Voyage 1 Limited

Harefield Lodge

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 08 February 2016 and was unannounced. This was the first inspection of this service since the change of ownership under a new provider organisation.

Harefield Lodge provides care and support for seven people, who have a learning disability or an autistic spectrum disorder. The home consisted of the main building where three people lived and contained offices and a communal kitchen and living area. To the rear of the property four people lived in self-contained flats and they were supported by staff to live as independently as they could.

The home did not have a registered manager; however, a manager had been appointed who had applied to become the registered manager. A registered manager is a person who has registered with the Care Quality commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care act 2008 and associated regulations about how the service is run.

People were kept safe as the provider had policies and procedures in place to protect them from abuse. Staff were aware of their responsibilities in respect of safeguarding. They had received training which enabled them to know how to report concerns and who they had to report this to.

Risks were assessed as part of the care planning process. Action was taken to mitigate the risks and enable people to receive care safely. There were plans in place to respond to all emergencies.

There were sufficient staff to deliver care safely to people. People's support needs were assessed and the provider identified when people required more support.

Medicines were managed efficiently and safely. Areas for storage of medicine were secure. Staff were trained and assessed as competent to administer medicines.

Care staff knew people's needs and how they communicated. They knew how people liked to be supported. Staff received adequate training and supervision to enable them to deliver care effectively.

Staff were aware of the Mental Capacity Act and their role in supporting people who could not make decisions for their own care. Staff ensured peoples' consent was given before delivering any care.

People were supported to eat and drink healthy and well balanced options. Staff were aware of how people demonstrated they liked particular foods and knew what their favourite meals were.
People accessed local health care and were registered with GP services near to the home. Specialist health care support was sought when required.

Staff demonstrated kindness and compassion when assisting people. People showed they were

comfortable with staff supporting them and chose when they wanted to spend time with staff. Where possible people were involved in their care planning and attended reviews where appropriate.

People's privacy and dignity was respected by staff when they delivered care, This was done by knocking on people's doors and delivering personal care to people in their bedrooms or bathrooms.

Care plans were personalised and contained information on what was important to the person. People were supported to be involved in a range of activities both within the home and in the community. Concerns and complaints were listened to and views of people, relatives and staff were encouraged and listened to.

There was a positive culture within the home and clear values that staff were aware of. People and staff were involved in developing the service. Management within the home were approachable and staff felt they could talk to the manager about any concerns they had.

The provider had a comprehensive quality monitoring process which identified where the service needed to improve. The manager prepared an action plan to show how they responded to issues raised within the quality audit.

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.

There were sufficient numbers of suitable staff to keep people safe and meet their needs.

People were protected from abuse and avoidable harm.

Risks were identified and managed in ways that enabled people to lead more fulfilling lives and to remain safe.

Is the service effective?

Good

The service was effective.

People received effective care and support from staff who were trained to meet their individual needs.

People were supported to maintain good health and to access external health care services when needed.

The service acted in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care.

Is the service caring?

Good

The service was caring.

People were supported in a homely environment by caring and considerate staff.

People were treated with dignity and respect and were supported to be as independent as they wished to be.

People were supported to maintain relationships with their family and friends.

Is the service responsive?

Good

The service was responsive.

People's individual needs and preferences were known and acted on.

People and relatives were consulted and involved in decisions about their care.

People, relatives, staff and other professionals were encouraged to express their views and the service responded constructively to feedback.

Is the service well-led?

Good

The service was well led.

People were supported by an inclusive and open management team and by motivated staff.

The service had a caring and supportive culture focused on promoting the best quality of life for the people who lived in the home.

The provider's quality assurance systems ensured the standard of service provision was maintained and improved.

Harefield Lodge

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 08 February 2016 and was unannounced. A single inspector undertook this inspection.

We looked at previous inspection reports prior to our inspection and looked at notifications that we had received. A notification is information about important events which the provider is required to tell us about by law.

We spoke with one person and observed care being given to other people in the home throughout the course of our inspection. Some people could not speak with us due to their limited vocabulary. We spoke with five members of staff, the manager and a senior manager from the provider organisation.

