Voyage 1 Limited

Voyage (DCA) Scotia 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?	**Inadequate**

Summary of findings

Overall summary

We completed an unannounced inspection at Voyage (DCA) Scotia House on 9 June 2016. This was the first inspection that had been carried out since the service had registered with us on 25 May 2016.

Voyage (DCA) Scotia House are registered to provide personal care. People are supported with their personal care needs to enable them to live in their own homes and promote their independence. Personal care was provided in a supported living setting, which meant accommodation was provided under a separate private tenancy agreement to people who used the service. The office was based within the same building where people had their own independent flats. People who used the service also had access to two communal lounges. At the time of the inspection the service supported 11 people in their own homes.

There was a registered manager who shared their time across two of the provider's services. 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 the systems in place to assess and monitor the quality of the service were not effective. Some of the concerns we raised at the inspection had been identified by the provider, but there had not been swift and appropriate action taken to mitigate the risks for people who used the service.

People's risks had not been assessed or monitored effectively to keep people safe. People were at risk of harm because records we viewed did not always match the support that staff told us people needed to keep them safe.

Medicines were not managed safely to protect people from the risk of harm. We could not be assured that people were receiving their medicines as prescribed.

Improvements were needed to ensure that people's health and wellbeing was monitored and managed effectively and people were referred to other health professionals where their needs had changed.

We saw staff treated people in a caring way and showed dignity and respect when they provided support. However, some improvements were needed to ensure that staff understood how other factors had an effect on people's care.

Improvements were needed to ensure that people's care was reviewed and changes in people's needs were reflected in their care records.

Staff had received training and an induction before they provided care and staff told us that they felt supported to carry out their role effectively.

The provider was acting within the requirements of the Mental Capacity Act 2005. Where people were unable to consent to their care assessments had been carried out to ensure people were supported to make decisions in their best interests.

People were supported to eat and drink sufficient amounts and people were supported to maintain a healthy diet.

We found that people's preferences in care had been considered and staff had a good understanding of people's preferences which enabled their care to be provided in a way that met their individual needs.

Staff gave people choices in how they wanted their care provided. Staff understood people's individual communication methods when making choices about how they wanted their care providing.

Staff and the registered manager understood their responsibilities to protect people from abuse and were able to explain the actions they would take if abuse was suspected.

We found there were sufficient staff available and staffing was managed in a way that ensured people received their care when they needed it.

The provider had safe recruitment procedures and we found that the required checks had been carried out, which ensured that staff were suitable and of good character to provide care to people who used the service.

The provider had a system in place to handle and respond to complaints that had been made by people who used the service or their relatives.

We identified 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 consistently safe.

People's risks had not been assessed or monitored effectively to keep people safe from the risk of harm.

Medicines were not managed safely to protect people from the risk of harm and we could not be assured that people were receiving their medicines as prescribed.

People were protected from the risk of abuse because staff and the registered manager understood their responsibilities to identify and report any concerns.

There were sufficient staff available and the provider had safe recruitment procedures in place.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were needed to ensure that people's health and wellbeing was monitored and managed effectively and people were referred to other health professionals where their needs had changed.

Staff had received training and an induction before they provided care and staff were supported to carry out their role effectively.

The provider was acting within the requirements of the Mental Capacity Act 2005. Where people were unable to consent to their care assessments had been carried out to ensure people were supported to make decisions in their best interests.

People were supported to eat and drink sufficient amounts and people were supported to maintain a healthy diet.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff treated people in a caring way and showed dignity and respect when they provided support. However, some improvements were needed to ensure that staff understood how other factors had an effect on people's care.

Staff gave people choices in how they wanted their care provided and understood people's individual ways of making choices about how they wanted their care providing.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Improvements were needed to ensure that people's care was reviewed and changes in people's needs were reflected in their care records.

People's preferences in care had been considered. Staff had a good understanding of people's preferences which enabled them to provide individualised care.

The provider had a system in place to handle and respond to complaints that had been made by people who used the service or their relatives.

Is the service well-led?

Inadequate

The service was not well-led.

