Voyage 1 Limited

Milehouse Lane

Inspection report

25 Milehouse Lane
St Albans
Hertfordshire
AL1 1TF

Tel: 01727835413

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31 March 2016

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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**

Summary of findings

Overall summary

Milehouse Lane provides accommodation and personal care for up to seven people who have a learning disability and the home was fully occupied on the day we inspected.

Accommodation is provided over two floors. All bedrooms are for single occupancy and there are separate toilets and bathroom/shower facilities. There is a kitchen, communal areas, including a dining room, a lounge and a conservatory for people and their visitors to use.

The inspection took place on 31 March 2016 and was unannounced. The home had a registered manager in post, a registered manager is a person who has registered with the Care Quality Commission (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.

Although we found sufficient numbers of staff were deployed to provide care and support to people living at Milehouse Lane, on occasions we saw from the staff rotas that people were required to work, excessive hours in order to cover vacancies. Risk assessments had not always been developed to positively manage risks to people.

People's wellbeing was not always supported by staff who met their individual needs and preferences by ensuring people's social needs and nutritional needs were met.

Medicines were not always managed effectively or safely.

People were supported by staff who had undergone a recruitment process that ensured they were of sufficiently good character to provide care to people.

Staff felt supported by the manager to enable them to carry out their role sufficiently although staff had not been provided with regular supervision. Staff had received training relevant to their role.

We saw that people had access to a range of health professionals, and records demonstrated they were referred to other professionals appropriately when their needs changed.

Staff spoke to people in a kind, patient and friendly way, however we observed staff, on occasions spoke to people in an 'Infantile' manner.

People did not always receive high quality care that was well led. The systems in place to assess and monitor the service had failed to identify errors in medicines and infection control which placed people at risk of harm.

We found that people were not offered the opportunity to offer their views or opinions on the service provided due to information being provided in a format that not everyone at the home could comprehend.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

People's identified risks had not always been robustly reviewed or updated.

Staffing levels were on occasions unsafe and were not always sufficient to respond to unplanned events.

People's medicines were stored safely but not managed effectively which placed people at risk of harm.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received training in a range of different areas relevant to their role.

We saw that staff gained people's consent prior to assisting people with each tasks.

Where required assessments of capacity had been carried out in line with the requirements of the Mental Capacity Act 2005. However we found that some staff had a limited understanding and knowledge with regard to their responsibility in relation to the Mental Capacity Act and how it affected the people they supported and cared for.

People had access to a range of healthcare professionals to support them where their health needs changed.

People were helped to eat and drink enough to stay well.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff treated people with respect and were knowledgeable about people's needs and preferences but on occasions spoke to people inappropriately.

People could choose how and where they spent their time.

People's dignity and privacy was maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care that was responsive to their needs.

Care plans were not person centred and did not always include people's likes, dislikes and interests. The plans lacked specific detail and guidance about managing people's behaviours.

A complaints policy and procedure was in place but it had not been produced in a format that everyone living at the home could comprehend.

People were encouraged to be part of the wider community and pursue interests and pursuits.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People's views and opinions about the quality of service they received had been not been sought with regard to the service provided.

The provider had systems available for the manager to review and assess the quality of service, however these systems had not been effective in identifying areas of the service that required improving.

People's records were held securely.

Statutory notifications that are required to be sent to the commission had been made.

Milehouse Lane

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 31 March 2016 and was unannounced. The inspection team consisted of one inspector.

We reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law. Before the inspection, we reviewed the information we held about the service. This includes the Provider Information Return (PIR). This is a form that requires them to give some key information about the service, what the service does well and improvements they plan to make. However on this occasion the PIR had not been requested from the provider, before the visit took place. We also received feedback from health and social care professionals, stakeholders and reviewed the commissioner's report of their most recent inspection.

During the inspection we observed staff support people who used the service, we spoke with three people who lived at Milehouse Lane, two relatives, three members of staff, and the registered manager.

We reviewed care records relating to four people who used the service and other documents central to people's health and well-being. These included staff training records, medicine records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We were unable to seek the views of everyone who lived at Milehouse Lane due to their complex needs. However people who were unable to talk to us showed us that they felt safe, happy and relaxed when staff approached them. We saw one person take the hand of a staff member and lead them to the kitchen and show them what they wanted to eat. Another person put their arms around a staff member and gave them a hug and smiled.

People's medicines were not managed safely or effectively. We carried out a stock check of PRN medicines and found that there were 80 paracetamol in a box where there should have been 100 tablets. The manager was unable to explain, reconcile or resolve this discrepancy before we left the home. We also discovered that one person's lunchtime medicine had been dispensed and left in the medicine cupboard for another member of staff to administer who had not been assessed as competent to administer medicines to people. This may have placed the person at risk of harm from a staff member who had not been assessed as competent to administer people' medicines.

