Voyage Specialist Healthcare Limited

Innovation Centre

Inspection report

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Ratings

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

Overall summary

This inspection took place over four days. The first visit was on 8 July 2015 and was announced. We returned to the provider on 9 and 13 July 2015, and visited people who used the service in their homes on 10 July 2015.

Innovation Centre is registered to provide personal care to adults and children with complex needs in their own homes. At the time of our inspection they were 36 people using the service.

We last inspected the service in February 2014. At that inspection we found the service was meeting all the regulations that we inspected.

This inspection took place over four days. The first visit was on 8 July 2015 and was announced. We returned to the provider on 9 and 13 July 2015, and visited people who used the service in their homes on 10 July 2015.

Summary of findings

Innovation Centre is registered to provide personal care to adults and children with complex needs in their own homes. At the time of our inspection they were 36 people using the service.

We last inspected the service in February 2014. At that inspection we found the service was meeting all the regulations that we inspected.

No registered manager was in place at the time of our inspection. The manager advised us they had submitted their application to CQC to become a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We noted safeguarding concerns had been investigated and referred to the local authority.

We saw risk assessments were present in people's care records and included pressure area care, medication and use of profiling beds. However the risk assessments were generic and identified the hazard and control measures and no reference was made to the person and their needs.

Procedures for managing people's medicines were not safe as records were inconsistent. There were a number of gaps in the recording of the administration of topical medicine on the medicine administration records (MAR) we viewed. We noted in one person's MAR we viewed in their home had not been completed for one full month.

We noted in the complaint logs 13 'service delivery failures', one service issue and one missed call. One complaint detailed, 'I'm so disappointed yet again to be informed today that my nightshift cannot be covered tonight, no explanation why or reason or offer of another night'.

We saw the provider had followed their recruitment and selection policy. Each file held two references with at least one from the previous employer and all staff had new Disclosure and Barring Service (DBS) checks prior to their employment.

We found that training and development was not up to date. Staff told us that they did not receive regular supervisions and appraisals.

We did not see evidence of Mental Capacity Act (MCA) 2005 assessments and 'best interests' decisions being carried out for people who lacked capacity to make decisions for themselves. The managing director showed us 'best interest' documents and told us the clinical case managers would be carrying out MCA assessments on those who needed assessing during their reviews.

Relatives we spoke to told us they had not been involved with reviews of their relative's care for a number of months, recalling that the last time was with a staff member who has since left the organisation.

We found a discrepancy in the quality of the detail recorded in children's care plans compared to adult care plans.

People and family members gave us positive feedback about the care workers providing the support. However relatives told us the management did not always listen to their needs.

We saw that a complaints policy and procedure was in place. People and relatives were aware of the complaints procedure.

The managing director told us the service was going through a transitional period and they and the management team were implementing a range of new practices across the service.

Relatives and people who used the service told us they welcomed the new management. One relative said, "I hope these are better than the last lot." Another said, "Things need to improve, there is a lack of communication." However, another said, "I don't know who the management is, no one visits."

The provider did not have an effective system in place to regularly asses and monitor the quality of the service provided.

We saw all policies and procedures were up to date with a clear process and review date in place.

The manager had been pro-active in submitting statutory notifications to the Care Quality Commission and had started the process of applying to become a registered manager.

Summary of findings

During our inspection we identified a number of breaches in regulation; 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?

Requires improvement

The service was not always safe.

Procedures for managing people's medicines were not safe as records were inconsistent.

The provider investigated safeguarding incidents and made appropriate referrals to the local authority.

We noted the risk assessments associated with people's care were generic. Each identified the hazard and control measures, however no reference was made to the person and their needs.

The service had a robust recruitment process. Each file held two references including one from the previous employer and a new DBS check prior to their employment.

Is the service effective?

Requires improvement

The service was not always effective.

We found staff training was not up to date. We also saw staff did not receive regular supervisions.

We found one person was working with a child with complex needs and there were no competency assessments in place.

We did not see evidence of MCA assessments and 'best interests' decisions being carried out for people who lacked capacity to make decisions for themselves.

Is the service caring?

Requires improvement

The service was caring.

People and family members gave us positive feedback about the care workers providing the support. However relatives told us the management did not always listen to their needs.

People and relatives told us staff were always respectful.

The management did not ensure they deployed the same care workers with people who used the service to maintain continuity.

Is the service responsive?

Requires improvement

The service was not always responsive.

Some care plans were detailed and reflected people's individual needs. However this was not implemented consistently throughout the service.

Summary of findings

We found care plans were not regularly reviewed. The manager said they were aware of the situation and had started conducting visits with the coordinators.