We found the systems in place to assess and monitor the quality of the service were not effective. Some of the concerns we raised at the inspection had been identified previously by the provider, but there had been not been swift and appropriate action taken to mitigate the risks for people who used the service.

Voyage (DCA) Scotia 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 planned to check whether the provider was 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 9 June 2016. We carried out the inspection unannounced because we had been made aware of concerns about the way the provider was managing the service.

The inspection team consisted of two inspectors.

Before the inspection, we reviewed information that we held about the service. This included notifications the provider is required to send us by law about incidents and events that had occurred at the service. We contacted local authority commissioners to obtain a view of their experiences with the service and provider.

We were unable to speak with people who used the service because of their communication difficulties. We spoke with three relatives, six care staff, the registered manager, the operational manager and the quality and compliance manager. We viewed five records about people's care and support. We also viewed records that showed how the service was managed, which included three staff recruitment and training records.

Requires Improvement

Is the service safe?

Our findings

We found that risks were not always assessed and planned. Staff we spoke with knew people well and were able to explain people's risks. Staff told us how they needed to support people in a way that kept them safe from harm, but the records we viewed did not match what staff told us. For example; one person needed support when they moved around their flat because they had a low tolerance and low stamina, which made them prone to falling. The records we viewed did not show that this person had been assessed as at risk of falls. There was not a mobility care plan in place to give staff who did not know this person information to support them safely.

Staff told us that another person was at high risk of pressure sores and had previously had a pressure sore. Staff told us how they supported the person to ensure that their risk of skin breakdown was reduced. We saw that the visiting district nurse notes recommended that the person needed a preventative care plan in place to monitor this person's skin. We found this was not in place and there were no pressure care risk assessments to give staff guidance on the signs to look for if there was deterioration in the person's skin and how to recognise when they needed to report any concerns. The registered manager was unaware that this person's records had not been updated to reflect the changes. Although regular staff understood people's needs we were told by the registered manager that the service used agency staff to provide support when there were staff absences. This meant people were at risk of inconsistent and unsafe care because up to date guidance was not available for staff to follow.

Where people's risks had been assessed we found that these had not always been managed to keep people safe. For example; one person needed one to one support throughout the day to keep them safe. We saw there had been an incident recorded which showed that this person had left their flat whilst the staff member was preparing their lunch and this had resulted an incident between them and another person who used the service. This meant that this person's assessed and planned risks had not been managed effectively to protect them from the risk of harm.

We found that medicines were not always managed safely. We found that where people needed 'as required' medicines there was not always guidance available to inform staff when these should be administered. For example; one person needed topical medicine applied to ensure they maintained their skin integrity. The Medication Administration Records (MARs) showed a large gap without this being applied. This included a gap of eight days leading up to a referral to the district nurse on the day of the inspection because the person had caused marks on their skin because of scratching. Staff we spoke with told us that they applied the topical medicine when the records said it was needed, but we found there was no guidance in the records for staff to know when and where this needed to be applied. This meant that this person's risks had not been managed safely and we could not be assured they had received their medicine as prescribed.

The above evidence shows people were at risk of harm because the provider did not assess, manage and mitigate people's risks and medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives we spoke with gave varied responses when we asked about the levels of staff available to provide support. One relative said, "On the whole there is enough staff, but with the recent changes I have noticed that there are quite a few new staff". Another relative said, "There has been some changes in staff due to the change in provider and it means that my relative doesn't always get consistent staff supporting them. It is important that they know the staff providing the support". Most of the staff we spoke with told us that they felt there was enough staff available to meet people's needs. We saw that staffing had been managed where possible in a way that meant people were supported by a consistent staff group. Staff told us and we saw the staff rotas that showed they were regularly assigned to the same people who used the service. This meant that there were enough staff available to meet people's needs although some improvements were needed to ensure support was provided by staff who knew people well.

We saw the provider had safe recruitment procedures in place. The provider had undertaken Disclosure and Baring Service (DBS) checks for staff to ensure that they were suitable to provide support to people who used the service. The DBS is a national agency that keeps records of criminal convictions.

