Care Quality Commission

Voyage 1 Limited

Grange House

Inspection report

9 Grange Road
Hayes
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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 28 September 2015. We gave the provider three days' notice of the inspection to make sure people using the service, the provider and registered manager would be available.

The last inspection of the service took place in November 2014 when we found the provider was in breach of regulations relating to care planning, safeguarding people using the service, treating people with respect and dignity and informing the Care Quality Commission (CQC) of significant incidents that affected people using the service. At this inspection, we found the provider had made some progress to improve standards of care, but more needed to be done.

Grange House is a care home for up to five people with a learning disability. When we inspected, two people were using the service. The home had a registered manager who had been in post since July 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found three breaches of the regulations. We also found three breaches where the provider had failed to take action following our last inspection and we are taking action against the provider. We will report on this when our work in relation to these specific breaches is completed.

The provider had not reported possible safeguarding incidents to the local authority or CQC.

There were not always enough staff to support people to take part in activities.

The provider did not take action to address risks to the health and safety of people using the service.

The provider was depriving people of their liberty illegally, as they had not obtained the agreement of the local authority.

The provider did not always assess people's care and support needs and staff did not always respond to people's needs in line with their individual care plans.

The registered person did not always carry out or act on the findings of audits of the quality of the service.

People received the medicines they needed safely.

The provider ensured staff completed the training they needed to work with people using the service.

The provider arranged for and supported people to access the healthcare services they needed.

Staff treated people with kindness and patience, respected people's dignity and privacy and offered people choices about aspects of their daily lives.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 was not safe.

The provider had not reported possible safeguarding incidents to the local authority or CQC.

There were not always enough staff to support people to take part in activities.

The provider did not take action to address risks to the health and safety of people using the service.

People received the medicines they needed safely.

Inadequate

Is the service effective?
The service was not effective.

The provider was depriving people of their liberty illegally, as they had not obtained the agreement of the local authority.

The provider ensured staff completed the training they needed to work with people using the service.

The provider arranged for and supported people to access the healthcare services they needed.

Requires improvement

Is the service caring?
The service was caring.

Staff treated people with kindness and patience.

Staff respected people's dignity and privacy.

Staff offered people choices about aspects of their daily lives.

Good

Is the service responsive?
The service was not always responsive.

The provider did not always assess people's care and support needs and staff did not always respond to people's needs in line with their individual care plans.

Staff respected people's diverse needs.

Staff supported people to take part in activities in the service and the local community.

Requires improvement

Is the service well-led?
The service was not always well led.

Requires improvement

Summary of findings

The registered person did not send statutory notifications to the Care Quality Commission.

The registered person did not always carry out or act on the findings of audits of the quality of the service.

Some audits the provider carried out were accurate and up to date.

Grange House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 28 September 2015. We gave the provider three days' notice of the inspection to make sure people using the service, the provider and registered manager would be available.

The inspection team consisted of one inspector.

Before the inspection, we reviewed the information we held about the service. This included the last inspection report, the provider's action plan they sent us in response to the last inspection and notifications of significant incidents.

During the inspection, we spent time with both people using the service. We were unable to communicate with either person verbally but we observed how staff offered care and support during the day. We also spoke with two members of staff, the registered manager and the provider's Operations Manager. We looked at the care records for both people using the service and other records, including medicines records, personnel records for three members of staff, accident and incident reports and audits carried out by the provider and the registered manager.

Following the inspection, we contacted the local authority's safeguarding adults and contract monitoring teams.

Inadequate

Is the service safe?

Our findings

At our last inspection in November 2014, we found managers and staff in the home were not responding to incidents affecting people's safety and welfare in line with the provider's policies and procedures. We found the provider was not telling the local authority or the Care Quality Commission (CQC) about possible safeguarding incidents so that an investigation could be carried out and lessons learned. The provider sent us an action plan dated 30 April 2015 and told us they would be compliant with the regulations by 31 October 2015.

