Voyage 1 Limited

Wellington House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Wellington House is a residential care home providing personal care to up to 10 people who have a learning disability or autism and/or have mental health support needs. The service is provided within one adapted building based in a residential area. At the time of the inspection 10 people lived there. Three people using 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
People told us they were happy living at the service. However, we identified areas where people's support needed to be improved.
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 statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of the key questions Safe, Caring and Well-led: The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support:
• Model of care and setting maximises people's choice, control and independence.
People were supported to express their views and make decisions about their care. People were supported to be independent and undertake tasks for themselves.

Right care:
• Care was not always person-centred and did not always promote people's dignity, privacy and human rights. For example, staff did not always follow people's care plans to support people to make day to day choices.
Where incidents and accidents had occurred, they were not always well recorded or reported to the manager. Incidents where not always investigated to determine if there were safeguarding concerns. Action had not always been taken following incidents to reduce the risk of them re-occurring.
Staff knew how to support people. However, people's care plans were not always up to date. Staff were not always aware what was in people's care plans.
People's privacy was respected.

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not always ensure people using services lead confident, inclusive and empowered lives.

Staff did not always demonstrate a respectful approach towards people. For example, we had concerns about how some staff spoke or had written about people.
The registered manager had identified some issues in relation to staff culture, but these had not been quickly addressed. Checks on the quality of the service had not always been effective in leading to improvements.

People were not always 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 policies and systems in the service did not support this practice.

Equipment used to support people with their medicine had not always been calibrated to ensure if was working effectively. Medicines were stored correctly, and administration records were completed. There were enough staff to keep people safe. The provider was recruiting more staff as people were not always receiving their one to one support hours.

Staff had not always been well supported after incidents where incidents may have resulted in staff being hurt. The registered manager was aware of their responsibilities under duty of candour and worked in partnership with other services. However, incidents were not always shared with partners. Safeguarding incidents were not always reported to CQC when they needed to be.

People were protected from the risk of infection.

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 Good insert date (published on 17 December 2020).

Why we inspected
We received concerns in relation to the culture at the service. As a result, we undertook a focused inspection to review the key questions of safe, caring 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 changed from Good to Requires Improvement. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the Safe, caring and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wellington House 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 breaches in relation to safeguarding people from abuse, treating people with dignity and respect, and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
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 caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Wellington House

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
The inspection team was made up of two inspectors.

Service and service type
Wellington House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought and received feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our

inspection.

During the inspection
We spoke with four people who used the service and one relative about their experience of the care provided. We spoke with eight members of staff including the registered manager, the operations manager, senior care workers, and care workers. We observed people and staff's interactions when people were in the communal areas of the service.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at one staff file 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 training data, records of meetings, further recruitment information and the recruitment policy and quality assurance 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 Good. At this inspection this key question has now deteriorated to Requires Improvement. 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

- Incidents were not always reviewed to determine if there was possible abuse which needed further investigation. For example, during one incident a person was noted have pushed another person. Another incident had occurred after staff had not followed the guidance in a person's care plan and had prevented a person from doing something they wanted to do. This had not been reviewed as a possible unwarranted restriction on the person and had led to an incident occurring as the person had become upset. There were no records to show these incidents had been investigated to review if abuse had occurred or discussed with the local authorities safeguarding team. We raised these incidents with the registered manager who was not aware of them and was not able to provide assurance action had been taken to investigate if abuse had occurred. There was no evidence action had been taken prior to the inspection to reduce the risk of re-occurrence.
- Staff were aware of how to identify and report abuse. Staff were confident the registered manager would act on concerns raised. However, they had not reported these concerns to the registered manager.

The provider had failed to ensure systems and processes were operated effectively to protect people from abuse and improper treatment. This is a breach of Regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- Incident records were not always complete. Whilst some incidents had been appropriately recorded and acted upon, other incidents were recorded briefly in a logbook and full records had not been completed when these incidents occurred. For example, when people had hit staff or when one person had scratched their own arm.
- Opportunities to learn lessons from incidents and reduce the risk of these incidents re-occurring had been missed. Incidents recorded in the logbook had not been investigated to determine the circumstances around the incident, how well mitigations had worked and whether any changes were needed to people's care plans to prevent the incident from occurring again.
- Where incidents had been fully recorded, they had been added to the provider's system which supported to registered manager to identify trends. However, there had been no analysis of trends in relation to those recorded in the logbooks.

