstable for a few years and there had been a lack of leadership. One staff said "There have been so many different managers and it's been very unsettling, many staff have left". However, the provider had appointed a new registered manager to run the home and the registered manager had identified several failings in the service. This included failings in the management of medicines, staffing and in the reporting of safeguarding concerns. We saw that they were addressing these concerns in order of improving the service. For example, they had implemented new procedures to manage people's medicines and we saw that this had improved the way in which people's medicines were managed.

Relatives and staff told us that it had been difficult to raise concerns about the service and sometimes their concerns had not been listened to or acted upon. For example one relative said "If you have any concerns you are hitting a brick wall and they all say the same thing, promise the world and nothing happens". The provider and the registered manager had identified the need to change the culture of the service to improve openness and build the trust of people, relatives and staff. Staff told us that the service was changing for the better and one staff said "We can see that there are changes to the service, and we can see that it is going to be good". Another staff said "some of the changes are being made for the better". The registered manager told us they encouraged staff to share their concerns about the service and we saw that staff had reported an increased number of incidents such as medication errors and incidents where people had behaviours that challenged the service. The registered manager had reported all safeguarding concerns appropriately to the local authority and to the CQC in line with their regulatory responsibilities.

The systems in place for people and their relatives to feedback about the service needed strengthening. For example, the provider had undertaken a people's and relatives survey in 2014. However, these findings had yet to be analysed and there were no actions in place to improve the service based upon this feedback. While we saw people and relatives meetings were held at the home there was limited information about suggestions for improvements; where suggestions had been put forward the provider could not tell us whether these improvements were going to be made. For example, one relative had requested the re-decoration of their relative's bedroom in September 2014, however the provider was unsure if these changes were going to be made.

The provider had a system of audits and checks in place. A senior manager working for the provider was responsible for checking the standard of care at the home. However, the system did not always identify shortfalls in the service. For example, the provider's auditing system did not include the management of medicines and medication errors had not been identified for a considerable length of time. The provider had also failed to complete a yearly review of the property, and this had been raised with the provider as a risk. However the review had still not taken place. While the provider had made improvements to the arrangements for privacy and dignity at the service, we had to raise our concerns with them before they took action to resolve the situation. The provider had not identified this as part of their routine monitoring of the service.

The provider and the registered manager acknowledged the failings in the service and have been working closely with the local authority to improve the service. We also met with the provider to discuss our concerns and look at their plans for improving the service. The provider has submitted a regular weekly and detailed action plan to CQC and the local authority with all areas of concern identified and progress on actions taken to improve the service.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **People did not benefit from a service that identified risks and made improvements to the quality of the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **People were at risk of unsafe care because there were not enough staff to meet people's needs.**

This section is primarily information for the provider

Enforcement actions

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