During this inspection, we found four further examples of possible safeguarding incidents that the provider had not reported to the local authority or CQC. These included an incident where a person using the service ran away from staff supporting them on a walk to a local park. Although staff had completed incident reports on each occasion, the registered manager did not carry out and record an investigation to establish what actions they needed to take to prevent similar incidents happening in the future.

This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in November 2014, we found that the level of staff support provided in the service did not always allow people to take part in activities outside the home. This was because the provider had judged both people using the service each needed support from two staff outside the service. Following the inspection, the provider's Behaviour Therapist carried out a full assessment of one person's support needs and concluded they needed support from two staff whenever they were outside the service and could see "food or drink outlets." The Behaviour Therapist did not carry out a full review of the second person's support needs but after talking with staff, observing the person and reviewing care records, concluded they needed support from one member of staff for most activities, inside and away from the service.

The staff rota showed there was a minimum of two members of staff on duty at all times. The provider had not changed this level of staff support since our last inspection. While this level of staffing was sufficient to support people while they were at in the service, it was not sufficient to enable people to access community activities. This meant a frequent activity involved staff supporting both people to walk to a local park when the weather allowed and we saw this happened during the inspection.

Staff told us they did this as one person needed support from two staff outside the service and staff could not take them to places where there were shops and cafes, as one member of staff could not support them if they wanted to have a drink or something to eat. People's care records showed that their access to activities was decided by the number of staff available to support them. This meant people had to take part in activities together or staff planned one person's activities around the second person's attendance at a day service.

A report from the local authority's monitoring officer in September 2015 also noted, "The staff ratio indicates there is an insufficient number of staff to provide 2:1 support for individual residents in the community. This would enable residents to choose to participate in individual activities rather than participating in joint activities."

This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and deputy manager carried out regular audits in the home, including a health and safety audit. Where they identified concerns, they did not always take action to make sure people were safe. For example, the record of hot water temperatures showed the temperature at some taps was dangerously hot and exceeded 60 degrees centigrade. Staff had recorded these temperatures for three consecutive weeks and although the provider told us they had reported the issue to their maintenance team, they had not carried out any remedial actions to ensure people's safety. We discussed this with the provider's Operations Manager during the inspection and they told us the engineer was due to visit the service that evening to carry out maintenance work.

The staff meeting minutes for June 2015 included instructions for staff that may have placed them and people using the service at risk in the event of a fire. The instructions contradicted the provider's fire safety procedures and the Personal Emergency Evacuation Plans for both people using the service. We brought this to the

Inadequate

Is the service safe?

attention of the provider's Operations Manager who said they would ensure staff were aware of the correct procedures they should follow in the event of a fire in the service.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a safeguarding adults policy and procedures and they had reviewed and updated these in October 2014. The provider also had a confidential whistle blowing procedure to enable staff and visitors to raise concerns and we saw they displayed this in the front hallway and around the service. Staff told us they had completed safeguarding adults training and records we checked confirmed this. Staff were able to describe types of abuse and were able to tell us what action they would take if they had concerns about a person using the service. They told us they would alert the home's manager or a senior manager within the organisation and they would make sure they investigated their concerns. Staff comments included, "I would tell my manager straight away if I was worried about someone living here" and "I must tell someone if I suspect abuse, someone in [the provider organisation] or the local authority or CQC."

The provider carried out appropriate checks to make sure staff were suitable to work with people using the service. Staff records included application forms, references, identity and criminal records checks.

The provider managed people's medicines so they received them safely. The medication administration record (MAR) sheets for both people using the service showed all required medicines were in stock and people had received their medicines as prescribed. Staff stored medicines securely in a lockable cabinet and fridge.

Requires improvement

Is the service effective?

Our findings

At our last inspection in November 2014, we found staff were not recording accurately when they needed to restrain people using the service. Although staff had completed appropriate training to enable them to support people when they challenged the service and reduce risks to the person concerned and others, the records they completed lacked detail and we could not be sure staff used restraint appropriately or safely. During this inspection, the registered manager told us staff no longer needed to use restraint to support people when their behaviour challenged the service and the records we saw confirmed this.

