Care Quality Commission

Voyage 1 Limited

Birchwood Bungalow

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

Overall summary

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 planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

The inspection was unannounced. When we inspected the service on 31 May 2013 we found that the service satisfied the legal requirements in the areas that we looked at.

Birchwood Bungalow provides accommodation and personal care for seven people who have learning difficulties. The registered manager has been in place since January 2013. A registered manager is a person who

Summary of findings

has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care or treatment. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of achieving this. DoLS require providers to submit applications to a 'Supervisory Body', the appropriate local authority, for authority to do so. We found that the service had complied with the requirements of MCA and DoLS.

Because of people's complex needs they were unable to communicate verbally. However, staff members communicated with people effectively and used different ways of enhancing that communication. Staff treated people in a caring, responsive and respectful way and with dignity and respect. They knew the people they cared for and supported well and always used people's preferred names.

People were involved in deciding what food and drink they had. They were supported to access healthcare services to maintain and promote their health and well-being. They were encouraged to make their rooms at the home their own personal space. People, their relatives or advocates had been involved in the development of their care plans which were reviewed on an annual basis, or more frequently if required. They were supported in a wide range of interests and hobbies, both as group activities or on an individual basis, which suited to their needs. They were encouraged to pursue their interests outside of the home to enable them to develop links with the local community.

There were enough qualified, skilled and experienced staff to meet people's needs. All necessary checks had been completed before new staff members had started work at the home and they had completed an induction programme when they started work. Staff members received additional training in areas that improved their capability in providing care and support to people who lived at the home and had regular supervision and appraisal meetings with the manager at which their performance and development were discussed

Staff members were able to demonstrate a good understanding of procedures in connection with the prevention of abuse. Risks in respect of the home and the provision of care and support to people had been identified, regularly reviewed and steps taken to reduce the on-going risk.

The provider had an effective system to regularly assess and monitor the quality of service that people received and an effective complaints system.

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.

People did not hesitate to go to any of the members of staff on duty at the time of our inspection which indicated that they felt safe with the staff members.

Staff members had received effective training in the safeguarding of vulnerable adults.

Staff members had received training in respect of the Mental Capacity Act 2005 and DoLS and were aware of the requirements for these.

Good

Is the service effective?
The service was effective.

People who had complex needs were able to communicate effectively in non-verbal ways with the staff members.

People were able to decide what they had to eat and drink and when they had it.

People had an annual health check and were supported to access healthcare services to maintain and promote their health and well-being.

Good

Is the service caring?
The service was caring.

People appeared to be happy at the home; some were smiling whilst one person was singing.

People had been encouraged to make their rooms at the home their own personal space.

People's privacy and dignity were respected.

Good

Is the service responsive?
The service was responsive.

People, their relatives or advocates had been involved in the development of their care plans which were reviewed on an annual basis, or more frequently if required.

People were supported in a wide range of hobbies and interests, both as group activities or on an individual basis, which were suited to their needs.

People had regular meetings with the manager and took part in making decisions about food, outings and the care and support provided at the home.

Good

Is the service well-led?
The service was well-led.

The registered manager was supported by a regional manager from the provider's organisation.

Staff members found the manager to be open and approachable.

Good

Summary of findings

The provider had an effective system to regularly assess and monitor the quality of service that people received.	

Birchwood Bungalow

Detailed findings

Background to this inspection

We carried out an inspection of Birchwood Bungalow on 29 July 2014. The inspection team was made up of one inspector and a specialist advisor with expertise in learning disability.

Before we undertook the inspection we gathered and reviewed information that had been provided by members of the public and the people who commissioned the services of the home, such as the local authority and health commissioning groups. We also contacted the GP who supported people who lived at the home. We looked at the notifications that the home had sent us. A notification is information about important events which the provider is required to send us by law. We also asked them to send us a provider information return (PIR) in which the provider gave us information about the home, how it met the requirements of a good service and any areas identified for improvement. They provided this information on 20 June 2014. We used this and the other information available to us about the home to plan our inspection.

