Voyage 1 Limited

Hibernia

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

Summary of findings

Overall summary

Hibernia is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Hibernia provide accommodation and personal care and support for up to five adults who have learning disabilities or autistic spectrum disorder. The accommodation is spread over two floors. There were five people living in the home at the time of our inspection.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

This inspection took place on 12 December 2018 and was unannounced.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.
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At this inspection we found the service remained Good.

The atmosphere throughout the home was friendly, calm and caring. The staff spoke about people in a respectful manner and demonstrated understanding of their individual needs.

Staff understood how to identify, report and manage any concerns related to people's safety and welfare. There were systems and processes in place to protect people from harm, including how medicines were managed.

There were sufficient numbers of staff deployed to meet people's needs. Safe recruitment practices were followed and appropriate checks had been undertaken, which made sure only suitable staff were employed to care for people in the home.

Staff were supported to provide appropriate care to people because they were trained, supervised and appraised. There was an induction, training and development programme, which supported staff to gain relevant knowledge and skills.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People received regular and on-going health checks and support to attend appointments. They were supported to eat and drink enough to meet their needs and to make informed choices about what they ate.

The service was responsive to people's needs and staff were prompt to raise issues about people's health so that people were referred to health professionals when needed. There were systems in place to help ensure any concerns or complaints were responded to appropriately.

People were supported to do the things that interested them, maintain relationships and to participate in community activities.

The provider and registered manager demonstrated an open management style and provided leadership to the staff team. There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving appropriate support.

Further information is in the detailed findings below.

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 remains Good	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

Hibernia

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. The 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 was a comprehensive inspection that took place on 12 December 2018 and was carried out by two inspectors. The inspection was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked other information that we held about the service and the service provider, including notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law.

During the inspection visit we spoke with the registered manager, the operations manager, and two members of staff. Although we were not able to have in depth conversations with the people living in the home, we were able to observe staff interacting with people. We looked at a range of records including care records for three people, staff recruitment files and training records, risk assessments and medicines charts. We also looked at information regarding the arrangements for monitoring the quality and safety of the service provided within the home. Following the inspection we received feedback from the relatives of two people.

Good

Is the service safe?

Our findings

Staff were aware of the policy and procedures for protecting people from abuse or avoidable harm. They understood the possible signs that could indicate abuse and were confident that any issues they reported would be responded to appropriately by the organisation. There was also a policy protecting staff if they needed to report concerns to other agencies in the event of the organisation not taking appropriate action.

People were supported to take planned risks to promote their independence. Risk assessment and management plans provided clear and relevant guidance for staff. For example, there was a risk assessment for taking a person out in a car. There was a seating plan showing where the person should sit and where staff should sit to support them safely. Risk assessments had been regularly reviewed and updated and were written in such a way to prompt staff to manage each risk in the least restrictive way possible.

Risks relating to the home environment were also assessed, monitored and regularly reviewed. There was a current fire risk assessment and records were kept of regular checks and tests of the fire alarm, emergency lighting and fire safety equipment. Staff fire safety instruction and drills were also recorded. Each person had a personal emergency evacuation plan, which included important information about the care and support each person required in the event they needed to evacuate the premises. A Legionella risk assessment and weekly checks were recorded and action taken to address any shortfalls, such as replacing the boiler as this had been identified as a potential risk.

The provider had continued to follow safe recruitment and selection processes to make sure staff were safe and suitable to work with people. The process included an interview and obtaining two references, the candidates employment history and satisfactory disclosure and barring service clearance (DBS). Each new member of staff had completed shadow shifts, induction training and a probationary period of three months to ensure they were suitable for the role.

A relative told us, "Permanent staff are very good with their care and support" for their family member. They added, "Sometimes there seems to be understaffing and agency staff are brought in, they are not so familiar with the care, support and routines"; however, "At present the home seems adequately staffed".

During the inspection there were enough staff to meet people's needs and provide care and support with activities. Staff were present when people spent time in the communal areas and people who were spending time in their rooms were suitably supported. Staff rotas were planned in advance and reflected the target staffing ratio we observed during the inspection. The operations manager told us staffing levels had recently improved. There was now just one staff vacancy. While this meant there was still some use of agency staff, these were all staff who had worked at the service before and knew the people living there.

Staff had continued to receive training in the safe administration of medicines and this was followed by competency checks. Up to date records were kept of the receipt, administration and stock checks of medicines. Most medicines came in pre-packed doses supplied by the pharmacist. The medicines cabinet was stocked with current medicines only, there was no surplus stock, which made it tidy and clear what was

being held and who it was for. There were detailed individual support plans in relation to people's medicines, including any associated risks. Guidelines were in place for when prescribed 'as required' (PRN) medicines should be given.