Relatives we spoke with told us they felt their relatives' were safe when they were being supported by staff. One relative said, "I feel they are safe. I don't feel concerned when I leave them after visiting". Another relative said, "They [the staff] are good and look after them well". Staff explained the action they would take if they felt someone was at risk of abuse and they would report any concerns that someone was not being treated properly to the manager immediately. We spoke with the manager who told us the procedures they followed if they had been made aware of suspected abuse. We saw that where there had been concerns about a person's safety this had been reported as required. This meant that people were protected from the risk of abuse.

Requires Improvement

Is the service effective?

Our findings

We saw that some people were not always supported to access health professionals when they needed to. For example; staff we spoke with told us that one person's mobility had changed and that they had difficulties walking. We asked the operational manager if a referral had been made for a wheelchair to assist them with their mobility. The operational manager said, "I requested a referral to be made but if this hasn't been responded to I was unaware so I haven't chased this up, but we will do it now". This meant this person had not been supported in a timely way to access specialist equipment to maintain their physical wellbeing. Another person's mental health had deteriorated and staff told us that this person's behaviour that challenged had escalated due to certain life events that had occurred. We saw that staff had recorded incidents in the daily records, but there was not an effective system in place to ensure that any changes were identified. We found that this person had not received any intervention from other health professionals to manage their mental health needs. This meant that this person's mental health needs were not being monitored and managed effectively.

We found the provider acted in accordance with the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the 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. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who were unable to make certain decisions about their care had mental capacity assessments in place to give staff guidance on how to support people with decisions. Staff told us they had received training in the MCA and they explained what the MCA meant for people. For example; one member of staff told us how they supported people to make decisions and if people were unable to do this for themselves they had guidance to help them support people in their best interests. This meant people received care in their best interests.

We saw that the registered manager had taken action where they considered people were being restricted. The registered manager showed us that referrals had been made to the local authority to request an assessment for restrictions that were in place such as; bedrails and where people were unable to access the community alone. This meant that the registered manager had acted in accordance with the Mental Capacity Act 2005.

Staff told us they had received an induction and training before they provided support to people. One member of staff said, "I completed an induction when I started, which included shadowing a more experienced member of staff. I have completed a lot of training and I have found it very useful and have learnt a lot from it". Another member of staff told us that they had training scheduled to ensure that they were kept up to date with their skills and knowledge. We saw training records that confirmed what staff told us. Staff told us they received support and supervision on a regular basis from their line manager. One staff member said, "I have had supervision, but I'm due another one soon. It's a good opportunity to discuss how the job is going and if I have any concerns". This meant that staff were supported with their role and encouraged to develop their skills to carry out support to people effectively.

Relatives told us that staff supported their relatives to eat and drink in a way that met their preferences. People's care records contained details of any nutritional risks, what food and drink people preferred and where people needed assistance to eat there was guidance for staff to follow. For example; one person was at risk of choking and needed to sit in an upright chair and wear specialist equipment to prevent them from choking. Staff we spoke with were able to explain in detail why it was important to support the person in this way and we saw that this person was supported as required. Another person was at risk of losing weight and we saw that they needed nutritional supplements to maintain a healthy weight. The medicine administration records showed that this person had received their supplements and their weight was stable. This meant that people were supported to eat and drink sufficient amounts to maintain their health and wellbeing.

Requires Improvement

Is the service caring?

Our findings

Relatives told us that the staff always treated people in a kind way and they were happy with the way staff cared for their relative. One relative said, "The staff have always been caring towards my relative. I haven't had any concerns about the way they are cared for and staff know my relative well". We saw staff supporting people in the communal areas in a caring and compassionate way. For example, we heard staff asking people how they were feeling and gave people compliments about the way they looked and what they were wearing. However, some improvements were needed to ensure people received support consistently in a caring manner. For example; we saw the daily records for one person showed that the person had told staff that they had a headache. We viewed the medicine records and saw that the person had not received their "as required" pain medicine on this day. This meant this person had not been supported in a caring way to manage their pain. We also saw and heard people's doors continuously banging throughout the day of the inspection when staff were entering and leaving people's individual flats. We saw that some people who had sensory impairments needed a quiet environment to promote their wellbeing. This meant staff were not respecting people's right to a quiet environment.