During the course of our inspection we spoke with one person who lived at the home. We also spoke with the manager, the regional manager, and two care workers. We reviewed records and carried out observations. We used our short observation framework tool (SOFI) to help us collect evidence about the experience of people where they were not able to fully describe these themselves. 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 and support records of three people who lived at the home. We reviewed the personal folders of five staff members. We looked at the home's policies and procedures, the complaint records and communication book. We reviewed the minutes of meetings held with people who lived at the home and their relatives. We looked at the risk assessments that had been completed. These included the personal risks for the people who lived at the home and the general risks associated with the home.

In this inspection we looked at how medicines were managed as there had been four incidents that involved medicines reported to us between February 2014 and 29 July 2014, the date of our inspection.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

People could not tell us themselves whether they felt safe living at the home. The GP who provided healthcare for all the people who lived at the home told us that they believed the people were safe there. We also observed that people did not hesitate to go to any of the staff members when they wanted support or assistance with a task. This indicated that they felt safe around all the staff members. Staff members kept people under discreet observation to ensure that they were safe.

The staff members we spoke with were able to demonstrate a good understanding of the types of abuse that may occur and the steps that they would take to report any suspicion of abuse. We saw that the home's policy on the prevention of abuse to people had been updated in March 2014. The training records showed that the majority of staff members had completed training in respect of this in the last year. Our records showed that the manager had reported appropriate incidents to the local authority's safeguarding department and to CQC.

The care records we looked at showed that staff members identified personalised risks that were associated with the care and support needs of people who lived at the home. These were rated with a traffic light system that visually highlighted to staff the level of risk involved. There were risk assessments for every activity that people undertook, including going to a weekly disco and eating out in restaurants. We saw one risk assessment that stated the person was at risk of eating too much when in a restaurant which would have an adverse effect on their health. The risk assessment gave advice as to how to reduce this risk in a positive manner which staff told us they were able to follow.

People, their relatives or advocates on their behalf were involved in determining the risks associated with their care and support needs. Most of the people who lived at the home were able to communicate their decisions on day to day matters with staff members using non-verbal communication methods, such as nodding or using facial expressions. Staff members had received training in respect of the Mental Capacity Act 2005 and were aware of the requirements of this. Where people lacked capacity to make decisions for themselves, and had no relatives who were able to make decisions on their behalf, an advocacy service visited the home to support them.

We saw that a capacity assessment had been undertaken for one person to decide whether they had the capacity to agree to the provision of a holiday, for which they would have to provide funding. We saw that an assessment had been made as to whether a person had the capacity to decide whether they should spend some of their money on going on a holiday. The assessment determined that they did not have the capacity to make or understand such a decision. A meeting was held and a best interest decision was made by staff members, together with the person's social worker and a relative that they should go on the holiday. This was documented and was included in the person's care records.

Where necessary applications had been made to the appropriate authority to deprive people of their liberty under the Deprivation of Liberty Safeguards (DoLS). We saw that there had been DoLS applications made and approved in respect of two of the seven people who lived at the home. Further DoLS applications were in the process of being made following a recent court judgment. This was because the grounds of the home had been secured by padlocked gates so that people could not leave without a relative or member of staff being with them.

There was enough qualified, skilled and experienced staff to meet people's needs. Where more than one member of staff was needed to support people in the community this was arranged. Staff members told us that there was always sufficient staff members on duty to provide the care and support that people needed. We saw that people's requests for support and assistance were responded to without any delay.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines. People had protocols in place for the administration of medicines that were prescribed on an 'as and when needed basis' (PRN medicines). We saw that people who lived at the home had their own lockable medicines cabinet in their room. We saw that all medicines were stored at an appropriate temperature.

Good

Is the service effective?

Our findings

People could not tell us themselves whether they believed that the staff who cared and supported them had the right skills to do so. We saw that the staff communicated with people effectively and used different ways of enhancing that communication. These included, by touching them to gain their attention, ensuring they were at eye level with people who were seated and altering their voice appropriately for people who were hard of hearing.

The staff were able to tell us of people's likes and dislikes, what might make them become distressed as well as the steps to take to defuse such situations. They told us some people did not like personal contact whilst other people responded well to it.