There service had infection prevention and control (IPC) procedures in place, including cleaning schedules which staff followed. These were detailed, such as regular mattress cleaning, so that staff were clear about their responsibilities. Daily fridge freezer checks were carried out to ensure food was stored safely. Staff received IPC training and were equipped with personal protective equipment, such as disposable gloves and aprons, for use when providing personal care and carrying out domestic cleaning tasks. The registered manager carried out IPC checks and audits as part of the monitoring of the safety of the service. The home was clean and tidy and cleaning materials were kept locked away when not in use.

An online record was kept of accidents and incidents, which were reviewed regularly by the operations manager, quality team and managing director. This helped to ensure any actions that were needed to improve safety in the service were taken in a timely way. The service also communicated with the local safeguarding and community health teams to discuss any incidents or concerns.

Good

Is the service effective?

Our findings

A relative told us their family member received "Health care and support for his needs. This includes personal care, routine health checks, access to doctor, dentist, opticians. He is also encouraged and supported with access to the community".

Each person had a comprehensive assessment of their health care and support needs, which included how they communicated. There was also a one page profile of each person for agency and new staff, which contained all the essential information needed, so staff could be confident of meeting the person's needs while getting to know them better.

Staff had continued to receive a range of essential training that included safeguarding, equality and diversity, basic life support, fire safety, moving and handling, food safety, fluid and nutrition, and person centred care. Staff had also undertook autism awareness and epilepsy training and were encouraged to undertake diplomas in health and social care. We saw that staff cared for people in a competent way and their actions and approach demonstrated that they had the knowledge and skills to deliver effective support. New members of staff received induction training based on the Care Certificate, which sets out common induction standards for social care staff. Staff were further supported through regular supervision and appraisal meetings. Supervision and appraisal are processes which offer support, assurances and learning to help staff development.

People were supported to be able to eat and drink sufficient amounts to meet their needs. Each person had an eating and drinking support plan based on their requirements, routines and preferences. Plans included support guidelines for mealtimes and where necessary, speech and language therapy (SALT) assessments had been sought to assist staff to minimise the risk of choking for people who may have difficulty swallowing. For example, one person had a pureed diet and there was guidance for staff about how to present food and drink to them. The guidance enabled the person to be as independent as possible in eating and drinking while minimising any risks. Staff demonstrated knowledge of people's individual support needs and associated risks in relation to eating and drinking.

The staff team worked well with other organisations to support people. This included regular engagement with occupational therapists and community nurses to ensure people had the right support and equipment in place to make life easier and safer for them. People had Health Action Plans and staff were proactive in requesting visits or reviews from GP's and other health professionals. Staff recorded all contacts and visits from health professionals in people's care plans and followed up any appointments where required.

The registered manager had worked collaboratively with a GP to improve communication. Together they had devised a health appointment passport containing key information a health professional may want, so that all staff could support any person effectively during a health visit. People also had a 'hospital passport' in readiness should it be necessary for their health and support information to be shared with external professionals in the event of their admission to hospital.

The environment was appropriate for the care and support of people living there. Environmental adaptations were made according to people's assessed needs. For example, a walk-in bath had been installed and there was a ramp from a person's bedroom into the garden, to promote their independence. A room within the home had been developed into a sensory room, which people used for activities and relaxation, and calming colours had been used to decorate the communal areas. People had been involved in designing and choosing artwork and decoration throughout the home; and their bedrooms were personalised in accordance with their own tastes and preferences.

The Mental Capacity Act 2005 (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. Where people lacked the mental capacity to make decisions the home was guided by the principles of the MCA. Mental capacity assessments had been completed appropriately and best interest decisions made with the involvement of relevant others. Care plans provided staff with guidance about how to involve the person concerned as fully as possible. For example, for one person this included advice about the best way to present them with choices and when was the best time of day for them to make decisions.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). The provider had applied for appropriate authorisation where required.

Good

Is the service caring?

Our findings

The atmosphere in the home was friendly and supportive and the walls in communal areas were decorated with people's artwork. A relative told us, "Staff look beyond (the person's) day to day needs, such as being aware of his moods, feelings and improving his environment. (The person) is happy at Hibernia and we feel he is well supported and cared for, by the services he receives". Another relative said there were a number of staff who had worked at the home for a long time and knew the person very well.

There was a core group of staff who knew the people they supported well and had developed positive caring relationships with them. Staff communicated with people using their preferred method and took time to listen and act on what people wanted. Sometimes a person found it difficult to make their needs known. Staff were patient and supported them using pictures, objects of reference, observing facial expressions and body language and enabling the person to take them and show them what they were trying to communicate. A relative told us, "Staff are very good at caring and supporting (the person). Communication with (the person), through Makaton (a form of sign language), verbal prompts, Pecs (the use of pictures) and communication with myself is also very good".

Regular meetings took place between individuals and their key workers, to ensure that they were consulted and informed about their support and what happened in the home. Relatives told us people's relationships with their key workers worked well. Formal reviews were held with the involvement of the person's family, staff and external professionals.