We looked at four peoples care plans and associated records of care. We also looked at six members of staff's recruitment and supervision files. Other records held by the service were looked at including their health and safety, training and quality monitoring records. We looked at the feedback the provider had received and how they responded to concerns, complaints and incidents.

Good

Is the service safe?

Our findings

One person told us they felt safe. They said, "Staff keep me safe." We observed how comfortable people were with the staff that were supporting them. For example, we saw where one person made a loud noise which startled another person in the room. This person approached a member of staff who gave the person reassurance and engaged them in another activity away from the room.

People were potentially more vulnerable to abuse due to their learning disabilities. Staff protected people from the risk of abuse through the provider having appropriate policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. Staff told us they had no concerns about any of their colleagues' practices but they would not hesitate to report something if they had any worries. Staff were confident the manager or the deputy manager would deal with any concerns immediately to ensure people were protected.

The risks of abuse to people were reduced because there were effective recruitment processes for new staff. This included carrying out checks to make sure new staff were safe to work with vulnerable adults. Staff were not allowed to start work until satisfactory checks and employment references had been obtained.

Care plans contained risk assessments with measures to ensure people received safe care and support. For example, there were risk assessments and plans for supporting people when they became anxious or distressed. Circumstances that may trigger anxiety were identified with ways of avoiding or reducing the likelihood of these incidents. Staff received training in positive intervention to de-escalate situations and keep people and themselves safe. Similarly, there were risk assessments for people to access the community, to participate in social and leisure activities, and to carry out daily living activities within the home.

Staff knew what to do in emergency situations. For example, there were protocols within people's care plans for responding when people experienced epileptic seizures. Staff received training in providing the required medicines and knew when and who to notify if the seizures were prolonged. Staff said they would call the relevant emergency services, speak with the person's GP, or other medical professionals, if they had concerns about a person's health and welfare.

There were sufficient numbers of staff to meet people's needs and to keep them safe. The service had experienced a difficult time in supporting an individual which had caused a number of staff to leave. New staff had been recruited who were experienced and committed to working with the people who had difficult to manage behaviours. Staffing levels were based on the assessed need for support of each person. There were usually nine support staff plus the manager, or deputy manager, on duty during the day shifts. Staff were shared across the main house and the studio flats to the rear of the property. People needed at least one to one staff support to access the community. One person regularly received two to one staff support according to their planned activities and their anxiety level. At night, there were two waking night staff and one sleep-in member of staff with a senior person on-call for advice or support. Staff told us there were sufficient staff numbers to meet people's personal care needs and their planned activities.

For short notice or unplanned staff absences, the service used the provider's relief team for assistance. The relief team comprised of bank of staff employed by the provider available to cover shifts at short notice. Relief team staff received exactly the same training as other support staff. They worked across a number of the provider's homes and became familiar to the people living in the homes. As a result, the service rarely needed to use external agency staff.

Systems were in place to ensure people received their medicines safely. All medicines were prescribed by the person's GP and were kept in secure and suitable storage facilities. Staff received medicine administration training and medicine rounds were periodically observed by the managers to ensure staff practices were safe. Each shift leader was responsible for checking staff completed people's medicine administration records correctly. We observed one person receiving assistance with their medicines. Staff engaged the person in a way they understood and the person was able to take their medicines safely in their own flat. Medicines storage was appropriate and staff demonstrated how they ensured medicines were kept secure. We saw the Medication Administration Records (MARs) were accurate and up to date.

Good

Is the service effective?

Our findings

People were observed to receive care and support when they required or requested it. Staff were particularly knowledgeable about how people made choices of foods and how they communicated where they had limited verbal communication. One member of staff said, "It's good that we get to know people and can identify what people need based on our understanding of their gestures and noises they make." Staff said they had received good support from the new manager and the deputy manager.