We looked at the personal records of five staff. All necessary checks had been completed before the new staff had started work at the home. All of them had completed an induction programme when they started working at the home. In addition they had received on-going training in areas such as implementing the duty of care, person-centred support and equality and inclusion. We spoke with two staff who told us that they had received additional training, such as understanding autism and a non-violent intervention programme which was mainly about de-escalation techniques to be used when people became distressed. This meant that staff were able to deal with situations that arose more effectively.

Members of staff we spoke with told us that they were aware of the content of people's care plans. This meant that they knew what care and support people needed and how this should be delivered. They said that they were advised by way of a communication book if there were any changes to the care plans. We saw that the communication book was used by both the manager and staff members to report on people's individual needs. One entry reminded staff that a person had a hospital appointment the following day.

Staff told us that they had regular supervision meetings with the manager at which they were able to discuss their performance and identify any training required to improve this. They had also participated in appraisal interviews at which their development plans were discussed. This showed that the staff had the knowledge and skills they needed to carry out their roles and were encouraged to improve these.

People were unable to talk with us about the food and drink they had. However, one person was able to communicate that they had enjoyed their breakfast and had plenty of food and drink. They were able to have drinks whenever they wanted one. We saw people help themselves to drinks from the refrigerator and indicate to staff when they wanted a hot drink. One person took a staff member by the hand and walked them to where the kettle was in the kitchen.

During the lunch time meal we saw that staff members asked people if they were enjoying their food and whether they wanted additional food or drink. We saw that the refrigerator in the kitchen was well stocked with a variety of fresh produce for main meals and snacks. Staff cooked the main meals and were available to assist people to eat their meal when this was required. People were able to help themselves to snacks and drinks whenever they wanted them. This meant that people could satisfy their needs and not feel hungry or thirsty.

The staff we spoke with told us that the people who lived at the home decided what they wanted to eat each week. People were able to indicate what they wanted by the use of photographs of different food and non-verbal communication. People's relatives also contributed to the menu planning by telling staff members what people liked to eat. This meant that people were protected from the risks of inadequate nutrition and dehydration.

The people who lived at the home were registered with a single GP who had a particular interest in the health care of people who had a learning disability. The GP visited the home on a weekly basis but also attended as and when needed in response to people's fluctuating health needs. The manager told us, and the care records we looked at confirmed, that the GP undertook an annual health check with people and reviewed their medicines on an annual basis. Where necessary referrals to the dietetic service, speech and language therapists (SALT) and podiatrists were arranged by the GP. The home had its own contract with a local dentist and optician although people usually went to alternative providers arranged by their relatives. We saw that each person had a healthcare folder which

Good

Is the service effective?

included a health action plan and detailed people's appointments with healthcare professionals. This showed that people were supported to access healthcare services to maintain and promote their health and well-being.

Good

Is the service caring?

Our findings

People and their relatives had been encouraged to contribute to the development and review of their care plans. Where people did not have relatives who could support them an independent advocacy service had been introduced to provide support.

Most people could not tell us themselves of their experience. However some people were able to make it clear to us that they were happy at the home and staff members supported them with their interests.

We observed the interaction between the staff members and the people for whom they provided care and support. We saw that staff members treated people in a caring, responsive and respectful way and that they knew the people they cared for well. All the people we observed at the home seemed to be happy. Some people were smiling, one was singing, which staff members told us meant that they were happy.

Although people could not verbally communicate we saw that the staff members were able to communicate in other ways with the people who lived at the home. We saw that there was a communication file in place which was in a picture format. This was used by people to communicate with staff by showing them the appropriate picture. A staff member told us that one person took them by the arm and led them to things the person wanted support with. Where people needed assistance to get dressed, staff members told us that people chose the clothes they wanted to wear. Our observations of the staff interaction with people showed that staff members engaged with them and encouraged and supported them to maintain their interests and hobbies.

People had been encouraged to make their rooms at the home their own personal space. There were ornaments and photographs of family and friends, personal furniture and their own pictures on the walls. This supported people during their move into the home by having familiar furniture and objects with them.

People's privacy, dignity and independence were respected. During our observations we saw that staff members treated people with dignity and respect. Staff members spoke with people in a caring, respectful way. We saw that when a person was unable to make their need known to a staff member the staff member patiently asked questions of the person until they were able to identify what the person wanted.