The relationships between staff and people receiving support demonstrated dignity and respect. Staff spoke about people in a respectful manner and demonstrated understanding of their individual needs. People's care and support plans were written in a respectful way that promoted their dignity and independence. This approach was underpinned by training all staff received. Some people living at Hibernia needed close supervision to keep them safe. Staff however respected people's privacy as much as possible, for example when people chose to spend time relaxing in their rooms this was respected by staff.

Good

Is the service responsive?

Our findings

The registered manager took part in pre-admission assessments in order to help ensure the service could meet the individual's needs and that there was compatibility between people living in the home. People had a range of complex needs such as learning disability, behavioural support needs and physical health needs including epilepsy. Staff sought appropriate support and advice from services such as Learning Disability Health Teams, GP and other health and social care professionals. Staff monitored people's changing needs through a system of regular reviews and observation and this was clearly recorded. This helped to ensure care and support plans were current and continued to reflect people's preferences as their needs changed.

The service was complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Each person had their communication needs assessed and documented as part of their care plans and was supported accordingly. There was also a policy describing the processes that were in place for the provision of accessible information and communication support to meet individual needs.

Allocation sheets showed clearly the tasks and activities assigned to each member of staff on duty, so that people received the support they needed to attend appointments and take part in various activities. There were brief summaries at the front of people's care files that gave an overview of what was important to them and how best to support them. A communication book helped to keep staff informed about any changes in people's needs.

People had access to a range of activities both within the home and in the community. Activities included shopping, cycling, walks pub trips, cooking and going to the cinema. Activity plans and schedules were flexible to accommodate changes in the choices they had made. One person was able to communicate their wishes in writing and through using a computer, others used alternative methods such as pictures, photographs, objects of reference or gestures to suggest activities. The registered manager told us that, whenever possible, staff interests and skills were matched to the person and activity they were supporting, which promoted more positive outcomes.

A complaints procedure was displayed in the home including an easy read picture format for people who were unable to read complex information. There had been one complaint since the last inspection, which the registered manager had recorded and a response had been made. Complaints were also logged on the provider's online system so concerns and actions taken were monitored and reviewed.

A relative told us, "For any concerns, I feel able to communicate to the home (registered) manager, generally all concerns have been addressed to my satisfaction, apart from the issue of staff recruitment, which I understand is influenced by market conditions. At present the home seems adequately staffed". Another relative said that since they had raised a concern, "It's better, good things came out of it", and the service "Do seem to have stepped up", for example improved communication with the relative and with the local GP surgery.

People's views were also sought via an annual quality assurance survey. The feedback received through these informed the quality development plan for the service. The registered manager also kept a record of positive feedback from relatives and other stakeholders.

Good

Is the service well-led?

Our findings

The service had a registered manager. 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.

The registered manager was promoting an open and inclusive culture within the service. Satisfaction surveys were conducted that included questionnaires sent to people who used the service, relatives and external professionals, and their feedback was used to drive improvements in the delivery of care. Staff also had opportunities to provide feedback about how the service was being delivered. Staff said they were able to raise any issues or concerns with the registered manager and were confident that they would be addressed. Minutes were kept of staff meetings and regular agenda items included policy updates, safeguarding people, health and safety, and discussion about ensuring good practice.

Registered managers meetings were held each month and were used as an opportunity to share good practice with other registered managers. The registered manager and operations manager spoke positively both about staff within the service and staff within the organisation, who they said supported them well. The provider had a clear vision and values that were shared and discussed within services. The operations manager told us the executive team were visible and actively involved in the organisation. For example, the company CEO worked a week every year as a care worker.

There were clear lines of accountability within the service with each shift having a clearly designated member of staff in charge. On each shift individual members of staff had delegated areas of responsibility, such as medicines. Staff had annual reviews of their performance and also opportunities for career progression and development within the organisation. Staff received recognition for their work and achievements, for example the operations manager gave the registered manager a thank you card for organising a recent social event.

The service worked in partnership with other agencies to help promote good practice and quality services. The registered manager had worked with a local GP to improve communication following an incident. The service only ordered 'as required' prescribed medicines when these were needed, which served to cut down on waste.

Regular audits of the quality and safety of the service had continued to take place and were recorded. The registered manager sent a weekly service report to the organisation's quality assurance team, who contacted the manager for further details and provided support if and when appropriate. The quality assurance team carried out unannounced audits of the service to check on standards of quality and safety. The registered manager also undertook a quarterly audit of the service, which focused on the five key questions: is the service safe, effective, caring, responsive to people's needs and well led? Audits were checked and monitored by the operations manager and quality assurance team and, where necessary, action plans were created and followed. The frequency of the audits could be changed according to an

organisational risk score, so that any service scoring less than a 70% compliance rate would be audited more frequently.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed in the home and on the provider's website.