Voyage 1 Limited

Nottingham Supported Living (DCA)

Inspection report

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Date of inspection visit:
28 June 2021
29 June 2021
05 July 2021

Date of publication:
13 August 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Nottingham Supported Living (DCA) supports people to live in the community. At the time of the inspection 38 people were receiving support from a few hours to 24 hours a day. People either lived alone in their tenancy or lived in supported living accommodation in and around Nottinghamshire. 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
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were fully meeting some of the underpinning principles of the Right support, right care, right culture. Improvements were required to ensure people were consistently supported to be involved in their care and support that maximised their choice, control and independence.

Some people using the service raised concerns about safety and experiencing bullying, intimidation and abuse by others they lived with. Some relatives and external professionals also raised concerns about safeguarding incidents, and staff's competency in managing people's needs and management oversight.

Staff deployment did not meet people's individual care and support needs and safety. 'Whilst during the inspection evidence of commissioned hours were not provided for two supported living settings, this information was forwarded post inspection. Information received confirmed hours had been provided and, in some instances, hours provided exceeded what was commissioned by the local authority. However, we remained concerned that evidence provided was not sufficiently detailed to show people had received their individual care and support hours.

Incident and risk management, including analysis and learning were not fully effective. People had not been sufficiently protected from the risk of abuse.

Staff training, skills and competency needed reviewing, to ensure people's care and support needs were effectively met.

People's support plans and risk assessments had not consistently been reviewed and updated at the frequency the provider expected. People received their prescribed medicines when required but related support plans required further guidance to be made available for staff.

Infection, prevention and control best practice guidance was followed. People were supported to maintain

their tenancy. Housing repairs were reported when required and health and safety checks on the environment were completed.

The staff team did not feel fully supported, valued or listened to and raised concerns about a staff bulling culture.

The provider had systems and processes to monitor quality and safety and an improvement plan was in place. However, this did not reflect the shortfalls identified in the expected fundamental care standards found during this inspection.

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 Outstanding (published 28 February 2018). The service has deteriorated to Inadequate.

Why we inspected
We received concerns about the safe care and treatment of people. Including concerns about staff deployment, skills and competency, people not being protected from abuse and staff bullying. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

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.

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 Nottingham Supported Living on our website at www.cqc.org.uk

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified three breaches in relation to staff deployment, staff training, skill and competency, protecting people from abuse and harm and governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This

means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Nottingham Supported Living (DCA)

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors carried out the inspection and an Expert by Experience made telephone calls to relatives to seek their feedback. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
People's care and housing are provided under separate contractual agreements. The Care Quality Commission (CQC) does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service had a manager registered with the CQC. 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. Following the inspection, the registered manager took the decision to remove their registration for this service. They continue to be a registered manager for another service within the organisation.

Notice of inspection

We gave a short period notice of the inspection because some of the people using it could not consent to a home visit from an inspector. This meant that we had to arrange for a 'best interests' decision about this.

The inspection activity started on 28 June 2021 and ended on 5 July 2021. We visited the office location on 5 July 2021.

What we did
Before our inspection, we reviewed our information we held about the service. This included information received from the local authority, information of concern shared with us, and statutory notifications. A statutory notification is information about important events, which the provider is required to send us by law, such as allegations of abuse and serious injuries. We reviewed the last inspection report. The provider had not been required to complete a Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We gave the provider the opportunity to share information with us.

During the inspection, we spoke with seven people who used the service. We spoke with the registered manager, the operations manager, a regional manager, and post inspection, with the managing director. We received feedback from 26 staff, these were a combination of support workers, field support supervisors, field support workers and office staff. We also received feedback from six external health and social care professionals, this included, social workers, specialist intellectual disability community nurses and an occupational therapist.

We reviewed a range of records, this included in part, 12 people's care records. We looked at three staff files in relation to recruitment, and a variety of records relating to the management of the service, including incident records and analysis, meeting records, staff rota's, complaints and the provider's quality assurance feedback.

After the inspection, we continued to seek clarification from the provider to validate evidence found. This included but was not limited to the provider's current action plan, training data, policies and procedures. The Expert by Experience spoke with six relatives for their feedback about the service.