The manager told us they used agency staff to cover vacancies and short notice staff absences. Where possible, they told us that they tried to use agency staff who had previously worked at the home in order to provide consistent care. However when we arrived we were informed that the manager and two other staff members were attending a medicine training course, which left one permanent member of staff and an agency care worker to support seven people. The permanent member of staff told us that they had not completed their competency assessment with regard to the administration of medicines. The manager was unable to provide evidence on the day of our visit that the agency staff member had received the appropriate training to administer emergency medicines to the people who were at risk of seizures, if required. This placed people at risk of harm from unsafe medicine practices.

Two staff we spoke with were knowledgeable about people's medicines. A staff member told us, "We are not allowed to administer medicines to people until the manager considers we are competent to do so, which I think is important and necessary to make sure people are safe." Where people required their medicines to be administered 'Covertly' there were clear protocols which had been signed by the GP to allow staff to do this.

There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment must be provided in a safe way for service users and the proper and safe management of medicines must be maintained.

There were risk assessment processes in place to ensure that people remained safe and that care and support would be appropriately delivered. Risks assessments included risks to the person when travelling on transport, risks of choking when eating and risks of harm due to epilepsy. However, we saw that a number of the risk assessments which were last reviewed in 2014 and had not been updated since. For example a risk assessment in relation to the management of person's behaviour that could challenge had not been updated since January 2015. We saw from this person's care plan that there had been an increase

in incidents of challenging behaviour but the care plan had not been updated to reflect the current risks to the person themselves, or others. This meant that people were not always protected from harm or unsafe treatment because a system of reporting, reviewing and identifying risks to people was not robust or consistent.

When we checked the fridge we found out of date food, cheeses that had several layers of mould on them and no date of opening on packets of cold meats. This placed people's health and welfare at risk from eating food that was not for fit for consumption.

Two staff demonstrated to us their knowledge on how to recognise and report any suspicions that people may have suffered any harm. They understood their responsibilities on how to safeguard people and both staff confirmed that they had received training regarding protecting people from the risk of harm, in the past year. They were aware of the safeguarding reporting procedures to follow when required. One member of staff said, "I have received safeguarding training and I would not hesitate in reporting any concerns." We saw that there were safeguarding reporting guidelines available in the office which included key contact numbers for the local authority safeguarding team.

Although the rotas showed sufficient numbers of staff had been allocated to support people, on the day of our visit we found that there was only one permanent member of staff on duty and an agency worker to support seven people. The third member of staff had taken a person to hospital who had suddenly become unwell. We were told that as a result of this emergency, people's day care placements had been cancelled due to insufficient staff on duty to transport people. We were told that on this occasion people would be offered daytime activities at home instead. However during our visit the only activity we saw being provided was one member of staff who assisted a person to complete a puzzle. We discussed these concerns with the manager when they returned to the home. They stated that they had, on this occasion made an error of judgement and should have not allowed three staff to all attend the training session on the same day as this had compromised people's safety and prevented people from attending their day care placements.

We spoke with one member of staff who was working a 14 hour day and when asked about arrangements for their required breaks they informed us that "I cannot take a break as it would only leave one person on duty for seven people." We asked the manager what arrangements were in place for staff to take their required breaks we were told "People can take a break in the office if they need one." However we found that the staffing levels on the day of our visit were insufficient for staff to take a break away from the service.

There was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. Inadequate levels of staffing placed people at risk of harm.

Staff confirmed that they did not start to work at the home until their pre-employment checks which included satisfactory criminal records had been completed. Staff personnel files confirmed that all the required checks had been carried out before the new staff started work. This meant that the provider had taken appropriate steps to ensure that staff they employed were suitable to work with people living at the care home.

There were personal fire and emergency evacuation plans in place for each person living in the home and staff confirmed they were aware of the procedures to follow. This demonstrated to us that the provider had a process in place to assist people to be evacuated safely in the event of a fire or emergency. Fire alarm, fire drills and emergency lighting checks had also been carried out to ensure people's safety.

Requires Improvement

Is the service effective?

Our findings

Although the majority of people who used the service were not verbally able to tell us about the care and support they received, we were able to observe some positive interactions between staff and people who used the service throughout our inspection. We saw that staff met people's needs in a competent manner which demonstrated that they knew the people well. For example one person had become very anxious when we arrived at the home. We observed a staff member offer to take the person's hand and gently walk them around the home until the person was able to point out what they wanted. This calm response by the staff member helped the person become less anxious and stressed.

People were supported by staff who received supervision and guidance, although we found that there were several gaps on the supervision records of three permanent staff members where staff had not received supervision for a period of four months. The manager informed us that this was an area that they were working hard to improve. One staff member told us that their one to one sessions covered aspects of their performance and any issues they may have with their day to day work with people. They told us "I think supervision is important in our development and helps us look at areas we are good at as well as areas that we can improve upon but we haven't had it for several months which has been difficult with all the changes that have been going on."