Staff were knowledgeable about each person's needs and preferences and provided support in line with people's agreed plans of care. Staff received training to ensure they had the necessary knowledge and skills to provide effective care and support. This included safeguarding, first aid, infection control, administration of medicines, food hygiene, diversity and dignity, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Person specific training was also provided to meet people's individual needs, including: learning disability, autism, epilepsy, sign language, communication systems using pictures and symbols, positive behavioural support, breakaway and restraint training. The provider also encouraged and supported staff to undertake continuing training and development, including national vocational qualifications in health and social care. This comprehensive range of staff training helped ensure people received effective care based on current best practices.

Each member of staff had an individual training matrix which was reviewed during their one to one supervision sessions. A relatively new member of staff told us they received a comprehensive induction programme when they joined the service. After the initial induction training, they then shadowed experienced members of staff for two weeks until they got to know each person's individual support needs. They said, "This is my first job in care and it was very daunting at first, especially with one person who was unhappy. The training helped me and I got great support from my manager and the team." The competency, knowledge and skills of new staff were assessed over a three month probationary period. Supervisions had been six weekly but a new supervision rota showed these were booked in as four weekly. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support and identify training needs. Staff also received annual performance and development appraisals by the manager to review their performance and identify any further training needs.

People's individual care and support was discussed regularly at shift hand-overs, staff supervision sessions and monthly team meetings. This helped ensure people received appropriate and effective care. Staff said everyone worked well together as a friendly and supportive team. They said they could turn to either the manager or the deputy manager for advice or assistance at any time.

People who lived in the home were not always able to express their choices clearly through speech. Staff were trained to communicate effectively in ways people could understand. For example, communication systems using pictures and symbols were sometimes used to aid people's understanding. Staff said people generally understood what others were saying but they tried to keep sentences short and allow people sufficient time to process the information. Some people preferred to vocalise their wishes whereas other people relied more on body language and physical gestures to indicate their choices.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We observed when people lacked the mental capacity to make certain decisions the service followed a best interest decision making process. Staff had also received training and had an understanding of the requirements of the MCA and the DoLS.

DoLS authorisations had been approved for all of the people in the home as certain restrictive practices were necessary to keep them safe from harm. For example, one person had a history of leaving the building but was unable to cross the road safely. They had been assessed as requiring two staff to support them in the community. The DoLS authorisation was to ensure staff supported the person when they left the building to keep them safe from harm. This showed the service followed the requirements in the DoLS. We saw associated risk assessments and best interest decisions documented in people's care plans. We were told restrictive practices were regularly reviewed with a view to reducing the number and impact of any restrictions on people's freedom, rights and choices.

People received sufficient food and fluids to maintain a balanced diet. Staff were knowledgeable about people's individual dietary needs and preferences. People were actively involved in menu planning and staff used a pictorial menu to help people show their selection. People were able to choose an alternative to the planned evening meal if they wished. People were free to choose their own breakfast and lunch options from a variety of foods available in the kitchen. People had access to the kitchen and could make snacks or drinks when they wished, although staff were always available if they needed assistance.

People were supported to maintain good health and wellbeing and had access to a wide range of health and social care professionals. Each person had an annual GP health check and medicine review. People were supported by a range of local healthcare practitioners, including the local GP and dental practices. More specialist advice was sought when required from the local hospital and mental health NHS trusts and from the provider's central intensive support team. Care plans included records of hospital and other health care appointments. Health care action plans contained a hospital passport which contained personal information that health professionals would need to know to support the person if they were admitted to hospital.

Good

Is the service caring?

Our findings

People appeared settled, happy and comfortable in their home environment. We observed people regularly engaged with the staff regarding their activities, food and drinks. All of the interactions we observed between people and staff were friendly and supportive. One person said about the staff "They are all alright".

The manager and the staff told us they wanted the best for the people who lived in the home and wanted them to have as happy and independent a life as possible. One experienced member of staff said, "The guys [referring to the people who lived in the home] are really happy. I'm very fond of them. I've worked with them for so long now". Staff explained how people's daily living skills had improved and how some were now relatively independent with their personal care needs and only needed occasional prompting.

