Voyage 1 Limited

39 Hawthorne Grove

Inspection report

39 Hawthorn Grove
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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

39 Hawthorne Grove provides accommodation and support for three people with a learning disability. This inspection was unannounced on the 23 August 2017. There were three people living at the service.

At the last inspection on 3 February 2017, we found breaches of Regulation 9 and Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to make improvements on ensuring the principles of the Mental Capacity Act 2005 were followed to gain consent. We also asked for improvement in the approach used to meet people's needs. The provider sent us an action plan on how these improvements were to be made. We found this action was completed.

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 people at the service were not able to tell us about their experiences of living at the home. f Staff were aware of how people communicated and how to interpret their body language and facial expressions.

We saw people moved freely around the home, spending time in their bedrooms, kitchen and conservatory. Some people congregated in the kitchen when staff were preparing meals. This meant people enjoyed the company of staff and were comfortable with the staff.

Staff had attended training in safeguarding of adults. The staff we spoke with were knowledgeable about safeguarding of vulnerable adults procedures. These staff knew the types of abuse, how to identify abuse and how to raise their concerns. We saw the "See Something Say Something" and Whistleblowing procedures on notice boards, which gave staff guidance on how to raise concerns directly to the organisation.

We saw staff encouraged people to participate in in-house activities and people joined in with the activities. People sought assistance from staff to undertake activities. We saw one person smiled when the staff helped them with sensory objects. Staff ensured people had access to the community and on the day of the inspection people went out together for lunch and in the afternoon one person went out with a member of staff.

Care plans in place included people's preferences and their abilities to manage their care. Care plans were reviewed regularly. We saw care plans directed staff on the non-verbal language used by people and how to respond to wishes and requests. Staff said they read the care plans and where there were changes to the care plan they signed them to indicate they had read, understood and agreed with the actions. Care plans were combined with the risk assessment. Where risks were identified measures were introduced to minimise the risk. Accidents were reported by the staff and where people sustained an injury a body map was

completed to illustrate the location of injuries.

The environment was suitable for the people living at the service. The accommodation was arranged on one level which meant that people with mobility impairments had access to all parts of the property. Bedrooms were large and decorated to reflect their personalities.

There were two staff on duty at all times. At night two staff slept in the premises. Staff said the staffing levels were adequate to meet people's needs. We saw staff were not rushed and time was taken with people.

We found safe systems of medicine management. Medicine care plans were in place for each person. Staff signed medicines administration records (MAR) charts to show medicines administered. Protocols were in place for medicines to be administered as required. Body maps were used to illustrate where on the body staff were to apply topical cream.

We saw staff offer people choices. Members of staff were aware of the day to day decisions people made. People's capacity to make complex decisions was assessed and included medical treatment, temporary relocation and finances. People were subject to continuous assessments and DoLS (Deprivation of Liberty safeguards) applications were in place.
Health action plans were in place on how people were to be supported with their ongoing healthcare needs. Professionals that supported them were listed in the plans, for example, dentists, speech and language therapists and district nurses. Reports of their visits were maintained along the outcome of their visits.

New staff received an induction when they started work at the service. Staff were supported with the roles and responsibility of their job. This included training, one to one supervision with the registered manager and annual appraisals.

The dietary requirements of people were catered for. Menus were prepared in accordance with people's likes and dislikes. The week's menu was on display with photographs of foods and meals which gave people a reference of the meals to be served that week. We saw one person preferred to have finger foods and this was catered for.

Quality assurance systems were in place. The views of people and their relatives were gathered. However people were not able to express their experiences about the care they received. Staff supporting people with the surveys documented how people responded when they took steps to gather their feedback. One relative responded and the staff received positive feedback about the care they delivered to their family member.

Audits were undertaken to assess the delivery of care people received. Where there were shortfalls an action plan was developed on how the standards were to be met.

Staff said the team worked well together and felt valued by the registered manager. Staff said they shared the values of the organisation and were aware of the challenges, for example improving the rating of the home.

We recommended the registered manager considers using visual information to help people understand the decisions to be made. Consideration should be given to social stories.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Personal emergency evacuation procedures were in place to safely evacuate the property in the event of an emergency.

There were sufficient staff to support people and we observed that staff were visible and available to people.

Medicines were managed safely.

Staff had attended safeguarding of vulnerable adults training. The staff knew the types of abuse and the responsibilities placed on them to report abuse.

Risks were assessed and action plans were in place to reduce the level of risk.

Is the service effective?

Good

The service was effective.

People were supported to make day to day decisions. Care plans contained mental capacity assessments. People's capacity was assessed where appropriate and best interest decisions were made for people who lacked capacity.