Staff told us they had the opportunity to undertake and refresh their training. One member of staff said, "We are informed about when we need to attend training and this is made available to us through our manager and head office." Staff told us that training was improving and that the manager was booking them on to a number of courses to be completed over the next six months.

Two staff told us that there had been several staff changes recently that had been difficult for staff morale but felt that this was now improving. One person told us "I like working here although sometimes the shifts are too long." Three staff members considered they received appropriate guidance and support from their manager.

The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. Where they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The home had made Deprivation of Liberty safeguards [DoLS] applications to the local authority which related to keeping people safe within the home.

Although we saw evidence that staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards two staff we spoke with did not know what steps were required to protect people's best interests. In addition, neither staff member was clear on how to ensure that any restrictions placed on a person's liberty were lawful. This meant that not all staff possessed the knowledge or skills to ensure that people were appropriately assessed and supported.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Consent.

Records showed that people were provided with a choice of meals that reflected their preferences and we saw that people had a choice of food at each meal time. However on the day of our inspection we saw that the pictorial menu board was out of date and displayed the wrong menu choice for the day. Which meant the meal that people had expected was not provided. Staff told us that people were involved as much as possible in all stages of preparing meals including laying the table and clearing away afterwards. This helped to engage people in the social aspect of mealtimes and enjoyed as a shared activity. Although people's weights were monitored on a monthly basis we saw that in one person's care plan their weight had not been recorded since January 2016.We passed this information on to the manager for their attention. We saw evidence that people were reviewed by the community dietician with regard to the management of their dietary needs, when necessary.

There was regular access to health and social care professionals and this was recorded in each person's file with regard to the most recent GP visit, optician and dental appointments. People were also supported by the local community learning disability team.

Requires Improvement

Is the service caring?

Our findings

Our observations showed the staff were kind and respectful to the people they cared for. Staff called people by their preferred name and spoke in a calm and reassuring way. One family member told us that staff showed a good understanding of people's needs. They said "I know that the staff are all there to help and make my [Relatives] life a happy one."

We saw a member of staff sitting next to one person and talking to them in a quiet and gentle manner and asking them if they would like help with the puzzle they were doing. We saw that the person looked up, smiled and took the person's hand and gave them a piece of the puzzle, in order to join in. We saw another staff member spoke to a person who was feeling unwell and proceeded to sit with them and chat about the clothes they were wearing and asked them if they were warm enough. This showed us that staff were considerate of people's needs.

Two relatives we spoke to were both complimentary about the care given at the home. One person told us "As a family we are very pleased with the care our [Relative] receives." Relatives also told us that they could visit whenever they wanted.

Two relatives told us that they considered that staff respected people's privacy and dignity when they supported them. Our observations throughout our inspection showed us that staff knocked on people's doors and waited for a response before entering. They also let people know who they were as they entered. This meant that staff respected and promoted people's privacy. However we heard on two separate occasions during our visit that one member of staff used 'Infantile' language when they spoke to people. For example 'Good girl' and 'Oh she's so cute'. This type of language could impact on people's dignity and shows a lack of respect towards the person. The plan of care for this person did not provide information on how they liked to be addressed or the preferred name they liked to be called.

People were supported to have regular contact with the family, where possible. Family and friends were welcome to visit at any time and during our discussions with staff in the home it was evident that they knew peoples families well.

When we spoke with staff we found that they knew peoples likes, dislikes and preferred routines although these had not always been recorded within their care plans. However we saw that two out of four care plans did not have any preferences recorded and only one out of the four care plans had the person's preferred choices of activities and interests. We also saw that none of the four care plans had been signed by either the person themselves or their relative in order to confirm they had agreed with the plan of care.

Staff were able to tell us how they maintained confidentiality by not discussing people who used the service outside of the home or with people who were not directly involved in the persons care. We saw that confidential information was held securely within the provider's office.

The manager told us that two people who lived at the home had used local advocacy services since moving

into the home. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Requires Improvement

Is the service responsive?

Our findings

All staff said how they worked hard, with two staff stating that they considered they worked well as a team and two staff told us that they felt valued by the manager. One of the relatives commented "All the staff are friendly with our relative; it's a homely friendly place."

We saw that staff meetings were held every two months which gave staff the opportunity to discuss or raise any issues they had and to also discuss the running of the home with the manager. The manager informed us that staff were provided with individual supervision every other month which gave staff another forum to communicate as well as be supported and receive feedback about their work. However records failed to demonstrate that people had been regularly provided with individual supervision since December 2015. One staff member told us "It's been difficult to fit supervisions in lately as we have been covering extra shifts but I am sure I will get one soon." We found a record within the staff meeting minutes that stated that some staff felt under pressure due to staff shortages and that they did not always feel supported when they found their work challenging.

