Voyage 1 Limited

Bridge House (Somerset)

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

Bridge House 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. 11 people with a learning disability were receiving care at Bridge House. They were between the ages of 29 and 67. Bridge House is a large terraced house adapted as a care home.

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.

At the last inspection, the service was rated Good.

At this inspection, we found the service remained Good.

Why the service is rated Good

People were safe at the service because recruitment, staffing, medicine management, infection control, and upkeep of the premises protected people from unsafe situations and harm. Individual risks to people were assessed and managed with as little restriction to the person as possible.

Staff had a good understood of how to protect people from abuse and discrimination. They knew to report any concerns and ensure action was taken. The registered manager was a strong defender of people's rights and protection.

Staff were supported to be skilled and efficient in their roles and spoke of good teamwork and how much they liked working at Bridge House.

People's legal rights were understood and upheld with as little restriction as possible. People's health care needs were met through working with external health care professionals and staff's detailed knowledge of the people using the service.

The premises provided people with a variety of spaces for their use with relevant adaptation to meet their needs where possible. Bedrooms were very individual and age and gender appropriate.

People received a home cooked and varied diet and specialist diets were met. Some people enjoyed eating out on a regular basis.

Staff promoted people's dignity and privacy. The service was centred on each person as an individual. Staff

were kind, caring and people enjoyed banter, laughter and a friendly atmosphere. Information was provided in different formats according to people's communication needs. However, the organisation had expected people to complete a form, which would require good reading, and interpretative skills, which people using the service did not have. The registered manager will discuss this with the provider.

Support plans were detailed and reviewed with the person when possible, staff who supported the person and family members. Staff looked to identify best practice and use this to people's benefit. Staff worked with and took advice from health care professionals.

Some people were reluctant to engage in activities but many options were available to them. These included art, crafts, music, sport, dancing, walking, and eating out. People had a holiday each year and went into the community on a daily basis. There was strong support of relationships with friends and family.

The registered manager showed strong leadership and a passion for the people in their care. People's views were sought and opportunities taken to improve the service. Staff were supervised, supported and were clear what was expected of them. Audits and checks were carried out in-house and through the provider, so any problem could be identified and rectified.

The registered manager understood and met their legal responsibilities.

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**

Bridge House (Somerset)

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 was a comprehensive, unannounced inspection. It took place on 7 and 8 February 2018.

The inspection team included one adult social care inspector.

Prior to the inspection, we looked at previous inspection reports. We also reviewed the information we held about the service and notifications we had received. A notification is information about important events, which the service is required to send us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We received feedback from five of the 11 people using the service and used informal observation to see people's experience of living at Bridge House.
We spoke with two people's family members, five staff, a provider representative, and the registered manager.

We reviewed four people's care records, sampled information from on-line staff files, training arrangements and looked at quality monitoring information relating to the management of the service and safety records. We received feedback from one health care professional and saw other feedback from questionnaires the service had received during 2017/18.

Good

Is the service safe?

Our findings

The service continued to be safe.

People told us they felt safe at the service and we observed they were relaxed in the presence of staff. People's family members said they felt people were safe at the service.

Staff protected people from abuse and harm because staff had a good understanding of how to respond to any concerns. All staff had received safeguarding training and had access to information telling them how to respond to any concerns. This included an independent support organisation. This meant that staff, if they lacked confidence to report abuse, would be more likely to take action.

The registered manager was very proactive in protecting people. They had informed the local authority safeguarding team, appropriately, when they judged abuse might have occurred. An example was to protect people's financial interests. They said, "We all have a huge passion to protect people". When the Care Quality Commission received information indicating abuse might have occurred the provider held a thorough investigation into the allegations, which were found to be unsubstantiated.

Staff protected people from unnecessary risks. A health care professional said, "All risks are assessed and staff are very aware."

Each person had risk assessments in place to protect them from harm. Risk management considered people's physical and mental health needs and showed that measures to manage risk were as least restrictive as possible. For example, relating to using the kitchen, visiting the community, finances and illness. A traffic light system determined the level of risk.

Any accidents and incidents were investigated and monitored by the registered manager and provider to look for trends and patterns. For example, following an accident the registered manager was asked to start a monitoring record. This showed there was oversight and partnership working to protect people.