Staff had the knowledge and skills to carry out their roles and systems were in place to support staff with the responsibilities of their role.

People had access to ongoing healthcare.

The dietary requirements of people were catered for

Is the service caring?

Good

The service was caring

People were treated with kindness and compassion. We saw positive interactions between staff and people using the service.

Staff knew people's needs well and there was a calm and friendly atmosphere.

Staff showed concern for people's well-being.

Personal details and profiles gave guidance to staff on people's relationships with family and friends, their likes and dislikes and preferences on how personal care was to be provided.

People's rights were respected and staff explained how these were observed.

Is the service responsive?

Good

The service was responsive

Care plans were person centred.

There were opportunities for people to participate in group activities and one to one activities.

There were no complaints received at the home.

Is the service well-led?

Good

The service was well led.

The views of people and their relatives were gathered using surveys. Positive feedback was received from relatives.

Quality assurance systems were in place and audits were used to assess the provision of care delivered.

Staff said the team worked well together and the registered manager was approachable and felt valued.

39 Hawthorne Grove

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 23 August 2017 and the first day of the inspection was unannounced.

Before the inspection, we asked the provider to complete 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 reviewed all of the information we held about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

The inspection was carried out by one inspector. We used the Short Observational Framework for Inspection (SOFI) to observe the way staff interacted with people. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the registered manager and three staff on duty. We contacted two relatives and spoke with one relative about the care their family member received. We also spoke with a commissioner of placements at the home.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included two care plans, staff training records, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

Good

Is the service safe?

Our findings

People were not able to tell us what keeping safe meant to them. We saw people sought the company and assistance of staff to undertake activities. One person smiled when a member of staff helped them with a sensory object. We observed people accompanying staff when activities were offered. A relative told us their family member was "definitely" safe with the staff working at the home.

People were protected from the risk of harm. Care plans were developed on how staff were to minimise risks identified for each person. A member of staff we spoke with knew how to support people to stay safe and explained that one person at times caused harm to themselves. They said a quiet and calm approach was used when people showed signs of self-injury and were offered pain relief in the event the behaviour was caused by pain.

Emotional behaviour care plans described the behaviours used by the person to show they were settled and the potential causes of distress, for example pain. The early signs which alerted staff to the person becoming distressed and how staff were to respond were part of the care plan. For example, staff were to use a calm approach, give the person time and to redirect them. The behaviours when the person had become settled were described to ensure the staff were aware the person was no longer unsettled. A member of staff said they had attended moving and handling training but people were able to transfer and reposition independently. The mobility care plan for one person described the way the person moved around the home and the equipment used in the community. The vehicle care plan confirmed a tail lift was needed for people using wheelchairs. This will ensure the person was able to transfer without support from the staff.

The potential risk of people developing malnutrition was assessed. The person's body mass index [height and weight] was used to assess the level of risk. People were weighed monthly to identify early signs of deteriorating health. We noted that one person had lost weight consistently over a period of time but no action was taken. The registered manager took prompt action following our feedback and made arrangements with the district nurse to carry out Malnutrition Universal Screening Tool (MUST) screening. The district nurse agreed to weigh the person weekly and record the weights as part of their weekly visits to the home This ensured people's health was monitored.

Accidents and incidents were clearly recorded and reviewed by the registered manager to ensure they had been responded to appropriately. A social care professional told us accident reporting was an area raised during a visit and the registered manager was asked to raise awareness amongst the staff team. The registered manager had responded to the concerns and at a team meeting procedures for reporting incidents and accidents was discussed. The procedure on reporting events and injuries was on display and accessible to staff in the office. This ensured staff were aware of the procedure to follow.

Personal emergency evacuation procedures were in place to identify the people most at risk in the event of a fire and detailed the assistance required from the staff for a safe evacuation from the home. For example, staff were to give verbal instruction and one member of staff was to assist the person to leave the property.

Annual fire risk assessments were undertaken by an external contractor to identify the potential fire hazards within the home and where appropriate action was taken to reduce or remove the risks. The actions identified to reduce the risk of fire included fitting smoke detectors in the laundry room and fire exit signs to be on the main entrance. There was testing and checks of equipment to reduce the potential of fire in the premises. Fire training and fire drills occurred regularly to ensure staff knew the procedure to follow in the event of a fire. We saw testing of equipment included emergency lighting checks and portable electrical appliance testing.