The law required the Care Quality Commission (CQC) to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. Staff told us and we observed that some restrictions were in place in the service. For example, staff locked the front door and kitchen door and both people using the service were not able to leave without staff support and supervision.

Records showed the registered manager had liaised with the local authority and had made applications where they applied restrictions on people using the service. However, there was no evidence that the registered manager or provider had followed up the applications they had made to the local authorities responsible for placing people in the service. This meant the provider was depriving people of their liberty illegally, as they had not obtained the agreement of the local authority.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records included an assessment completed by staff of people's capacity to make specific decisions for themselves. Where the assessment showed a person was unable to make a decision about their care and support, the registered manager had arranged meetings with relatives and other people involved in their care to agree decisions in the person's best interests, a requirement of the Mental Capacity Act 2005.

The provider ensured staff completed the training they needed to work with people using the service. Training records showed all staff were up to date with training the provider considered mandatory. This included safeguarding adults, fire safety, medicines management and food safety. In addition, staff had completed the provider's induction programme when they started work in the home. Staff told us they felt well trained to do their jobs. Their comments included, "I've done all the training I need to do to work here" and "The training is generally good and I'm sure I'm up to date."

The provider arranged for and supported people to access the healthcare services they needed. People's care plans included details of their health care needs and details of how staff met these in the service. Records showed staff supported people to attend appointments with their GP, dentist and hospital appointments.

Staff understood people's nutritional care needs. One member of staff told us, "We try and offer healthy choices for people." A second member of staff said, "I know what [person's name] and [person's name] like to eat and I know they enjoy the food we give them."

Good

Is the service caring?

Our findings

During the inspection, we saw staff treated people with kindness and patience. The staff on duty during the inspection knew people's care needs well and worked well together as a team to make sure they met these needs. They supported people to go out in the service's vehicle in the morning and later in the day took people out for a walk to a local park.

Staff also respected people's dignity and privacy. For example, we saw people were able to use their bedrooms at any time and staff always knocked on the bedroom door before entering. People were able to choose where they spent their time. We saw both people spent time in their rooms when they wanted privacy and spent time in the lounge or kitchen when they wanted to be with other people.

Staff offered people choices about aspects of their daily lives throughout the inspection. We saw people staff offered people choices about what to eat and drink, the clothes they wore and activities in the service.

Staff were able to tell us about significant events and people in each person's life and their individual daily routines and preferences. They also told us how they had worked with one person and their family to ensure they kept in touch and how they supported the other person to visit a relative regularly.

The provider kept information about people using the service secure. Care records and other documents were kept in lockable cabinets in the office. Medicines management records were securely stored.

Requires improvement

Is the service responsive?

Our findings

The provider did not always assess people's care and support needs and staff did not always respond to people's needs in line with their individual care plans. People's care records included information about the person, such as their life history, significant events and people, health, social, emotional, cultural and spiritual needs. Staff recorded people's likes, dislikes, preferences and associated risks so they could provide individualised care. Care records provided a good picture of each person, their needs and how staff should meet these in the service.

However, people may have been at risk of receiving inappropriate care or support, as the provider did not always review people's individual care needs. For example, staff had not updated one person's support guidance for personal care and mobility since October 2013. Staff had updated support guidance for emotional and behaviour support and they had contributed to a local authority review in December 2014, but there was no evidence of a person centred review since August 2012 and they had not updated important support guidance following these reviews.

This was a continuing breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's Behaviour Therapist had completed an interim review of the second person's care and support needs in November 2014. The review recommended that staff should update all risk assessments and concluded the person needed support from two staff outside the service "where food and drink outlets are present." Following the review, staff updated the person's risk assessments between March and July 2014. However, risk assessments did not always consider the level of staff support the person needed. There was no evidence the provider's Behaviour Therapist had followed up their interim report or provided further guidance and advice for staff working with this person.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records included details about people's ethnicity, preferred faith and culture and daily records showed staff supported one person to attend a church club each week. Staff were able to tell us the importance of respecting people's diverse needs and choices.