Staff were clear about their roles and the focus on people who they supported. One staff member said "It's been a bit tricky lately as we have had some staff leave, so agency staff have been covering the vacancies so we have to try and make sure the agency staff know people and how to support them. I think there is an induction programme for new staff but I usually give them a tour around the building and show them where everything is before they start on shift."

Staff had access to information and guidance about how to look after people, based on their individual health and social care needs. This included information about their preferred routines, medicines, health needs, relationships that were important to them, dietary requirements and personal care preferences. We were told that care plans are reviewed and updated on a monthly basis, however on the day of this visit four care plans looked at had not been updated in the past three months. This meant that staff did not have all the up to date information required to ensure they supported the person in the best possible way.

Staff also had access to detailed information and guidance about how to communicate with people who lived at the home, which included people who were non-verbal, and how to recognise potential signs and triggers for pain, discomfort and behaviour that may challenge staff and others. A staff member commented, "Knowing and understanding people well is key to providing good care and to know how they communicate their needs and feelings."

Although we saw that people had individual activity planners within their main care plan on the day of this visit people's day care placements had been cancelled due to inadequate staffing which left the two staff on duty to provide activities to each person. The only organised activity we saw being provided was one member of staff assisting a person with making a puzzle. We saw two people sat in the lounge area and watched television throughout our visit with neither person being offered an opportunity or choice to take part in any activity.

One person showed us around the home and was also pleased to show us their room. We were told by the manager that this person had been involved and consulted with regard to the colour scheme and decoration of their room. Each person's room was personalised to their taste and personality.

Requires Improvement

Is the service well-led?

Our findings

We looked at how the provider monitored the home through auditing and reviewing the quality of service within the past three months. We found that there had been no night time checks carried out by the manager in the 15 months to ensure that people's safety was maintained. The manager informed us that this was because they were "Unable to access the front door due to not having the correct key." However they had not taken any action to rectify the key issue.

People's care plans did not always contain sufficient information about a person's life history, needs or preferences, and had not always been sufficiently reviewed when required. The care plans we reviewed also did not always reflect people's preferences or choice and some individual risk assessments had not been completed or reviewed. This included people who presented with behaviour that challenged. This meant that staff had not maintained an accurate, up to date record of people's care needs. We found that records were incomplete and not up to date with regard to the monitoring of people who were at risk of harm from epilepsy during the night time. These records were pointed out to the manager at the time of the inspection for their attention.

We were told that due to the complex needs of the people who lived at Milehouse Lane there were no formal meetings held to discuss the running of the service. The manager told us that they chose to speak to people informally with regard to any ideas or suggestions they may have. However the manager, when asked, was unable to provide records of any issues discussed or comments made by people who lived at the home with regard to how they felt about the home or if they had been consulted about anything the home could do better or improve upon. This meant that there was no verifiable way of knowing what issues people had discussed and if these had been resolved or actioned.

Although we were informed that staff were supported with individual supervision every two months we found that some staff had not received formal supervision for over four months. We reviewed the staffing rota for March 2016 and found that one member of staff had worked in excess of their agreed working hours and on the day of the inspection was required to work 14 hours. The manager told us that this was not their preferred practice but due to three staff vacancies, permanent staff had been covering additional shifts.

The provider had a policy and procedure that was available to staff regarding whistle blowing and what staff should do if an incident occurred. Whistle-blowing occurs when an employee raises a concern about a dangerous or poor practice that they become aware of through work. Staff we spoke with clearly demonstrated an understanding of what they would do if they observed bad practice. Staff told us that they were confident that if ever they identified or suspected poor care practices or harm they would have no hesitation in whistle blowing. Staff said that they felt confident that they would be supported by the manager to raise their concerns.

We saw that any repairs and maintenance issues were reported to the organisation's maintenance team for further action. However the manager informed us that the issue relating to not being able to access the home via the front door remained unresolved for a period of 15 months and during this time the deputy

manager carried out night time monitoring checks by entering the home over the perimeter wall. There were no records available to demonstrate that night time monitoring checks had been carried out within the past year.

Medicine systems in place failed to identify a serious error with regard to one person's pain relief medicine and the manager was unable to clarify or resolve the error at the time of this visit. The most recent medication audit had failed to identify this serious error.

Infection control audits had also failed to identify the mouldy and out of date food that was found in the fridge on the day of this visit. This could have placed people at risk of harm from eating food that was contaminated by mould.

The lack of effective leadership and governance and deficiencies in the monitoring and auditing of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were placed at risk due to staff not having a full understanding or knowledge with regard to how to obtain consent from people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk from unsafe practices of the administration and management of medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of effective leadership and governance and deficiencies in the monitoring and auditing of the service placed people at risk of not receiving proper care and treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were placed at risk of harm due to inadequate levels of staff being provide.