People's relatives told us that they had observed staff treating their relatives with dignity and respect when staff were supporting them. One relative said, "The staff give my relative the privacy they need. My relative always looks clean and tidy which gives them their dignity too". Staff told us that they always made sure that people's dignity and privacy was protected when they were providing care and support. One staff member said, "I always make sure people feel comfortable and make sure personal care is provided in private". We saw staff talking to people in a dignified way that met their individual communication needs and staff were respectful of people's wishes. However, we found that some improvements were needed to ensure that records contained language that protected people's dignity. For example; terms that we saw recorded in daily records when people had continence issues and had displayed behaviours that challenged were recorded in an undignified way.

Relatives told us that people were supported to make choices and staff promoted independence as much as possible for their relatives. People were given choices in the support they received and we saw staff asked people what they needed. The records we viewed contained guidance for staff to follow on people's preferred choices and how to recognise and support people with their choices. For example one person was unable to communicate verbally, but used sign language to help them communicate their needs and wishes to staff. Staff we spoke with were able to tell us how they supported this person with their choices and told us that they also used pictorial aids to help people make choices. One staff member said, "I always make sure I give people choices. Some people need help with choices and people have their own individual ways of communicating. I also show people choices such as; clothes and meals they would like".

Requires Improvement

Is the service responsive?

Our findings

We found that reviews of people's care needs were out of date and we saw that care plans and the risk assessments had not always been updated to reflect the changes in people's needs. For example; one person's skin care needs had changed and the support staff needed to provide had changed, but the records did not reflect that this was in place. Staff told us that another person's mobility needs had changed, but the care records had not been updated to give staff guidance on this person's change of needs and the support required. Most staff were aware of the changes in people's needs, but newly employed staff or agency staff would not have this information available to them. This meant that there was a risk of people receiving inconsistent care because the records did not contain up to date guidance for staff to follow.

Staff we spoke with knew people's preferences and they described how people liked to be supported to maintain their independence and individuality. We saw that people were supported in a way that met their preferences. For example; one person's records stated that they preferred to wear trousers and a particular type of top as they did not like wearing skirts or dresses. We visited this person in their home and saw that they had been supported to wear clothes that met their preferences. We saw that people's life history and preferred daily routines had been discussed with family members to enable staff to provide support that made people feel comfortable and in a way that people were used to.

We saw that staff were responsive to people's individual ways of communication. Staff gave people time to respond and understood what people needed although they had difficulties communicating verbally. Staff were aware of people's individual physical ways of communication. Staff told us how they recognised what people needed by people's individual ways of communication. For example, some people found verbal communication difficult and staff explained that it was important to speak clearly and give people time. We saw that records gave guidance on how to recognise what people needed when they made certain sounds and gestures.

Relatives told us they knew how to complain if they needed to and they were comfortable raising concerns if they needed to. One relative said, "I have made a complaint, which was dealt with by the manager. I was happy with the outcome". The provider had a complaints policy in place and we saw that there was a system in place to log any complaints by the registered manager. The complaints we viewed had been acted on and a response sent to the complainant. This meant that the registered manager acted on complaints received to improve the quality of the service provided.

Inadequate

Is the service well-led?

Our findings

We found the provider did not have a clear overview of the service. For example; the provider did not have effective systems in place for the monitoring and management of the service, which meant people were at risk of harm because the provider and registered manager were unaware of the risks that we had identified.

There were not effective systems in place to ensure medicines were managed safely to protect people from harm. For example; we found that there were gaps in the Medicine Administration Records (MARs) and we saw that staff did not have guidance to help them understand when some people needed their prescribed and "as required" medicines. For example; one person had not received their asthma prevention medicine as prescribed for a period of eight days. We saw that daily checks had been undertaken by staff, which stated "missing signatures", but there were no actions recorded to show what had been put in place to ensure that this person had received their medicine as prescribed. We fed back our concerns to the registered manager who was unaware of the concerns we had identified with the management of medicines at the inspection. We saw that the provider had systems in place to monitor and manage the service, but these had not been completed. We saw blank templates in place, but there had been no monthly monitoring completed since the provider's registration with us (CQC). This meant effective systems were not in place to monitor and manage the risks associated with medicines.