Inadequate

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 Good. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● People, and staff told us, and information from care and management records confirmed, people's additional commissioned hours was not provided. Following the inspection, information was forwarded that showed commissioned hours had been provided, However, information provided was not sufficiently detailed. We therefore were not fully assured people had received the individual hours they had been assessed as required. The management team recognised recording of these hours needed to be improved upon and were making improvements to address this. Staff deployment in two supported living settings were identified as being unsafe, due to people's dependency and support needs. This had a negative impact on people's safety.

● Staff had received accredited training in the Management of Actual or Potential Aggression (MAPA). This included verbal de-escalation and disengagement skills. In Addition, the provider's behavioural support practitioner had provided some additional support. However, staff feedback confirmed they did not feel sufficiently skilled or confident in some aspects of care. This included concerns in managing challenging behaviour and meeting associated mental health care and support needs. External professionals also raised concerns about staff competency in managing conflict and behaviours between people.

● Staff had received ongoing support and opportunities to share any concerns they had about their training and development. However, staff repeatedly told us they did not feel sufficiently supported, Following the inspection, the provider forwarded examples of actions they had taken to seek staff feedback and provide staff with support following whistleblowing concerns raised by staff in April 2021. This included an increase in senior management involvement and oversight

The failure to ensure staff deployment met people's individual care needs and safety, and staff were trained and supported effectively compromised people's safety. This was a breach of Regulation 18 (Staffing) (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● People were not sufficiently protected from abuse or harm. Six people told us they did not always feel safe due to behavioural incidents they had experienced from others they lived with. One person said, "There's bullying from other people, I've been hit, spat at, I feel frightened, I've threatened to self-harm, I sometimes call the police and have hit back too, I know I shouldn't." Relatives also raised concerns about the safety of their family member from others. One relative said, "[Relation] hears screaming and shouting and doors banging all the time and is very scared. The environment is noisy, and the other people are always kicking off. Sometimes [relation] is too scared to leave their room."

● At the time of the inspection, the registered manager told us 30 incidents were still being investigated. Due to a safeguarding allegation being received during the inspection, we raised four safeguarding alerts to the local authority safeguarding team who take the lead role in investigating safeguarding concerns. We are

awaiting the outcome of their investigation.
● Safeguarding procedures were not fully effective. Staff had received safeguarding training and had a safeguarding and whistle-blowing policy and procedure available to them. Staff told us they were not always confident that safeguarding concerns reported to the management team were acted upon. Following the inspection, the provider forwarded evidence of actions taken in response to safeguarding concerns raised by staff. This showed the provider had safeguarding systems and processes.
● Feedback from external professionals raised concerns that recommendations made to assist staff in managing behaviours were not consistently followed. This reflected our observations and findings. For example, one person's emotional and behavioural support plan provided staff with guidance of how to communicate with the person using picture cards, to support their understanding and help reduce anxieties and behaviours. However, staff told us the picture cards were not consistently used, and when we asked to see them, they could not easily be located and were found in the office.
● Incident management processes were not fully effective. The management team had a reactive approach rather than a proactive approach to managing incidents. Safeguarding incidents were reported to the local authority safeguarding team and CQC as required, they were also analysed. However, there was a lack learning to understand and manage incidents effectively and a lack of action post incident to support people's well-being.

The failure to ensure people were protected from abuse and having effective systems and processes to manage actual and allegations of abuse, put people at risk of harm. This was a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● Risk management procedures were not consistently effective. People's support plans and risk assessments were not always reviewed and amended in a timely manner following incidents. We also found examples when care records had not been reviewed at the frequency the provider expected. This increased the risk of people not receiving safe and effective care.
● We were told amendments to care records were recorded in the staff communication book. We noted a person's care records had been amended on Friday 25 July 2021. A member of the management team told us staff had been alerted to the changes via the staff communication book. We checked this and found no entries in the communication book as described to us. This increased the risk of people not receiving care and support that met their current care needs. Following the inspection, the provider forwarded examples of how changes to people's care records had been communicated with staff.

