Voyage 1 Limited

Voyage (DCA) Wiltshire

Inspection report

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27 January 2020

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Voyage DCA Wiltshire is registered to deliver personal care to people in their own homes or in a shared house arrangement. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided

People's experience of using this service and what we found
There were people who at times expressed anxiety and frustrations, using behaviours that placed them, the staff and others at risk of harm. While action plans gave staff guidance, these were not always consistently followed.

Staff were not aware of how to mitigate risks to themselves when managing incidents that placed their safety at risk.

Incident reports were completed where there were behaviours which placed the person and staff at risk. However, there was little evidence of an analysis of the actions taken by staff in relation to known and emerging triggers about the person. This meant there was a lack of consistent approach from the staff. The way staff documented events was not always person centred.

We responded to concerns we received about one person, by undertaking a focussed inspection of Safe and Well-Led. As part of the CQC methodology, we also raised a safeguarding alert with the local authority safeguarding team. Staff acknowledged that they had not always reported poor practice they witnessed from other staff. Once senior managers were made aware of concerns they acted promptly and appropriately. Since the inspection senior managers provided us with further information on safeguarding and whistleblowing procedures.

Some safeguarding referrals were made by the provider, however not all notifiable incidents had been reported to CQC.

People were not fully supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests

The registered manager had requested from commissioners they apply for Court of Protection order. However, the legal framework was not in place to restrict one person's liberty and for continuous supervision which included 2:1 staff at all times. Staff were not clear on the principles of the Mental Capacity Act and how to apply these to their role. Standard phrases were used in best interest decisions for mental capacity assessment. For example, 'all restrictions are care planned and accepted.' This meant there was a lack of person-centred detail in the decisions considered as the least restrictive.

Medicine systems needed further improvements. For example, medicines were identified in the medicine administration record (MAR) as discontinued, but no formal documentation was in place for this. Medicine profiles were out of date which meant that staff didn't use current guidance on people's medicine regimes. The recording of "when required" (PRN) medicines were handwritten for one person which was not in line with good practice guidance. The recording of medicines administered were inconsistent and was not identified as part of the audit.

MAR's detailed the prescribed topical creams although body maps were not in place. Cream and eye drops were not always dated when opened.

Staffing levels were mostly maintained.

The registered manager had recently registered with CQC and since their appointment was being supported by senior managers on developing a plan to progress the service. However, there were improvements needed to gain a better oversight of all services. For example, the systems for monitoring including that for staff performance were not robust.

The quality of service delivery was assessed, but not all shortfalls were identified. Action plans were developed and monitored weekly. However, these did not include the concerns we found relating to medicines systems and reporting processes.

Systems were in place to manage risk. Care plans and risk assessments were combined. We noted where care records were updated the risk assessments were separate from the care plan. The care plans were reviewed, and were mostly person centred, including people's preferences and support needed from staff.

Recruitment procedures ensured the staff employed were suitable for the role they applied for.
The staff we spoke with were positive about the team and that they shared learning amongst themselves. There was some potential for staff developing their own ways of working instead of following good practice guidance.

Environmental risk assessments were in place. Personal emergency evacuation plans were developed and updated on the actions needed for a safe evacuation of the property. We noted in the communication book where staff often ran out of personal protection equipment. While the location was clean there were some improvements needed for the storage of frozen foods. We recommended the providers seek guidance on the reasonable actions that must be taken to secure improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 10 December 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
We received concerns in relation to the care people received. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those

Key Questions were used in calculating the overall rating at this inspection.
The overall rating for the service has not changed. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Voyage DCA Wiltshire on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to care and treatment and to good governance at this inspection.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.
Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Voyage (DCA) Wiltshire

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats and in specialist housing.
The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short notice period for the inspection, because some of the people using it could not consent to a home visit from an inspector. Voyage DCA Wiltshire is a small service and we also needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 22 January 2020 and ended on 27 January 2020 We visited the office location on 22,24 and 27 January 2020.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service and observed the interaction between staff and one person. We spoke with four members of staff as well as three field support supervisors, registered manager, operations manager and managing director.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at procedures for reporting behaviours that challenge, records of safeguarding notifications, team minutes meetings, emails and incident reporting records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

● There were people who at times expressed feelings of frustrations and anxiety using behaviours that placed them, staff and others at risk of harm. Emotional and behaviour care plans were in place around how staff were to manage situations. Where there were known triggers these were listed in the care plans along with any strategies staff should use to make a situation or a person safe.

● Despite documented strategies some staff were developing strategies which did not reflect the guidance on managing incidents. We found two incidents where staff did not follow the guidance in people's care plans. In one incident medicines were administered before the person's preferred time as recorded in their care plan. When the staff were then asked by the person to leave their bedroom, staff did not follow the guidance to allow time and showed a lack of disregard for the person's request. For another person, the staff made the decision to barricade the television if the person was to approach during periods of aggression.