There was an equalities and diversity policy in place. Staff received training on equalities and diversity and the registered manager had undertaken a five-day course with the local authority. Staff understood their responsibility to help protect people from discrimination and ensure people's rights were protected. For example, they ensured people had equal access to the community; each person went out every day to a place of their choosing.

There were recruitment processes in place coordinated through the provider organisation. These included pre-employment checks including references from previous employers and Disclosure and Barring Service (DBS) checks. A DBS check helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people. Staff confirmed that they did not work at the service until all checks had been completed.

Sufficient numbers of staff ensured people's needs were met. There had been a recent staff turnover and three new support staff were recruited and about to start at the service. The registered manager said that they employed 10% more staff than people's support needs required so as to cover staff holidays and sickness. The registered manager had flexibility in how she used staffing hours. For example, to enable people to attend activities or health care appointments.

Medicine management arrangements protected people. No person using the service was able to manage their own medicines because of their complex needs and so staff trained in medicine management did this for them. Medicines were stored, administered, and recorded appropriately. For example, detailed protocols informed staff when medicines could be given and under what circumstances where these were 'as required'. Regular audits ensured medicines were kept and administered safely.

People were protected from infection. The premises were clean and fresh. A coloured coded system was used for mops and cutting boards and staff had personal protective equipment, such as gloves, to reduce any possibility of cross contamination. Laundry equipment was suitable for the needs of people using the service. For example, washing machines had a sluicing and hot wash cycle. There was an infection control policy and the staff received appropriate training in infection control and food hygiene.

The premises were maintained through a programme of maintenance and servicing. For example, gas, electricity, and water checks were carried out in accordance with the level of risk. A maintenance person was available from the provider organisation. Staff had received health and safety and fire safety training to ensure they knew their roles and responsibilities when protecting people in their care. People were protected because the organisation took safety seriously and had appropriate procedures in place.

Vehicles used by people using the service were safe to transport people. There were arrangements in place for ongoing maintenance of the vehicles, one of which was owned and one leased to the provider organisation.

Arrangements were in place should an emergency occur. For example, there was a grab bag containing high visibility jackets, torches and staff knew how to respond to if the fire alarm sounded. There was an arrangement to evacuate to a local sister home should this be necessary.

People's finances were protected. People's families said they had no concerns about those arrangements. People's allowances were kept securely on their behalf, with daily and weekly balance checks in place and detailed record keeping, checked by the registered manager and a provider representative who visited on a regular basis.

Good

Is the service effective?

Our findings

The service continued to be effective.

People did not comment directly on whether they thought staff were well trained. However, we observed people were happy with the staff that supported them.

People's family members said, "(The person) is well looked after" and "(The staff) follow up on health concerns straight away." People's ability to communicate was affected by their complex communication needs but the staff were able to understand and provide for their needs quickly and effectively. For example, staff described how they would know if (named people) were unwell. For example, the body language and words they used.

Health care needs were met in accordance with people's medical needs. For example, from a learning disability district nurse, ophthalmologist, dentist, chiropodist and epilepsy specialist. Some people used alternative therapy. A health care professional described the care provided as "Very professional" adding that staff sought assistance appropriately and followed professional advice. Positive health was promoted through reviewing people's prescribed medicines and 'well man' and 'well woman' checks.

Each person had a health care file, which included a health care passport with information relevant to their support needs, should they require admission to hospital.

Staff had completed an induction when they started work at the service, which included the nationally recognised Care Certificate as required. The Care Certificate is an identified set of induction standards that health and social care workers should adhere to when performing their roles. Staff said the induction helped them understand the work. Two staff member said how they shadowed an experienced staff member when new to the service and how this helped them understand each person's specific support needs. During staff probation regular meetings were held to ensure the correct amount of support was being provided.

A staff team who had the skills and knowledge to effectively meet their needs cared for people. The provider organisation provided regular training for staff. This included aspects of health and safety and training specific to people's support needs, such as understanding autism and epilepsy. Most training was e learning and some staff said how more effective face to face training could be. The registered manager said this had been noted and there were arrangements in place to achieve this in the near future. Staff confirmed that they felt supported when it came to their professional development.