We observed two staff were on duty at all times during our visit. A relative told us there were usually two staff on duty but there were occasions when one member of staff was on duty. They said this happened when staff had to provide cover at other services within the organisation. The registered manager said there had been the "odd occasions" when unplanned absences had occurred at short notice and one member of staff was on duty for a "short time". They said the commissioner had agreed for one member of staff to be on duty for short periods outside peak times.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. We saw for a new member of staff there was an email from the organisations Human Resources to the registered manager giving approval for the induction to start as all checks undertaken were completed.

Medicine systems were safe. Members of staff said they had attended medicine training and their competency was checked before they administered medicines. A member of staff said their competency was checked before they administered medicines. The registered manager said there were no medicine errors.

Medicines care plans stated that trained staff were to administer medicines, audits of medicines were to take place monthly and reviews of medicines by the GP were to be annual. Where there were known allergies these were recorded in the care plan. We found the medicines prescribed, including topical medicines and how people liked their medicines to be administered, were recorded. Where medicines were to be administered as required (PRN) procedures were in place on how these medicines were to be administered.

Medicine administration records (MAR) included any known medicine allergies and a photo of the person for easy identification of the person. MAR sheets were signed following administration and there were no gaps on the sheets reviewed. The receipt of medicines was being recorded on MAR sheets.

Records relating to the application of prescribed topical medicines were seen recorded separately. Body maps, to specifically indicate which area of the body the topical medicine should be applied to, were in use.

Good

Is the service effective?

Our findings

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At the previous inspection that took place in February 2016 we found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's capacity to make specific decisions was not always assessed. Where people lacked capacity to make decisions consent was gained from relatives without the legal powers to do so, for example a lasting power of attorney. Deprivation of Liberty Safeguards (DoLS) applications were not made to the supervisory body for people subjected to continuous supervision. The provider sent us an action plan on how the requirements of this regulation were to be met. During this inspection we found improvements had been made.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At this inspection we found DoLS authorisations had been sought and were reviewed annually by the registered manager.

We checked whether staff were working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The register of decisions and decision making agreements accompanied mental capacity assessments and gave staff a quick reference guide on the decisions the person was able to make for themselves. Where the person lacked capacity to make a complex decision, the people and social and healthcare professionals involved in decision making were listed. Mental capacity assessments were in place for specific decisions and where people lacked capacity best interest decisions were taken. These decisions included intrusive procedures, dental treatment, screening and temporary relocation while repairs were carried out and financial management. We noted that mental capacity assessments lacked details on how the information about the decision was presented. While we accept people used non-verbal language to communicate there was no evidence that visual information was used.

People were enabled to make day to day decisions. Staff said people were given opportunities to make decisions. A member of staff explained the way people were supported to make decisions. People were shown options to help them make decisions. For example, people were asked about meal choices from the visual options shown. Care plans included how staff were to support people with making decisions. For example, the eating and drinking care plan for one person instructed staff to use objects of reference to help them make choices. We saw information on the principles of MCA was on display within the home, which ensured staff were aware of their responsibilities towards supporting people with decision making.

We recommend the registered manager considers using visual information to help people understand the

decisions to be made. Consideration should be given to social stories.

People were involved in decisions about their meals. Staff confirmed rolling menus were developed on their knowledge of people's likes and dislikes. We saw in the kitchen notice board the week's menu with pictures of food items and meals on display. This gave people a pictorial reference of the meals for the week. Menus showed that generally people had a choice of cereals and toast, a light lunch and a main meal in the evening. We saw there was a good range of fresh fruit and vegetables, and stocks of tinned and frozen food which ensured people had enough to eat, including snack between meals.

The eating and drinking care plans gave guidance to staff on the meals people liked, how the meals were to be served and the adapted cutlery needed by the person to eat their meals. For one person the eating and drinking care plan followed guidance from speech and language therapist to cut high risk foods into bite size pieces. Also included was their meal preferences, the times of meals and that snacks were to be offered between meals.

New staff received an induction to prepare them for the work they were employed to fulfil. A member of staff said following the apprentice programme, they completed the Care Certificate [new minimum standards that should be covered as part of induction training of new care workers]. Another member of staff told us they were undertaking the organisation's induction, which was over a 16 week period. They said they had shadowed more experienced staff until they felt confident to work alone. and their practices were observed to check their competency to undertake their role. The records of induction covered conditions of employment, Health and Safety and pay.