We found that the systems in place to monitor people's health and wellbeing were not effective. For example; the daily records we viewed showed that some people who used the service had experienced deterioration in their mental health. We saw that they had become more anxious and displayed heightened periods of behaviours that challenged. The records did not show that any action had been taken to We asked the registered manager how they monitored people's mental health and wellbeing to enable appropriate action to be taken to alleviate people's anxieties. They told us they had behaviour charts in place which needed to be completed by staff. We told the registered manager we had found that people did not have these in place. We asked the registered manager how they were able to assess if a person's mental health and wellbeing was being managed appropriately if the charts were not being used. We were told, "I'm not able to at this time as I thought the charts were in place, but I will make sure these are put in place immediately". We were provided evidence within 24 hours of the inspection that these had been put in place. We will assess the action taken at the next inspection. This meant there was not an effective system in place to monitor and mitigate risks to people's health and wellbeing.

We found the records we viewed did not contain up to date assessments or risk management plans when people's needs had changed or incidents had occurred. For example; staff knew people's risks and were able to explain how they needed to be supported to keep them safe, but the records we viewed did not reflect this. Staff told us that they felt the records could be improved to contain up to date information. We were told by the management team that they had prioritised other areas to make improvements and they felt that the care records contained the correct information about people's needs. The concerns we identified showed that the records did not contain the correct information and the registered manager was unaware of this. This meant that service users were at risk of inconsistent and inappropriate care because there were not effective systems in place to ensure that there was an up to date and accurate record of

people's current needs.

Staff told us they had no way of calling for assistance when they were providing one to one support in people's homes. For example; staff could not alert other staff quickly when a person needed two staff for support or in the event of an emergency. We saw that there were lone working risk assessments, but these had not been completed. Lone working assessments are needed to ensure that staff members get the appropriate support when they need it. The operational manager told us there were two mobiles available for staff to use, but staff were not aware of these and there were more people that needed one to one constant support than there were mobiles available. This meant that the provider did not have systems in place to ensure staff had the appropriate resources available to them to ensure that people received support when they needed it. The operational manager contacted us within 24 hours of the inspection and informed us that they were looking at implementing a call system for staff to use whilst lone working. We will assess if this system is effective at our next inspection.

We saw that an audit of the service had been carried out in April 2015, which contained actions to be completed to make improvements to the service provided. There was an action plan in place that highlighted areas that needed improvements, such as medicines management. We saw that a specific member of staff had not been allocated to undertake the action and the actions had not been completed at the time of the inspection. We saw that a note had been added onto the plan by the operations manager that identified that the actions needed to be allocated. The concerns we identified at the inspection had also been identified in the audit, but steps had not been taken to improve the quality of the care provided. This meant that although the provider knew that improvements were needed they had not taken action to monitor and mitigate risks to people swiftly or effectively.

This meant the provider did not have effective systems in place to ensure that the quality of service people received was assessed and monitored. The provider did not maintain accurate records to ensure that staff had sufficient guidance available to support people effectively and safely. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us that they felt that there had been some improvements at the service over the last two months. One member of staff said, "I can see some minor improvements, we have training scheduled and people are getting more support to access the community now". Another member of staff said, "The management are more approachable and we have been kept informed of the changes that have taken place. The registered manager listens to the staff and will put things in place we have suggested". We saw there had been a staff meeting to ensure staff understood the provider's policies and procedures and staff had an overview of the organisation.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The above evidence shows people were at risk of harm because the provider did not assess, manage and mitigate people's risks and medicines were not managed safely.

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.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to ensure that the quality of service people received was assessed and monitored. The provider did not maintain accurate records to ensure that staff had sufficient guidance available to support people effectively and safely.

The enforcement action we took:

We served a warning notice to the provider telling them to make immediate improvements to the quality of care.