Staff spoke to people in a patient and considerate manner and respected their wishes. We heard staff consulting with people about their choices and activities and no one was made to do anything they did not want to. People were encouraged to make their own decisions, as far as they were able to. For example, people could choose to socialise with others in the communal parts of the home or could decide to return to their own rooms if they wanted some private time alone.

One person was being supported by a member of staff to prepare their breakfast. The staff member offered the person a choice of cereals. They sat down with the person and talked about what the person wanted to do after they finished the meal. The person chose to have a shower and then watch a dvd in their room. The member of staff identified a number of activities they knew the person liked and waited for them to nod or say yes or no before offering an alternative activity.

Staff respected people's privacy and dignity. Personal care took place in the privacy of people's own rooms or bathrooms. Staff ensured doors were closed and curtains or blinds drawn when personal care was in progress. If people asked staff to assist them this was done in a discrete and respectful manner.

Each person had an assigned key worker. This was a member of staff they had a good relationship with. The key worker had particular responsibility for ensuring the person's current needs and preferences were identified and acted on by all staff.

The manager told us people were also supported to access independent external advice for certain important decisions. Where people had Deprivation of Liberty Safeguards (DoLS) authorisations in place, advocates were appointed by the authorising authorities to help protect their rights. Independent advocacy services were made available for people with no appropriate family or other representation to support them with important decisions about their care.

Staff spoke warmly and respectfully about the people they supported. They were careful not to make any comments about people of a personal or confidential nature within ear shot of other people. Staff understood the need to respect people's confidentiality and to develop trusting relationships. For example,

staff made sure care plans were not left unattended for others to read. Care plans were kept in an office and the door to the office was locked when staff were not present.

People were supported to maintain continuing relationships with their families and friends. Relatives could visit or call the home as often as they wished without any unreasonable restrictions. Staff also supported people to visit their families, where this was agreeable to all concerned.

Care plans included information about people's spiritual or religious beliefs, if any. Staff were aware of people's beliefs and preferences and respected their views and choices. One member of staff said, "It's hard to tell what people's belief may be and we rely on what relatives tell us about this. If someone liked to go to church we would support the person to attend a church service."

Good

Is the service responsive?

Our findings

People's needs and preferences were understood by staff and they were able to respond to people's choices. One person said "They [staff] know what I like and they help me." One member of staff said, "We have enough information about people's likes and dislikes. That is so helpful as some people can't tell us what they like." A new member of staff said, "Where there are a few of us new staff we have learned so much about people from reading their care records. They were really clear and accurate and gave a good picture of how to support the person."

People participated in a range of activities to suit their interests and needs. Activities included going into town, shopping, visits to cafes, visiting a local farm, going to the pub, swimming, and afternoon and evening day centres and activity centres for people with a learning disability.

Within the home people assisted with daily living tasks to promote their independence; including housekeeping, tidying their room and assisting with meals and drinks. People watched TV, listened to music and socialised with staff.

Some people needed to have structured daily routines and activity plans for each day of the week. This included going out into the community most days. However, people could refuse, or choose a different activity, if they decided they didn't want to do something.

The home provided good size, modern and well-appointed accommodation throughout. People's rooms were furnished and decorated to suit each person's tastes and choices. For example, one person who invited us into their flat had pictures on their walls which reflected their interests. They were very keen to show us their kitchen and encouraged us to help them make a cup of tea. They had an iPad and enjoyed playing games on this. Staff told us they had asked for this instead of a computer and they used it as an aid to their communication as they accessed pictures and photographs to show what they wanted to do.

In the main house, people were free to use the communal areas, such as the kitchen/dining room and the living room, or to return to their bedrooms if they wanted time on their own. People's rooms contained personal belongings; such as family photographs, model cars, DVD and CD collections; to make the rooms more personalised and homely.