Staff had the knowledge and skills needed to carry out the roles and responsibilities. The staff we spoke with confirmed they had attended mandatory training set by the provider. Mandatory training staff had attended, included medicine competency, infection control, fire safety, equalities and diversity. Staff also attended other company required training that was specific to the service for example, moving and handling. for example

Staff had effective support to undertake the responsibilities of their role and with their professional development. The registered manager said one to one supervision meetings with staff happened eight weekly or four per year. They said where necessary an action plan was developed to be followed up at subsequent meetings. For example lead roles for staff that included infection control and mentoring of new staff. A member of staff said part of their one to one supervision with the registered manager was for discussing people at the service and asked their suggestions for improving the service. They said the registered manager always took time to remind staff that there was "an open door policy where issues can be discussed in confidence."

People had access to ongoing healthcare. Health files included reports of visits and appointments from healthcare professionals. For example, optician appointments and podiatry visits. The reports detailed the outcome of the visits and where appropriate guidance on meeting people's ongoing healthcare needs. We saw there had been referrals for specialist support and for community services such as district nurse for medical procedures.

Health Action Plans were in pictures and simple English to help the person understand about their healthcare. Health action plans included an assessment of the person's health and wellbeing and the action plan listed the steps that must be taken in order to achieve a specific goal. For example, monitoring one person's weight monthly and continence support from the staff.

Hospital passports listed the social and healthcare professional involved in the care of the person and known allergies. Things that were important to the person were included for medical staff in the event of an admission to hospital. Records showed staff recorded the appointments which included routine check-ups and the outcomes of these visits.

Good

Is the service caring?

Our findings

People were not able to tell us how they experienced care from the staff. A relative told us their family member disliked change and they benefitted from continuity of care staff they were used to.

We saw during mealtimes two people preferred to eat together in the kitchen/dining room while another person ate their meal on their own in the conservatory. Staff were knowledgeable about people's likes and dislikes and knew how to respond to people when action was needed to relieve the person's distress. A member of staff said when people were showing signs of distress they "got to eye level with the person, reassured them that everything is ok." Another member of staff said "I understand their [people's] needs and what they want. I give people what they want. I approach them softly when they become distressed. I know the signs when they become settled. X[person]will smooth your arm".

Staff had a good understanding that people needed to feel they mattered and it was important to build trusting relationships. A member of staff said they showed empathy [the ability to understand and share the feelings of another] and staff acknowledged "what people were trying to say". They said staff became aware that trust was "built from people's behaviour. For example, X[person] will follow staff and will link arms with staff." Another member of staff said they knew by the behaviours of people there was trust. They said the team was stable and offered people continuity of care.

Personal histories and information about the qualities of the person was recorded to ensure staff had a good understanding of the people they were caring for and supporting. We saw people's life stories were recorded and included their education history and life events that led to their admission into the home. The relationships with family and friends was recorded in the relationship map and showed the people that were close to the person. Information about the person included "What others liked about the person", for example one person was liked for their "relaxed with an easy going personality" and for another their "smiles". Under the section for "What was important to the person" staff recorded for one person that family, activities and having their care delivered at an appropriate pace was important. For another person "moving freely around the home" was important. People's care plans had guidance on "How staff were to support them" . A member of staff told us flowers were sent to a person's relative who was important to them when they became ill. Staff checked their well-being regularly on behalf of the person living at the home.

A typical day care plan included the preferences of people and how staff were to assist them. For example, the times people liked to rise and retire. Included was the person's ability to manage aspects of their care, the choices people were able to make about their clothes and the non-verbal language used to show assistance with routines was needed. For one person staff were given guidance to stop the task if the person should become distressed with the delivery of personal care.

The environment was suitable for the people living at the service. The accommodation was arranged on one level which meant that people with mobility impairments had access to all parts of the property. Bedrooms were large and decorated to reflect their personalities.

The equality and diversity policy confirmed the organisations principles included promoting the rights of people. Members of staff gave us examples on how people's rights were respected. A member of staff said people were not exposed when they left bathrooms and contractors were not given access to the home until people were suitably dressed.

People's preferences and choices for their end of life care were recorded. Care plans included their wishes and how staff were to respect them.

Good

Is the service responsive?

Our findings

At the previous inspection on February 2016 we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because support plans lacked detailed guidance for staff on meeting people's needs. Following that inspection, the registered manager sent us an action plan on how the requirements of the regulation were to be met. During this inspection we found people received care and treatment that was person centred.

The people at the service were not able to tell us their involvement with the planning and delivery of their care. A relative told us they were invited to care plan review meetings and they were able to express their views and make suggestions. These views and suggestions were used to develop and update care plans.

People's needs were assessed and reviewed to ensure care plans were reflective of their current needs. Individual care and support needs assessments included the names and contact details of health and social care professionals with regular involvement in the care of the person. A checklist was used to identify and score the level of need, which was then used to develop a care plan on meeting the identified need.