We saw that privacy was maintained at all times when people were supported with their personal care. Doors were closed and curtains were drawn in people's rooms on the ground floor. People's care records indicated the name that they preferred to be called by. We noted that staff members always used people's preferred names when talking with them.

Good

Is the service responsive?

Our findings

The care records we looked at for three of the people who lived at the home showed that a full assessment of their needs had been completed before they had been accepted to live at the home. This was to ensure that the home could fully meet their assessed needs. The care records had usually been completed with the assistance of a relative and included information about what was important to the person and how to support them well.

We found the care records to be personalised and detailed. We noted that care records were reviewed at least once a year but more frequently if there were changes in people's assessed needs or new activities were undertaken. This ensured that the care plans addressed people's changing needs.

There was a wide range of activities available to people, both as group activities or on an individual basis which were suited to people's needs and supported their hobbies and interests. Most of the people at the home attended day centres for some days of each week. People were encouraged to participate in the group activities at the home, but staff members respected people's decision if they chose not to join in. Activities at the home included weekly music, art and aromatherapy sessions.

People were supported in promoting their independence and community involvement. People were encouraged to participate in activities outside of the home to enable them to develop links with the local community. One person attended church services on a weekly basis, other people were supported to go shopping at a nearby centre, go out for meals in local restaurants and attend a weekly disco at a community centre. People were also encouraged and supported to go out on day trips and to have an annual holiday.

Relatives and advocates could access the complaints policy and this was also available in an easy read format for people who lived at the home. The manager told us that they had received no complaints that referred directly to the service provided.

People who used the service were asked for their views about their care and they were acted on. There were regular meetings with the manager and the people who lived at the home to discuss the service and their wishes. Minutes of a recent meeting showed that people had been asked about outings and their satisfaction with the service. People had decided that they wanted to have outings to a local farm and Clacton-on-Sea. These were being arranged.

Good

Is the service well-led?

Our findings

The registered manager had been in post for more than 18 months at the time of our inspection and was supported by a regional manager from the organisation, who was also present during our inspection.

The manager had held a family morning in June 2014 when all the relatives of people who lived at the home were invited to an informal meeting to discuss matters about the home and any improvements that they wanted. No suggestions for improvement were made at this meeting.

The two staff members we spoke with told us that the manager at the home was approachable and supportive. One staff member said, "I love it. It's a really good team." A second staff member told us, "It is a good team. Everybody pulls together for the residents." They went on to say, "Management are very accessible."

The staff members told us that they were able to discuss any concerns they had about the people who lived at the home, the care and support provided to them and suggestions for improvements with the manager and they listened to them. They said that they participated in regular team meetings where they were given the opportunity to discuss any matter of importance to them. We saw minutes of team meetings which confirmed that a variety of topics had been discussed, including feedback from staff members on what worked well and what had not gone so well. The meetings also discussed new policies and procedures as well as areas of best practice identified by the provider and through training staff members had attended. This meant that the staff were able to provide people with care and support in ways that worked well and followed best practice.

The provider had an effective system to regularly assess and monitor the quality of service that people received. The manager completed quality checks and four self-assessments of the home during the year. One of the provider's operations managers also visited the home and completed assessments four times a year and the regional manager completed a quality audit on a quarterly basis. This meant that the home and the care and support provided were checked on a monthly basis by a member of the provider's management team. Areas for improvement in the home and the way in which care and support was provided for people were identified and actioned. The manager had produced plans to address areas for improvement identified in the assessments and audits. These had been updated as the actions identified had been completed. This improved the care and support given to people who lived at the home.

We saw that where there were areas in which staff performance failed to reach the required standards the manager had taken appropriate steps. We saw records of disciplinary meetings with staff members which had resulted in performance improvement plans being implemented. There were robust attendance management systems in place and return to work interviews took place after periods of sickness. These steps ensured that people were cared for by staff members who had the appropriate knowledge and skills.

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented. Following the investigations into incidents in respect of people's medicines the staff members involved had received additional training to prevent similar incidents in the future.