People's consent to care and treatment was sought where possible. Staff involved people in their care and gave them time to make their wishes known. Advocacy helped to ensure that people's rights were upheld where there was no independent person to speak on their behalf.

Staff worked in accordance with the Mental Capacity Act 2005 (MCA). No person using the service had capacity to make all necessary decisions relating to their care and support. The MCA provides a legal

framework for making 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Records showed that people's capacity to make decisions was assessed and decisions were made in people's best interest where this was necessary, for example, in relation to protecting a person's menu choices.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interest and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). There had been a DoLS application for each person using the service for their protection and some legal authorisation had been agreed and put in place to lawfully deprive people of their liberty, for example, to provide personal care. The registered manager had a system for ensuring they reapplied for authorisations in good time for them to be reviewed.

Restraint was only used where legal authorisation had been granted to do so. Staff said that they received training in how to help people manage their behaviours and de-escalate any situation, which had the potential to cause a person harm. Each person's care plan included emotional and behavioural support. These plans gave staff the information and guidance they required to appropriately support people.

People were supported to receive a nutritious diet and enjoy food. Some people's preference was for 'take away' foods but we observed healthy, nutritious meals being prepared and enjoyed by people using the service. People said that they liked the food, one saying, "I like pasta" and another "I like the food. I like curry." Specialist diets were being met in accordance with choice, health care needs and religious observance.

People's diverse needs were promoted through the way the premises were used. People had a variety of spaces in which they could spend their time. Each bedroom was ensuite and bedrooms were much personalised. For example, one person's room reflected their love of arts and crafts. Another person's room was decorated with film heroes. People had access to an attractive, functional garden space providing lots of room.

Where people moved across services, the service ensured their best interest was promoted. For example, on arrival one person's support plan did not meet their needs and so it was completely reviewed offering the person choice and involvement. This had included the person choosing how to decorate their room and write their care plan.

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Good

Is the service caring?

Our findings

The service continued to be caring.

People said that the staff were kind. One person's family member said, "I can't fault (the staff)". A health care professional said, "I do think staff genuinely care".

Staff adopted a positive approach in the way they involved people and respected their independence. Staff supported people in an empathic way. They demonstrated this empathy in their conversations with people they supported and in their discussions with us about people. Staff showed an understanding of the need to encourage people to be involved in their care. For example, one person enjoyed involving staff and visitors in their creative interest and staff helped them achieve this several times during our visit. When a person expressed anxiety and distress staff immediately provided reassurance.

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We looked at how the provider complied 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. People receiving support had a learning disability and varying communication abilities. Staff were able to use and understand non-verbal communication methods. A staff member said, "Our guys let us know what they like and what they want". Care records contained clear communication plans explaining how people communicated.

A variety of communication tools helped to enable effective communication. For example, there was pictorial information explaining visits to a GP and about having a blood test. However, the provider organisation had wanted people to complete their agreement to a quality monitoring questionnaire but this was in a format that would require good reading and interpretative skills. The registered manager confirmed that no person using the service would have that level of skill and they would talk to the provider about this.

Staff were observed respecting people's right to privacy and a visiting staff member confirmed they did not work in a person's room unless the person agreed. People's records included any gender preference of staff to support the person.

Staff relationships with people were caring and supportive and we observed a lot of laughter and banter between staff and people using the service. Staff spoke confidently about people's specific needs and how they liked to be supported. Staff were motivated to provide support that was kind and compassionate. One talked of the importance of confidentiality when handling people's information.

Staff showed a commitment to working in partnership with people and spoke confidently about the people using the service and each person's specific interests. Staff understood the importance of involving people in their care to ensure they felt consulted, empowered, listened to and valued.

Staff had shown empathy and kindness when supporting people who had been bereaved. A person's family

member said, "Staff handled it very gently". Staff had discussed the best way to help one person understand the situation and how to provide the necessary support in a consistent way.

Personal relationships were supported. The registered manager understood the importance of relationships with friends and family and did what they could to support them. For example, one person would be taken every few months to visit a friend in another county. The person told us how much they enjoyed meeting their friend.

Good

Is the service responsive?