Each person had a comprehensive care plan (individual support plan) based on their assessed needs. The care plans provided clear guidance for staff on how to support people's individual needs. People contributed to the assessment and planning of their care, as far as they were able to. For example, one member of staff told us they had regular informal chats with the person they supported and then wrote their wishes and views into their care plan. Each person had a 'circle of support', including relatives, staff and other professionals involved with their care. The 'circle of support' were involved in the person's care planning and reviews.

One person's care plan contained an assessment that identified when the person was distressed and how

they showed this. This identified how the person showed they were happy such as smiling face. When they were distressed their face looked tense and was reddened. This contained information about activities staff could use to assist the person to become calmer.

Each person had a designated key worker who was primarily responsible for ensuring the person's needs and preferences were identified and acted upon by all staff. Care plans were reviewed on a monthly basis by the keyworker and were updated to reflect any changes in people's needs or preferences. The manager also carried out monthly checks to ensure care plans were tailored to each individual's current needs and preferences.

The provider had an appropriate policy and procedure for managing complaints about the service. This included agreed timescales for responding to people's concerns. One complaint we saw was from a neighbour concerning noises they had heard from one of the flats. The manager met with the neighbour and listened to their concerns and shared information about the home and how people communicated by sounds and gestures. This had all been recorded in the complaints file and the complaint had been addressed to the general satisfaction of the complainant.

Good

Is the service well-led?

Our findings

The home was managed by a person who had applied to be registered with the Care Quality Commission as the registered manager for the service. They were supported by a deputy manager who knew the home and people well. Another manager from one of the provider's local services had been supporting the home after the registered manager had left and was offering support to the new manager until they were registered.

The manager had a vision they had shared with staff for the service ethos. This encouraged staff to think of the service as people's home and not a workplace. It outlined the high standards of care people should expect and involved staff in planning for the future of the service. Values were identified as care, compassion, competence, communication, courage and commitment. A member of staff told us they liked this statement as it encouraged them to make a difference to people's lives.

The service philosophy was further reinforced at monthly staff meetings, shift handovers and one to one staff supervision sessions. The provider's approach was supported by associated policies, procedures and operational practices. A member of staff said "They are a really good employer. The best thing is the quality and quantity of training, its brilliant".

Staff told us the management team were very accessible, approachable and supportive. A member of staff said "Our management are very committed to the service users and we concentrate on what's best for the guys. Our manager and deputy are really good, I'm equally happy to go to either of them. The director is supportive too and so approachable".

Decisions about people's care and support were made by the appropriate staff at the appropriate level. There was a clear staffing structure in place with clear lines of reporting and accountability; from support workers to the team leaders, managers, director, trustees and Board. Staff said everyone in the service worked really well together as a close, friendly and supportive team.

The provider had a quality assurance system to check the service continued to meet people's needs effectively. The management team carried out a programme of weekly, monthly and quarterly quality audits and safety checks. These checks covered all key aspects of the service to ensure high standards were maintained and any identified areas for improvement were actioned. For example, the provider carried out a quality assurance visit every four to six weeks. This included meeting with staff and the people who lived in the home and checking documentation, such as care plans, to ensure people's individual needs were being met. We saw the most recent service review showed a predominantly satisfactory assessment with particular references to the impact one person's behaviours had been having on the service.

People, relatives and staff were encouraged to give their views on the service through routine conversations and more structured care plan reviews. The annual satisfaction survey was due to be circulated in the summer to relatives, staff and external professionals involved with people's care. The last one had reflected concerns about how some people's behaviours had been unsettling and the action plan showed how the provider had engaged with commissioners to provide extra support for the person.

The provider regularly reviewed and updated its policies and procedures in line with current legislation and best practice. Monthly management team and staff meetings were held to discuss and disseminate information and new ideas throughout the organisation. The service worked in partnership with other agencies. They had good links with local health and social care professionals. More specialist support and advice was sought from the provider's own support team and from other external healthcare specialists when needed. This helped to ensure people's complex mental and physical health needs continued to be met.

The service had good links with the local community and people were supported to engage in the community as far as they were able to. Staff supported people to go out most days of the week. This included a range of social and leisure clubs, as well as swimming, shopping and visits to the local pub.