The provider had failed to fully assess and mitigate the risks relating to the health, safety and welfare of people. This is a breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The registered manager had identified how many staff needed to be on shift to support people to remain safe. There were enough staff to keep people safe. However, we looked at the rota and there were a number of days where staff numbers were below the level needed to provide people with the one to one or two to one support they expected to receive. We spoke to the registered manager about this. They told us they were aware of the concern and were actively recruiting new staff. Some people also spent time away from the service with their family. Following the inspection, the registered manager provided evidence that new staff had started and the concern was being addressed.

● Staff supervision was completed every four to six weeks by team leaders. Staff would discuss any training needs they had, review any new guidance, for example relating to Covid-19 and had the opportunity to raise any concerns with team leaders.

● Disclosure and Barring Service (DBS) criminal record checks were obtained when staff were recruited. DBS checks help providers make safer recruitment decisions. There was a probation system in place to support new recruits and provide extra support and supervision.

Assessing risk, safety monitoring and management

● There were risk assessments in place to provide guidance to staff on how to support people. However, a number of these risk assessments needed to be updated. For example, one risk assessment referred to the use of an 'as and when medicine' which was no longer in use or in stock. Two risk assessments included the use of physical interventions when people were emotionally distressed. Staff and the registered manager told us physical interventions were not in use at the service and not all staff were trained in these. We found no evidence physical interventions had been used. We raised this with the registered manager who made amendments to people's care plans at the time of the inspection.

● One person needed support with constipation. The risk assessment included guidance for staff to monitor the person's bowel movement for frequency and type. Staff had provided the person with appropriate support. However, there was no current bowel monitoring chart in place. We raised this with the registered manager and a chart was put in place at the time of the inspection.

● One person was at risk from diabetes. Staff knew how to provide support to the person and how to identify the person was becoming unwell. Staff were aware of what action to take if the person was becoming unwell with their diabetes. People were supported to attend regular health appointments to assist in managing the risks to their health.

● Environmental checks had been completed. For example, checks on the safety of the gas and electric supplies. Staff had undertaken fire drills.

Using medicines safely

● One person was supported with medicines to help manage their diabetes. Staff supported the person to test their blood sugar. However, the machine used to test this had not been calibrated. We raised this with the registered manager. Action was taken to address the concern during the inspection.

● The support people needed with their medicines was assessed. Where people were able to be active in the management of their own medicines they were supported to do so. People's medicines were reviewed to ensure they were on appropriate levels of medication. We did not find any concerns that medicines were being overused to manage behaviours.

● Medicine administration records (MARs) were signed to show people had received their medicines and there were no unexplained gaps. People's medicines were stored safely. Where medicines where stored in a fridge the temperature was monitored to ensure it remained at the correct level for the medicine to be stored at. Some medicines such as injections and eye drops need to be stored between 2ºC and 8ºC in order to remain safe and effective.

● One person's relative told us they were happy with the support their relation had with their medicine.

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 promoting safety through the layout and hygiene practices of the premises.
- 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.
- The provider was facilitating visits for people living in the home in accordance with the current guidance.
- There was an effective system in place to assure the provider had checked that all staff and professional visitors had complied with the requirement to be vaccinated against covid-19, unless they were exempt.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not always treated with kindness and respect. Language used by staff was not always respectful. Documentation we reviewed referred to people as not being 'permitted' to do something they wanted to do. One staff we spoke with spoke about a person in a disrespectful way. We observed one person tell another they could not have a food item. Staff did not intervene or reassure the person they could have the item. We spoke with the team leader who confirmed there is no reason that food items should be restricted to the person, and they would have expected staff to intervene. We spoke to staff about an issue relating to one person's personal grooming. We asked staff if they had offered the person support in this area. Staff told us they had not considered the issue.
- The communication book detailed that on more than one occasion staff had not supported one person to change their bedsheets for weeks. Staff confirmed this was the case. The team leader told us they are monitoring this to ensure that the person's bed was changed regularly going forward.

The provider had failed to ensure people were always treated with dignity and respect. This is a breach of Regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We observed there were also kind interactions between staff and people. Staff knew people well, and people gravitated towards staff to joke and laugh with them. When we asked people if they were happy one person said, "I am I know I am."

Supporting people to express their views and be involved in making decisions about their care

- People were able to express their opinions and share these with staff. For example, some people were due to go out on a trip to the shops, however one person changed their mind. The person requested to go to a local shop with staff, which was accommodated.
- People told us staff listened to them. People's preferences around which staff supported them with personal care were respected.
- People did not need additional support with communication, however staff told us that if people needed support to make decisions, they would be supported by family members or staff would contact advocates to be involved.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was respected. We observed staff knocking on people's doors before entering their room. One person told us, "Yeah they do knock before they come in, yeah they do actually."