People were aware of how to raise any complaints or concerns. We saw complaints were appropriately dealt with.

Is the service well-led?

Requires improvement

The service was not always well-led.

The service was going through a transitional period and the new management team were implementing a range of new practices across the service.

Relatives and people who used the service told us they welcomed the new management. One relative said, “I hope these are better than the last lot.” Another said, “Things need to improve, there is a lack of communication.”

The service did not have an effective quality assurance processes to monitor the quality and safety. However the service was in the process of moving to the provider’s systems which included a comprehensive audit process.

The provider ensured statutory notifications had been completed and sent to the CQC in accordance with legal requirements.

Innovation Centre

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 location 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 over four days. The first visit was on 8 July 2015 and was announced. We returned on 9 and 13 July 2015, and visited people who used the service in their own homes on 10 July 2015.

The inspection team consisted of two adult social care inspectors.

Before the inspection, we contacted the local authority safeguarding team and commissioners for the service. We reviewed other information we held about the service, including any statutory notifications we had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale.

We looked at seven care plans for people who used the service. We examined seven staff records including recruitment, supervision and 18 training records and various records about how the service was managed.

We spoke with two people who used the service and 11 family members. We also spoke with the new manager, the managing director, three nurses, one co-ordinator and five health care assistants.

Requires improvement

Is the service safe?

Our findings

We asked the manager about staffing levels. They told us that staffing levels were set by the needs of the people using the service and the provider allowed a 10% overlap to cover times of leave and sickness.

We noted in the complaint logs 13 'service delivery failures', one service issue and one missed call. One complaint detailed, 'I'm so disappointed yet again to be informed today that my nightshift cannot be covered tonight, no explanation why or reason or offer of another night'. Another reported, 'We have only just been told that tonight's shift will not be covered this is after not receiving any care last night either and we are getting none this weekend either'.

We asked relatives of people who use the services if enough staff were in place. One relative told us, "I knew [staff member] was moving on so asked them to get a new carer to shadow so they could help support [my relative], it never happened then they couldn't find staff to cover." Another told us, "No organisation, they ring up to say they don't have the staff to come and how they are waiting for staff to come back to them."

Parents told us they had the rotas in advance and knew who was coming to the house to care for their children. However one parent told us children needed to know who was caring for them and had only recently got updated rotas where there had been changes. Another relative told us, "We were receiving rotas with no carers names on so were unaware each evening who would be coming to look after [my relative]."

The manager told us they are aware of the issues and had an on-going recruitment drive to ensure they had enough staff. They advised nine new staff had recently been recruited and they were conducting interviews for clinical case managers on the first day of our inspection.

We found the provider did not have sufficient suitably qualified, competent and trained staff to ensure an effective delivery of their contractual requirements.

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

We asked to see audits of people's medicine administration records (MARs). The manager was unable to provide all the archived records of people's MARs we requested. They were unable to tell us if any audits had been conducted and no records were available. There were a number of gaps in the recording of administration of topical medicine on the MARs we viewed. We viewed one person's MARs in their home which had not been completed for one full month. We brought this to the manager's attention who advised that the matter would be looked into.

We viewed assessments of staff competence in regard to the management of medicines. This included staff answering questions about their practice and being observed. We asked the manager about the frequency of testing staff's competency. They advised the provider did not have a set period but they hoped to implement a yearly review.

Medicines were not handled safely because records relating to medicine were not completed correctly placing people at risk of medicine errors.

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

We looked at safeguarding training and found staff working with children and young people had undertaken child protection training. However we found one staff member who was working on their own with children had not completed this training. Staff we spoke to were able to describe the various types of abuse and knew how to report concerns. One staff member, "I haven't had safeguarding training for a while but if I had concerns I would speak to the manager."

The manager showed us a staff information pocket book which held information on safeguarding and the whistleblowing scheme, 'See something, say something.' The scheme outlined what staff needed to do if they witnessed any abuse or harm of a person. They advised all staff would be receiving the booklet in the next couple of weeks.

We asked to see the provider's safeguarding log. The manager told us that they did not have a specific safeguarding log. They advised that incidents, accidents, complaints and safeguarding matters had previously been held on a number of different systems and were being collated together on to one spreadsheet for future input into the provider's corporate systems. We noted

three safeguarding concerns had been investigated and referred to the local authority.

Requires improvement

Is the service safe?

We asked the manager if analysis had been carried out to identify lessons learnt. They told us at present no analysis had been carried out but they had started to record information on the weekly service report and in the future this would enable them to produce reports identifying areas of cause and risk.