●There was little evidence from the incident report we saw that they were monitored to see if there had been an increase or decrease in a person's behaviours, if the guidance was followed and if there had been any restrictive practices used by staff. Reviews of care plans relating to people's emotional and behavioural support needs, and any associated risk assessments had not taken place following incidents.

● The organisations procedures around documenting and reporting incidents were not being consistently followed. Not all incident reports were uploaded to the provider's electronic system for monitoring reports of people's incidents and behaviours. We also found that some incidents had been recorded in people's daily notes or communication book, rather than following the formal process.

● According to the provider's policies, staff should, 'identify parts of the intervention which worked well, areas where response was weak, delayed or poorly handled, and whether anything would have been done differently in retrospect.' We found the incidents reported in people's daily notes and communication books lacked detailed descriptions of the incidents and the actions staff took. In one person's notes, an incident was only described as 'shouting and banging doors.' There was a lack of consistent detail in incident reports about the triggers identified and how staff had responded to these prior to the incident.

While the provider had a clear policy on accident and incidents the cause of the injuries sustained by one person were not always known despite having continuous supervision from staff. The staff had documented in reports for this person where injuries were noted on her upper right leg but cause of the injuries were not reported. The registered manager had introduced body maps to record injuries to people using the service, however a clear cause of injury was not always recorded." For example, on 16 December staff documented where a blister was noted for this person. It was recorded "we believe this to be from [name] biting this area. No body map done as none available".

●Where body maps were completed the cause of the injuries were not always detailed. For example, on the 9 January 2020 redness on the right hand was noted but there was no explanation on the cause. On the 10

January 2020 redness on the buttock was noted and there was no explanation on the cause of the redness. On the 14 January a boil and bruising was noted on the left elbow and staff documented that "could be a result of banging doors."

● Risk assessments and agreements were not in place for one person to stay safe in their relationships.

● Staff had attended training in MAPA (Management of Actual or Potential Aggression or MAPA on management and intervention techniques on managing incidents from escalating). However, staff had not associated MAPA techniques with disengagement from situations that placed them at risk of harm. This meant the staff were developing their own methods of disengagement. For example, staff had documented where another member of staff had to "come and remove [one person] from my arm." While staff took action to prevent the person from injuries the staff had documented "[name] was unable to hit her head and was told to say sorry to me".

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Prior to the inspection we received concerns about the staffing arrangements and about the management of incidents and accidents. We raised a safeguarding referral in relation Court of Protection documentation. Court of Protection was not in place for people who lacked capacity and their liberty was restricted and were subject to continuous supervision. This meant there were restrictive practice for one person because they had limited control over their living space.

●There were mental capacity assessments and best interest decisions recorded for some people, however we saw that standard phrasing had been used and it was not clear which options had been considered before choosing the least restrictive action.

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Using medicines safely

At the previous inspection in October 2019 we recommended the provider refer to current guidance on medicine systems to the management of medicines. We found at this inspection, improvements had not been made.

●Medicines were not always stored safely. Topical creams and ointments had not been labelled with the date of opening, this meant that there was a risk that some topical medicines in use may have been expired.

●People had 'Medication profiles' in their care plans. These were not always updated, this meant that staff did not have access to up to date information about peoples prescribed medicines. We saw that one person was consistently having a line put through their MARs, when we asked the staff why they were omitting this medicine, they were not sure.

●Recording of medicine administration was not always in line with best practice guidance. We saw the there was no clear system for recording if 'as required' medication was offered or declined. This meant it was not clear if people had been offered their 'as required' medicines.

●There were some gaps in the MAR's for peoples regularly prescribed medicines. These had not always been identified, followed up or raised as a medicines error.

●Field supervisors completed monthly audits on medicine administration, storage and documentation. We saw that concerns regarding record-keeping had not always been identified. Where they had been identified, we saw the actions taken stated were, 'Gap missing written in comments to fill'. This suggested staff were asked to backdate signatures. This meant that medicine administration records may not be an accurate reflection of people's experience.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

●Court of Protection orders were not in place for all the people whose liberty was restricted and were subject to continuous supervision. This meant there were illegal restrictions of people liberty because the legal framework was not in place.
● Systems were in place to manage risk, including care plans and risk assessments. The registered manager had reviewed care planning and risk taking documentation. For example, care records were updated the risk assessments were separate from the care plan. The care plans that were reviewed were person centred overall and included people's preferences and support needed from staff.
● We experienced an incident where one person became distressed. We observed the action staff took which was consistent with guidance and the response from the person was to become calm.