Our findings

The service continued to be responsive.

People received the care and support they needed and staff were responsive to their needs. Some people using the service had lived there for very many years. People were supported to be involved in their care and support if they wanted to. The staff worked around their wishes and preferences on a daily basis. People said or indicated to staff about the care and support they wanted and how they preferred to have things done. Staff followed people's wishes unless legally authorised to support them in a different way for their protection.

Each person had a support plan and health care file, which was regularly reviewed, taking into account the person's wishes and information from people who knew them best, such as family members. Support plans make sure that staff have all the information they need to provide care and support which is personalised to the individual, for example, a detailed plan of how a person was to receive the personal care which they needed.

Support plans were well organised with information easy to find and containing in-depth information relevant to the person. For example, what made the person happy and what might cause them distress and how to minimise that possibility. Each person also had a yearly review which included people relevant to their care. A health care professional said that the information, both verbal and recorded, which the service used, was as required and "Very professional. They added "(The staff) know people very well". One person's family member said "I can't fault (the staff). (The person) is spoilt rotten".

People's life histories and details of their family members had been recorded in their care plans, so that staff could get to know about people's backgrounds and important events. Some people had no family to provide that information but staff knew their preferred ways through the experience of supporting them.

People were supported to enjoy an active lifestyle according to their preferences. People had opportunities for meaningful occupation in accordance with their abilities and interests. Staff described trying to encourage people to engage in activities and they tried to find new activities which might interests people. For example, it was arranged that one person was going to try dry-slope skiing.

People spent time in the community every day unless they chose not to. They benefitted from a central location in the town and two vehicles for their use. People told us about going bowling, the cinema, a weekly disco, playing pool, swimming, coffee, and shopping. There were regular in-house art and music sessions. One person said, "I wear funky clothes". Some regularly attended social/learning settings. We were told that most people were not interested in household activities. However, we saw people getting their breakfast and one liked to help with office work. A meeting was held with people once a month to explore what was going well and what they might prefer to do.

The importance of planning end of life care was understood. The registered manager was looking into what

end of life care people might choose. Some people were able to engage with this and some were not.

Staff were able to describe how they would recognise if a person was unhappy for any reason. Some people were able to verbalise what was troubling them and did so during the inspection. People's family members said they had no concerns about talking to staff or the registered manager and, if necessary, would feel able to complain. No complaints had been received by the service and the Care Quality Commission had received no complaints.

Good

Is the service well-led?

Our findings

The service continued to be well-led.

There was a registered manager at the service. They were registered with the Care Quality Commission in June 2014. 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 organisation's core values were set out in a statement of purpose. They were empowering, together, honesty, outstanding and supportive. The registered manager said they never got complacent in supporting the people in their care and we observed their strong leadership approach and enthusiasm for their role. Teamwork was very evident and the team was well led. People using the service did not comment about the management but regularly sought out the registered manager with information or requests. One person's family member said the management was "Doing very well". Staff said "Staff work really well together as a team" and "It's very well led. There is a strong senior and management team and really good communication".

Feedback about the service was sought through questionnaires, which included professional visitors and people's family members. People's views were sought on a day to day basis, through a monthly meeting and at care reviews.

Supervision meetings and shared staff meetings kept staff up to date and gave them a formal route for their views and ideas. For example, staff had said they preferred more face-to-face training and this was being arranged.

The quality of the service was monitored and improvements planned. For example, following feedback from questionnaires an improvement plan would be produced. Where necessary staff performance was monitored and action taken.

The registered manager looked for ways to improve people's lives and the service, for example, one person's mobility was becoming more limited and it was identified they might benefit from a wet room or walk in shower.

There were systems in place for auditing and monitoring the service. For example, audits of medicine management and risk management. Regular visits and monitoring audits from the provider organisation included: financial records, safety in the premises, staff files and how well people were being supported. These helped to make sure people received a good standard of care and support, which was in accordance with up to date good practice guidance.

The registered manager was supported through the provider on line systems, such as recording accidents

and incidents, reporting maintenance issues and through regular contact with their line manager in the organisation.

The registered manager understood and complied with their Duty of Candour and understood and met their regulatory responsibilities.