We looked at the accident and incident information held. We noted three medication errors incidents were recorded. The manager told us the matters were investigated and staff involved had received additional medication training.

We saw risk assessments were present in people's care records and included pressure area care, medication and use of profiling bed. The risk assessments were generic and identified the hazard and control measures. However no reference was made to the person and their individual needs.

We also looked at the risk assessments for people under 16 years old. We found the risk assessments were not personalised and did not take into account the presence of the parent acting on the child's behalf. For example, we found risk assessments in place indicated staff were to ensure people had sufficient medicines in place. However parents we spoke with confirmed they did the ordering and ensured their child had sufficient medicines at home.

The manager told us they were reviewing the care plans and reviewing risk assessments was a large part of that work. They did not have a time scale for when this work was to be completed. They showed us a recently reviewed plan, we noted the risk assessments had information specific to the person and detailed what action to take.

People told us they felt safe. One relative said, "Staff are really good, I have no problems with [staff member]." Another relative told us, "It has taken a while but I trust [staff member] to look after [my relative], I know they are safe when I'm not here."

We examined seven staff files and saw the provider followed a robust recruitment procedure. Each file held two references with at least one from the previous employer. We noted all staff had new Disclosure and Barring Service DBS checks prior to their employment. The change manager told us, "We always ensure new DBS checks for all new staff and are rolling out a three year review for existing staff." We also saw a risk assessment had been carried out on an applicant prior to employment as information had been disclosed on a DBS check.

Requires improvement

Is the service effective?

Our findings

We found that training and development was not up to date. We asked to view staff training records and were provided with information from two systems which held conflicting information. Innovation Centre employed 110 care workers in different locations around the country at the time of our inspection. We examined the training records of staff who were deployed to support the adults and children whom we had reviewed. We looked at 18 staff training records and saw training had expired in the following areas: manual handling (Level 1) for nine staff, safeguarding of children for eight staff and medication administration for care for two care workers.

We reviewed 26 staff training records in regard to safeguarding and noted 13 members of staff had not received safeguarding training for over 12 months.

We spoke to staff regarding training. One care worker told us, “I was shown by the mam of the child I was looking after then I had to do it, if I have to remove the tube I think I could do it in an emergency.” Another care worker told us, “The training isn’t enough, people have complex needs. We are shown it once then we have to do it.”

The manager told us they were aware of the issues with training and advised they and the clinical case managers were reviewing staff records and transferring all information onto one system. The manager told us they had recognised the need for training and had recently employed a recruitment and training coordinator and were recruiting a quality and training officer to implement and delivery a programme of training.

Staff told us that they did not receive regular supervisions and appraisals. A lack of records confirmed this. We examined 18 staff training records and saw two records did not hold information on supervisions or spot checks and 10 records showed the last supervisions or spot checks carried out were between January 2013 and December 2014. One care worker told us, “I have never had supervision.” Another told us, “I met the new coordinator recently and I had my first supervision.”

Supervisions and appraisals are important so staff have an opportunity to discuss the support, training and development they need to fulfil their caring role. The manager told us, “With the support of the clinical case managers and quality and training officer I’m looking at conducting supervisions every six months with three evidence based observations and appraisals at end of the year.”

We reviewed staff competencies. These were set against the needs of the person they were supporting. Competency booklets we viewed were dated 2013. We asked the manager if the service had a policy outlining frequency of reviews. The managing director advised us that the Royal College of Nursing Accountability and Delegation guidelines did not state a required timescale or frequency for reviews. The manager did advise that they intended to carry out yearly reviews in the future.

We spoke with the managing director and the manager who confirmed to us staff were trained to be child specific competent. However we looked at the care documentation of four children and found in only one file a list of competencies required by the staff.

We looked at the training provided to staff and found there were no specific competencies for each

child. In one child’s care documentation we saw staff were advised to use a pain score chart. We checked to see if the staff caring for the child had training and found there was no training listed.

We found one person was working with a child with complex needs and there were no competency assessments in place. We asked parents how were staff trained. One parent said, "Seasoned carers train others’" and then told us the nurse come along and signed them off.

We found the provider did not provide staff with appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

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

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and to report on what we find. MCA is a law that protects and supports people who do have the ability to make their own decisions and to ensure decisions are made in their ‘best interests'.

Requires improvement

Is the service effective?

Staff had an understanding of their responsibilities under the MCA. They were aware of the capacity of people they were supporting and described how decisions were made in people's 'best interests'. Staff told us they had completed training on the MCA and this was confirmed on their training records.