Care files contained one page profiles about the person as well as personal details with key facts about the person. This included the person's medical diagnosis and areas of needs for example nutrition, wellbeing and relationships.

People's care was personalised. Care plans were person centred and were reviewed annually by the staff. People's preferences and how staff perceived the person to like their care delivered was included in the care plans. Staff told us they read the care plans. A member of staff said they signed the updated care plans to show they had read, understood and agreed with the changes of the care plan.

The people at the service used non-verbal language to communicate with staff. Communication care plans detailed the non-verbal language used by the person and how staff were to interpret their wishes and feelings. For example, one person would get their coat and stand by the door to show they wanted to leave the building. For another person, placing a finger to the mouth indicated to staff the person wanted a drink and smiling showed staff this person was "happy with the activity" and wished to continue. People's ability to understand staff was part of the care plan. For example, one person was able to understand simple sentences such as "your lunch is ready".

Daily record of the care and support people received was maintained. Individual workbooks included the daily routines staff supported the person to undertake, the meals served and activities. Staff said when they came on duty there was a handover where staff were informed about people's current needs.

Activities care plans and weekly rotas were in place which showed people participated in a range of group and individual activities. There were opportunities for people to have in-house activities which included reflexology, musical and sensory objects. Group in-house activities included baking. A relative told us activities were offered but their family member at times refused to undertake activities. During our visits we

saw people had gone out for a trip and lunch. A member of staff said activities were daily which included community activities such as bowling and meals out and in-house activities such as reflexology.

The complaints procedure was in simple English and in large print. There were no complaints received at the home since the last inspection. A relative told us if they had complaints and concerns they would "inform" the staff.

Good

Is the service well-led?

Our findings

The vision and values of the organisation were on display within the home and included empowering together, honesty and being supportive.

Staff said they were supported by the registered manager. A member of staff said "The registered manager respects my opinion and my input. We work closely as a team and appreciate the time it takes to complete tasks." This member of staff also said the registered manager explained how to complete tasks where necessary, took time to listen and "thanked" staff. Another member of staff said "the team is strong and everyone gets on. [Staff] support each other and cover time off or provide emotional support. Everything has worked. We understand why [the registered manager] does things, definitely making a difference, very supportive." This member of staff made reference to the previous inspection report and stated that the registered manager had said "we need to show we are not what the report said and we are better than that. Families have never had a problem."

Staff meetings were organised and the minutes of the meetings were recorded. Staff signed the minutes to show they had read and agreed with the actions from the meeting. Areas of discussions included the actions from previous meetings, people living at the service and training.

A registered manager was in post and had an understanding of the key challenges. The registered manager told us their approach was "fair and listening to staff with shared respect". They told us that being available was important to staff. This registered manager worked across three locations which meant when they were not on duty at the home, contact was by email and by telephone.

Service reviews were annual. Surveys were used to gain feedback from people, their relatives, and professionals with regular contact with people e and staff. Surveys were sent to people and there was an expectation that staff explained to each person the purpose of the letter. Where staff had supported people to gain their feedback, a record of their response was documented. We saw staff had recorded "no interest shown," "person walked away "and "XX was not able to answer. However, XX seems happy". Two relatives were sent surveys and one responded. We saw the feedback received from one relative was positive on all areas of care delivered to their family member. This relative confirmed they were kept informed about important events and were welcomed by the staff when they visited.

Accidents and incidents involving people were recorded and reviewed by the registered manager. There was a centralised electronic system in place which documented the type of incident, who was involved and the actions taken, including any follow up actions. For example, one fall had occurred and report of the accident was dated 25 May 2017. The person had tripped because they were walking with their eyes closed. The member of staff had provided first aid. A body map was used to illustrate the location of the injury in the body. The person sustained a minor injury and was not notifiable to the CQC under Regulation 18.

Auditing systems were in place to measure and review the delivery of care, treatment and support people received. Audits were quarterly and Key Lines of Enquiry (KLOE) were used to assess the delivery of care. The

score of the most recent sample check was 95.71% and the action plan devised to achieve 100%, included the responsible staff or contractor to complete the task and the completion date. For example, there were to be repairs to the property and the landlord was responsible to completing the task. The staff knowledge of Deprivation of Liberty Safeguards was to be refreshed by 31 August 2017. The area manager also audited systems and had assessed all standards met at their most recent visit.

Consolidations action plans were developed from audits and from recommendations made by commissioners of services. For example, for one person the action plan was to source swimming activities within the community. The date of the action was to be achieved and the outcome of the actions taken for the recommendation was included in the plans.