Using medicines safely
● Some people told us they received support to manage and administer their medicines and how they received their medicines at regular times. We noted people's medicine support plan, risk assessment and other additional care records were not fully detailed or consistent. This was confusing for staff and increased the risk of people receiving unsafe care and support.
● Medicines were stored following best practice guidance and a sample stock check was found to be correct. Medication administration records (MAR) reviewed, confirmed people had received their prescribed medicines. We noted handwritten entries were not consistently signed by two staff. This is required to ensure safe transcribing. We shared this with the field support supervisor who agreed to follow this up with staff.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Inadequate

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 Good. At this inspection, this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The Care Quality Commission (CQC)'s principles of Right support, right care, right culture were not fully embedded within the service. For example, staff deployment in some supported living settings were not sufficient, and this had a negative impact on people achieving positive outcomes.
- A person said, "Sometimes I need staff to help calm me but there's not always enough staff." For some people it was important for them to know which staff were due to be on duty. However, this information not being provided created increased anxieties for some people, resulting in incidents of challenging behaviour.
- Staff recruitment was the responsibility of a paid employee who was also a recipient of commissioned care and support from the service. Whilst this demonstrated the provider's commitment to developing an inclusive service, other people who accessed the service were not involved in the recruitment of staff. This was a missed opportunity and shows a limited approach to the principles of self-directed care.
- We received concerns during our inspection which required referrals to the local authority safeguarding team to investigate. We raised these concerns with the management team who told us they were not aware of these allegations. This raised concerns about communication, accountability and staff culture and neglect.

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; Working in partnership with others

- Where safeguarding incidents had occurred, there was a reactive approach, with limited learning to reduce further risks. The incident analysis system and processes were not sufficiently robust or measurable and affected the provider's understanding of when things went wrong.
- People's support plans and risk assessments, including additional records were not consistently kept up to date. This was important guidance used by staff to understand people's individual care and support and used to monitor health care needs. This increased people's risk of receiving unsafe care.
- Relatives reported they found it difficult to contact the registered manager to raise issues or concerns. One relative said, "I have asked for a meeting with the manager, I have phoned and left messages, but they never got back to me."
- External professionals raised concerns about receiving a negative response to offers of additional training and support for staff. These examples show a closed staff culture.
- Referrals were made to external professionals. However, concerns were raised by some external professionals about how their recommendations were not implemented or consistently followed having a negative impact on people.

● Pre-assessment and planning were identified as a concern. This included compatibility of people in some supported living settings. Also, staff not being sufficiently trained, skilled and supported in meeting some people's individual care and support needs.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

● Staff structure, roles and responsibilities were a constant concern raised by staff during this inspection. The management team told us due to shortfalls in key staff roles they were aware this had a negative impact on staff. A new staff structure had been developed and was being rolled out.

● The provider had systems and processes to review the quality and safety of the service. The registered manager reported monthly to senior managers, including a quality team who also completed audits and checks. At the time of the inspection, there was an action plan in place based on the findings from these internal audits. However, we noted the shortfalls in the fundamental care standards found during this inspection, had not been identified by the provider's internal checks.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff reported they did not feel valued, supported or listened and allegations of staff bulling were reported. We raised this with senior managers who agreed to follow this up. Staff meetings and communication were also raised as areas of concerns. We identified staff handover documents used to share information with staff about people's care and support needs were poorly completed. Information was limited impacting on staff ability to provide safe and effective care.

● Staff reported feeling stressed and not having enough time to complete tasks and meet their responsibilities. A reoccurring concern was not receiving adequate notice of the staff rota and the difficulties and pressure this caused them. Following our inspection, senior managers took immediate action to make improvements and this included ensuring all staff received a rolling rota.

The failure to ensure internal systems and processes that monitored quality and safety, including oversight were sufficiently robust increased the risk of harm to people. This was a breach of Regulation 17 (Good governance) (Regulated Activities) Regulations 2014.

● The registered manager and provider had met their regulatory registration responsibility of notifying CQC of reportable incidents they were legally required to do. People were supported with their tenancy agreements with the housing provider, this included reporting any housing repairs and completing health and safety checks.

● People told us they received opportunities to share their experience, and overall, they felt confident they would be listened to. Information had been made available for people in easy read to support their communication and understanding. The provider completed quality assurance checks. Feedback questionnaires were sent to people, relatives, staff and external professionals. Information shared was analysed and any actions were added to the overall action plan for the service.

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 17 HSCA RA Regulations 2014 Good governance The failure to ensure systems and processes used to monitor quality and safety were sufficiently robust placed people at increased risk of harm. Regulation 17 Good Governance (1) (2) (a) (b) (c)