We did not see evidence of MCA assessments and 'best interests' decisions being carried out for people who lacked capacity to make decisions for themselves. The managing director showed us 'best interest' documents and told us the clinical case managers will be carrying out MCA assessments on those who needed assessing during their reviews.

We saw people's care plans described the support they needed with eating and drinking, including any risks associated. For example one care plan indicated, '[Person] has a delayed swallow and must be supervised at all times when eating.'

We observed external health professional's details were held in people's health records. Parents told us they organised their own child's medical appointments. The manager told us they were proactive in liaised with commissioning services to ensure people received the right package of care.

Requires improvement

Is the service caring?

Our findings

People and relatives we spoke to told us that the staff were caring.

One person told us about their care workers, “I can’t speak more highly of them. I can’t fault their care and professionalism.” A relative told us, “Most staff are ok, some have attitude they have to remember it’s our home.” Another said, “[My relative] is happy with their carers. The carers are good, lovely people and I can trust them.”

People and family members gave us positive feedback about the care workers who provided the care and support. However, relatives told us the management did not always listen to their needs.

One person told us, “Management were aware of staff leaving so we asked them to organise the appropriate training for new staff to look after [my relative], it did not happen.” Another said, They just ring up and say they can’t cover and don’t think of the impact on the family.”

Relatives told us they wanted staff to get to know their relative and understand how to care for them. One relative told us, “[My relative] becomes distressed with new faces so it’s important they have the same staff.” Another relative said, “I asked for staff to be introduced to [my relative] before they start caring for them but it didn’t happen.” One parent told us they asked to meet with staff before they met their child and on one occasion met the staff member half an hour before their child was due to meet them.

Some parents told us they were happy with the service provided and staff arrived at the agreed times. One person described the service as, ‘Brilliant’ and told us the carer can pick up on their child having fits.

We found that staff had good knowledge of the people they cared for. One staff member told us, “I have cared for [person] for a while and I have got to know them and their family.” Another said, “It can take time to gain trust but we work with the families.”

We asked relatives who used the service if care workers treated their relative with respect and dignity. One relative told us, “Yes they are great with [My relative].” A family member told us, “The staff are good and treat [my relative] with respect and dignity”. Staff told us they gave people privacy whilst they undertook aspects of care. One care worker told us, “I always explain what I am doing when providing care or assisting [person].”

At the time of our inspection, no-one used an advocacy service, but the manager was aware of the local advocacy service. We saw posters advertising the service in the office.

Requires improvement

Is the service responsive?

Our findings

We found care plans were inconsistent. We viewed seven people's care plans. We noted adult care plans were thorough and covered personal hygiene, nutrition; mobility; communication medication and social activities. These were written from the perspective of the person receiving the care. For example, in communication, 'I am unable to communicate verbally but can communicate by facial expressions if I am unhappy.'

We found a discrepancy in the quality of the detail recorded in children's care plans compared to adult care plans. We found children's care plans to be lacking in appropriate detail. For example, information in a care plan document did not describe appropriate moving and handling techniques to prevent one child feeling pain. The care plan also did not include the safe use of a stairlift.

During our visits to people's homes we noted the care records contained the same information as held in the office. We saw these also contained a daily log were staff recorded all their activity throughout their shift.

The managing director showed us a new assessment form, which included consent to assessment, relationship circle, personal details, family and friends, commissioning information, professional support services, assessment, medical history activities and learning and development. They advised the form was being introduced immediately for all new clients and on reviews for existing clients.

We found care plans were not regularly reviewed. Relatives we spoke to told us they had not been involved with reviews of their relatives care for a number months recalling the last time with a staff member who had since left the organisation.

We asked the manager about the frequency of reviewing people's care plans. They said they were aware of the situation and had started conducting visits with the coordinators. They showed us a record of reviews they had recently conducted and they advised that they were aiming to visit and to introduce themselves to all clients within four to five weeks.

The manager showed us a communication table it detailed a person's preferred communication, on call comments, notification of issues and communication expectation. They told us they planned to conduct introduction visits with all clients and their families.

We a saw a review dated 22 May 2015, which had discussion points including update of MARs, additional staff and the agreed timescale for reviews. The managing director told us two clinical case managers had been recruited and one of their roles was to ensure care plans were reviewed appropriately.

People and relatives were aware of the complaints procedure. One relative told us, "I would contact the office if I had any problems." Another said, "I made a complaint in December but no one got back to me." We discussed this matter with the manager who advised they were currently looking into the matter and the managing director had spoken to the person earlier that day.

We saw that a complaints policy and procedure was in place. We examined records relating to compliments and complaints. The manager told us they had recently collated the information

together as they were transferring the information on to the provider's weekly service reports.