● Staff told us that when they supported people with personal care, they ensured people were always covered to protect their dignity. People were encouraged to complete as much of their personal care as possible.

● People were encouraged to be as independent as possible. Staff told us some people did their laundry with staff support and tidied their rooms for example. One staff member told us how she supported someone to learn how to change their own bed sheets which was an accomplishment for them. Another person was taking part in a course which supported them to gain independence skills, for example cooking. They purchased, prepared and cooked their own meals with staff support a few times a week.

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 Good. At this inspection this key question has now deteriorated to Requires Improvement. 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.

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

- There were areas where the culture of the service needed to be improved. We found concerns about how staff respected people and their home. Some concerns about the culture within the service had been identified by the registered manager, but had not been quickly resolved. For example, at the staff meeting in August it was identified that staff were in the office when they should have been supporting people. This same concern was noted in the September and November staff meeting. Staff using their mobile phones and sitting in the smoking area in groups had also been noted as continuing concerns.
- Staff told us they felt supported by the registered manager. However, there had been a number of incidents recorded in a logbook where a person had sworn or struck out at staff. There were no records of debriefings having taken place after these events to ensure staff were okay and provide support to staff. We spoke to one staff member who told us they did not always feel safe following an incident and that they spent time in the office as a result.

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

- There were systems in place to audit the quality of the service. However, these had not always been effectively utilised. For example, we found care plans were out of date and needed to be updated. We asked for records of care plan audits, but were told these had not been recorded. There was a medicines audit in place and checks on medicines stocks. However, we identify a recording error in the stock levels which the audit had not identified.
- Where quality checks had been identified issues, action had not always been taken to address the concerns. For example, there were areas on the ground floor where the floor was ripped and could be a trip hazard. Although this risk had been identified there was insufficient mitigation in place to reduce the risk.
- There was a lack of oversight at the service. Staff told us they reviewed people's incident logbooks. However, there were no records of this, and the registered manager was not aware of some incidents when we raised them with them.

The provider had failed to fully assess, monitor and improve the quality and safety of the services. The provider had failed to ensure complete and contemporaneous records were maintained. This is a breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection we identified two incidents which had not been raised as safeguarding's and reported to CQC, as required by law. For example, we had not received safeguarding notification in relation to a staff member not following the person's care plan and possibly placing unwarranted restrictions on them.
The provider had failed to ensure that notifications were submitted to CQC when there was a notifiable event. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● The rating was displayed at the service and on the providers website as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff surveys had been sent out to staff to gather staff views on the service. However, no staff had responded. There were meetings for staff. However, the meeting notes did not evidence there was two-way collaborative discussion between management and staff. This is an area for improvement.
● Surveys had been issued to people and there were meetings for them. Feedback from these was positive. There were also meetings for people where people could raise any concerns or express what they were happy with.

Continuous learning and improving care
● The registered manager had opportunities to meet other managers virtually through the providers support networks. However, they had not been able to meet face to face to develop relationships due to the pandemic. The provider had recently appointed a regional support manager. After the inspection the operations Director informed us that the regional support manager would spend time working with the registered manager to drive forward improvements.
● The registered manager had also identified the service would benefit from more onsite management time to assist with the day to day management of the service. Changes to the structure of the service and a sister service were being undertaken to put this in place.

Working in partnership with others
● The service had worked in partnership with the local authority. However, we found not all incidents had been shared with them when they needed to be.
● Staff worked with other health professionals such as the speech and language team and medical professionals to improve outcomes for people. Staff were aware of the advice professionals had provided.
● Feedback from health and social care professionals was mixed. Some feedback was positive. One professional told us they found staff had a good knowledge and understanding of individual's needs.

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 was able to evidence they understood their responsibilities under duty of candour. A duty of candour incident is where an unintended or unexpected incident occurs which result in the death of a service user, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.
● We did not identify any incidents that qualified as duty of candour. However, we did not find incidents were always well recorded.

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
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to ensure that notifications were submitted to CQC when there was a notifiable event.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure people were always treated with dignity and respect.

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 had failed to ensure systems and processes were operated effectively to protect people from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to fully assess, monitor and improve the quality and safety of the services. The provider had failed to fully assess and mitigate the risks relating to the health, safety and welfare of people. The provider had failed to ensure complete and contemporaneous records were maintained.