Learning lessons when things go wrong
● Staff told us accidents and incidents were reported. The operations manager and registered manager said all reports were analysed. However, we noted accidents were not reported for one person that had sustained injuries and healthcare professionals were involved. These injuries were not reported to CQC as required by legislation. We were not notified of any injury or other event that caused a person pain lasting, or likely to last, for more than 28 days.
● Once senior managers were made aware of concerns they acted promptly and appropriately. During the feedback to the registered manager and senior manager we were told, "we do a lot, we have a whistleblowing policy which is regularly updated. The chief executive officer (CEO) wrote to all staff about speaking up. We are an organisation that learns lessons."

Staffing and recruitment
●Recruitment processes were safe, the service completed appropriate pre-employment checks such as references and a check with the Disclosure and Barring service (DBS). A DBS check helps employers make safer recruiting decisions.
●Staffing levels were mostly consistent. Agency staff were used to maintain staffing levels where needed. In one service an agency staff was used but the handover was only for 15 mins. The staff may not be aware that the agency staff coming into the locations was known to the person. The registered manager told us exiting staff were always on duty with agency staff.

Preventing and controlling infection
● The provider had worked with other agencies, the person and their relatives to deliver safe care where concerns arose about the premises and equipment.
● The package of care for some people included the catering of meals. We found there were adequate supplies of fresh, dried and frozen foods. However, we found items of frozen foods not labelled and without cooking instructions.

●Freezer temperatures were recorded daily. We saw that these had often been out the safe range recommended by the food standards agency. When we discussed this with the registered manager, they stated that this had been raised with the person's family, who did not wish to purchase a new freezer. There was no risk assessment in place regarding food safety.

We recommend the providers seek updated guidance on food safety in relation to frozen foods

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Although there were systems for monitoring service delivery, improvements to gain a better oversight of all locations were needed. For example, monitoring staff performance and ways of working.
- There were a range of audits in place to support a managerial oversight of the service. These included audits covering medication, staff skills, mealtimes and staff interactions with people. However, the audits had not identified some of the concerns found at this inspection. For example, shortfalls in medicines management, recording of incidents and injuries, and deprivation of liberty.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager was supported by an operations manager. The leadership oversight around service delivery was maintained by monthly meetings between the registered manager, with field support supervisors and with service managers. The registered manager said at monthly meetings action plans were set and monitored to ensure improvements were continuous. There was guidance from the quality team on their analysis of audits within the organisations domiciliary care agencies and how they link together.
- The registered manager told us they were aware that care plans and medicines needed review, we saw that this had been included in the action plan. Concerns identified as part of the audit process were used to form an action plan. This was updated regularly and reviewed weekly by the registered manager and senior management team.

- The registered manager was recently appointed and was recently registered with CQC as manager .
- The registered manager told us visits to locations with field support supervisors were taking place. There were regular field support supervisor workshops for developing the role of line managing locations. There was human resources support for performance management of staff.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff said the organisation promoted a caring culture although they were not always clear on the values of

the organisation.
●The staff said the teams worked well together and their main contact was with their line manager (field support supervisors). Some staff told us they learnt from each other. One member of staff said they had "learnt from other staff" about their role. This practice had the potential of staff developing their own ways of working instead of working within the organisation's values framework.
●We found that language used by staff was not always appropriate and did not promote people's dignity. This had not been identified as part of quality assurance processes. When we raised this with the registered manager, they assured us that it would be addressed with staff promptly.

Continuous learning and improving care
●The registered manager told us there were domiciliary care agencies workshops and stated the workshops were "very interactive and about learning and development."
●The registered manager said incidents and accidents were analysed by the quality team. This registered manager said they "check all information [and reports] and give [staff] advice on reporting."
●Field support supervisors discussed incidents with staff involved. While the discussions about the incidents took place between the staff involved and field support supervisions there was little evidence that an analysis of repeated behaviours took place. For example, staff documented in reports for one person that consistently injured themselves, the staff and the property "not sure what she got out of it. Staff was calm." This meant there was little learning from events.
●A managing director told us part of the admission process included an assessment from SBSS (specialist behavioural support services). The managing director told us, "we would identify additional training needed for people such as resilience training. We also have behavioural specialists who look at risk and compatibility of multi occupancy premises. We review this at senior management meetings (SMT). We discuss the behavioural therapist report, what we need to do, and lessons learnt."
●The registered manager told us complaints were investigated.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
●The service held regular 'inclusion days'. These were events that aimed support at care staff as well as developing skill and knowledge.
●The service sought annual feedback from people they support.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
●The registered manager had good knowledge of their responsibilities regarding the duty of candour. They were able to provide us with an example where they had met this in the past.

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 Support guidance was not always followed for people that placed themselves, staff and others at risk of harm. There was little evidence to support an analysis of the actions taken by staff in relation to known and emerging triggers about the person. Medicine system were not managed safely. Where people lacked capacity to make decisions the appropriate legal framework was not in place for restriction and continuous supervision.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of connection between locations and the service. Monitoring systems were not robust. There were areas not identified for improvements. These included staff performance, medicine management and deprivation of liberty safeguards.