People's care records included a weekly programme of activities, in the home and the local community. Daily records showed staff supported people to take part in activities, such as going bowling, attending a local day service, visiting the park, eating at local restaurants and visiting family and friends. However, people's access to activities was often restricted due to staff levels in the service. For example, this meant that every Friday one person had their breakfast, staff took them for brunch at a local restaurant, while the second person was at the day service and then both people returned to the home for lunch. Daily care notes showed that this person had eaten three meals before 1:00 pm each Friday. Staff told us this was the only way they could provide the person with support from two staff to take part in community activities. We discussed this with the provider's Operations Manager during the inspection and they told us they would arrange changes to the way staff supported people to access community activities.

The provider kept a record of complaints and compliments in the hallway for visitors to complete. There were two recorded complaints and we saw the provider had taken action to resolve both.

Requires improvement

Is the service well-led?

Our findings

As part of our planning for this inspection, we looked at the notifications sent to us by the manager and provider. It is a legal requirement that the provider notifies the CQC of certain significant events and incidents affecting people using the service. These notifications include any abuse or alleged abuse. We found the provider had not sent any notifications to CQC since our last inspection in November 2014. During this inspection, we identified a number of incidents that should have been referred to the local authority safeguarding adults team and notified to the CQC, but the provider had failed to do this.

This was a continuing breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The home had a registered manager who had been in post since July 2014. However, the registered manager also managed another service for the provider and there was little evidence of the time they were able to spend at Grange House. The registered manager was not on the rota and staff told us they did not always know when to expect them in the service. Staff meeting records showed the registered manager was not usually present. There was little evidence that the registered manager had followed up concerns we identified at our last inspection and audits carried out by the provider and manager had not identified concerns we found during this inspection. A report from the local authority's monitoring officer in September 2015 noted, "The Manager is based at another service and visits the home when required."

People using the service were at risk of inappropriate care and support as the provider had arrangements in place to monitor the quality of the service but these were not always effective. Care plan audits had not identified delays to care reviews and failures to review risk management plans and although health and safety checks had identified dangerously hot water temperatures, the provider took no remedial action for more than three weeks. The provider had also failed to act on their own assessment of one person's care and support needs to review staffing levels and improve access to activities in the local community.

These were breaches of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other audits carried out by the provider and staff in the service were accurate and up to date. For example, fire safety checks, cleaning records, records of people's personal finances, daily checks of the fire system, escape routes and vehicle safety and monthly health and safety checks of the environment were up to date, although the provider did not always take action to address risks staff identified.

Each person had a Personal Emergency Evacuation Plan (PEEP) in their care records that detailed the support they needed in an emergency. The provider updated their fire safety risk assessment in May 2015 and we saw the Fire Service had recently visited the service and were satisfied with fire safety standards. Staff kept a record of food temperature checks and storage temperatures in the fridge and freezer. The service had a five star rating for food hygiene from the local authority's Environmental Services department.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1. The registered person did not assess risks to the health and safety of service users. Regulation 12 (2) (a) 2. The registered person did not do all that is reasonably practicable to mitigate risks to service users. Regulation 12 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not assess, monitor and improve the quality and safety of the services provided. Regulation 17 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not deploy sufficient numbers of staff to meet service users' care needs. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not always review people's care needs.**

The enforcement action we took:
We issued a Warning Notice and required the provider to become complaint with the regulation by 31 December 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider did not inform the local authority or the Care Quality Commission (CQC) about possible safeguarding incidents**

The enforcement action we took:
We issued a Warning Notice and required the provider to become complaint with the regulation by 31 December 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider had not notified the Care Quality Commission of significant incidents affecting people using the service, including possible safeguarding incidents.**

The enforcement action we took:
We issued a Warning Notice and required the provider to become complaint with the regulation by 31 December 2015.