We noted 16 complaints were recorded from February 2015, these related to missed calls or service delivery failings. The complaint records we viewed were filtered to the appropriate person, investigated and responded to in a timely manner. The manager recognised the number of service delivery failings was not acceptable and told us they had recruited more staff to ensure future service delivery was not affected. As the manager had only been in post for two weeks they were unable to comment on issues prior to that date.

Requires improvement

Is the service well-led?

Our findings

The managing director advised us the service was going through a transitional period and they and the management team were implementing a range of new practices across the service. They told us they had been in post since the end of May and the manager was only in their second week of their new role.

The managing director showed us the monthly audit it covered five areas: caring, effective, responsive, safe and well-led. The manager told us, "Each service completes an audit and action plans are put in place if an area has failed." These included checks of the medicine systems, safeguarding, audits of care plans and risk assessments. The service had recently moved on to this system. The manager told us the week before our inspection they had completed training on the providers audit systems.

The managing director told us the provider's monthly audit was not suitable for the service as it didn't cover all the areas involved with the delivery of care for people with complex needs. They told us were in discussions with the head office to amend the audit to ensure all appropriate information was captured.

We asked to view all quality assurance audits. The manager was unable to show us previous audits conducted and was unable to say if they had been completed. Throughout our inspection the manager told us about their plans to carry out reviews of care plans, risk assessments and staff files. We did not see evidence of the commencement of this work and no action plan was available outlining how the work was to be prioritised.

Although the provider had a system of quality assurance checks and audits we found it was not been used. The manager was not able to demonstrate its effectiveness in assessing and monitoring the quality of care people received.

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

The manager and managing director both told us they had experience of setting up domiciliary care services. The manager said, "There is work ahead but I feel supported by [the managing director] we have the same vision." They told us the service was currently transferring many processes over to the provider's systems. They advised us new staff had been employed including two clinical case managers, a recruitment and training coordinator and were recruiting a quality and training officer to implement and delivery a programme of training.

Staff told us they had recently attended a meeting which outlined the future of the organisation. The managing director showed us the presentation given to the staff on the introduction of the new management team. One care worker said, "It's not going to change overnight but they seem to be trying." Another said, "It seems better with this management."

Relatives and people who used the service told us they welcomed the new management. One relative said, "I hope these are better than the last lot." Another said, "Things need to improve, there is a lack of communication." However another said, "I don't know who the management is, no one visits."

The manager told us they intended to develop all channels of communication with people who use the service, their relatives, staff and external professionals. They said, "I have the ability to listen and we need to demonstrate accountability for our actions."

We looked at what the provider did to seek people's views about the quality of the service. The manager told us questionnaires were sent to people and relatives once a year. The manager was unable to locate the last collected feedback. One relative told us, "I think I have had a questionnaire but couldn't tell you when." The manager discussed with us their programme for gathering information with visits and showed us a questionnaire which was to be sent out to all end of August.

We asked the manager how children's views were captured. The manager told us the children they currently looked after were unable to communicate their views. However the clinical case manager detailed three children who they said," Would love to tell you."

The United Nations Convention on the Rights of the Child states children have a right to receive and impart information, to express an opinion and to have that opinion taken into account in any matters affecting them from the early years.

We asked family members if children were involved in the evaluation of the service and were able to express their

Requires improvement

Is the service well-led?

views. Parents told us their children liked their carers but another told us their child had not been involved in service feedback. This meant the provider was not taking into consideration the rights of the child.

None of the parents we spoke to experienced spot checks being carried out with staff members.

Parents we spoke to told us they had not had any unannounced visits from mangers to check on the quality of the service. We looked at the provider's records and found there were no spot checks carried out.

We saw all policies and procedures were up to date with a clear process and review date in place.

The manager had been pro-active in submitting statutory notifications to the Care Quality Commission. The submission of notifications is important to meet the requirements of the law and enable us to monitor any trends or concerns. The manager told us they had started the process of becoming a registered manager.

The manager told us the provider had a monthly magazine, KITE, which was to be sent to people who use the service. We saw the provider had a mission statement which clearly outlined the values of the service.

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
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines were not handled safely because records relating to medication were not completed correctly placing people at risk of medication errors. Regulation 12(2)(g)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found the provider did not have sufficient suitably qualified, competent and trained staff to ensure an effective delivery of their contractual requirements. We found the provider did not provide staff with appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties. Regulation 18(1)(2)(a)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have an effective system in place to regularly assess and monitor the quality of the service provided. Regulation 17(2)(a)