Voyage Specialist Healthcare Limited

Voyage Specialist Healthcare (DCA)

Inspection report

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Date of inspection visit:
17 November 2016
24 November 2016
25 November 2016
02 December 2016

Date of publication:
17 March 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection took place on 17, 24 and 25 November and 2 December 2016 and was announced.

The last inspection of this service was carried out in July 2015. At that time the provider was failing to meet the regulations relating to staffing levels, staff training and support, medicines management and effective quality assurance processes. The provider sent us an action plan showing how they intended to address these matters. During this inspection we found the provider had made improvements in all these areas.

Voyage Specialist Healthcare is registered to provide personal care to adults and children with complex needs in their own homes. At the time of the inspection there were 59 people in receipt of a care service.

The service had a registered manager who had been in post since December 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

People received their medicines in a safe way. All staff administering medicines had received up to date training and competency checks. Medicine administration records (MARs) were completed.

Staff levels and rota systems were monitored to ensure they were more efficient in the deployment of staff. The service had ongoing recruitment processes in place at the time of the inspection. The provider recruited staff in a safe way, ensuring all appropriate checks were completed prior to staff commencing work.

Staff received regular supervisions and annual appraisals to discuss their personal development and success in their roles. Staff had received up to date training in a number of areas and the registered manager had an ongoing training plan to ensure staff training was kept up to date. Staff also received specialist training specific to individual people, based on their needs.

The registered provider had a robust quality assurance system in place to monitor service provision and inform ongoing development and improvement.

Staff had a good understanding of how to safeguard people, including what potential signs to look out for with people and how to report any concerns. The registered provider had an up to date whistle blowing policy which they ensured staff were aware of through the induction process as well staff meetings and supervisions.

All risks to people's safety were assessed and monitored. All risk assessments had associated detailed care plans in place to guide staff how to support people to manage those risks safely.

People were supported to meet their nutritional needs with staff supporting them when required. People had appropriate nutritional care plans and risk assessments in place if they required support to maintain a healthy balanced diet as well as to support with specific dietary requirements.

People had access to a range of healthcare professionals and staff supported them to access them in a timely way.

People's needs were assessed shortly after admission to the service and details of their life history were included in care records. People's care plans were very detailed and personalised to each person and included details of preferences, likes and dislikes. Care plans were reviewed regularly and updated in line with people's changing needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's medicines were managed safely.

People and their relatives told us support was provided in a safe way.

Staff had a good understanding of how to safeguard people and report any concerns.

Risks to people's safety and welfare were identified and managed appropriately.

Is the service effective?

Good

The service was effective.

Staff received regular training in relevant areas.

The provider ensured staff received supervision at regular intervals as well as annual appraisals.

People were supported to meet their nutritional and hydration needs.

People had access to health professionals as and when necessary.

Is the service caring?

Good

The service was caring.

People and their relatives told us they were happy with the service and felt staff were friendly.

Staff treated people with dignity and respect when supporting them with daily activities.

People had access to and received support from advocacy services.

Is the service responsive?

Good

The service was responsive.

Care plans were robust, detailed, personalised and specific to people's individual needs.

People and relatives were involved in planning and reviewing care and support.

People and their relatives knew how to raise concerns. All complaints were fully investigated and outcomes were fed back to complainants.

Is the service well-led?

Good

The service was well-led.

The registered provider had a robust quality assurance system in place which informed the future development of the service.

There was an established registered manager in place. Staff, people and relatives told us they were approachable and supportive.

Staff attended regular meetings to discuss the service.

Voyage Specialist Healthcare (DCA)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 17, 24 and 25 November and 2 December 2016 and was announced. We gave the registered provider 48 hours' notice as it was a domiciliary care service and we wanted to make sure someone would be in the office. We spoke with relatives in the office during 17 and 25 November and contacted people and relatives on 2 December 2016 for their feedback regarding the service.

The inspection was completed by one adult social care inspector.

Before the inspection took place we reviewed the information we held about the service. This included notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also completed a Provider Information Return (PIR) and this was returned before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We contacted the local authority commissioners of the service, the local authority safeguarding team and Healthwatch. Healthwatch England is the national consumer champion in health and care. There were no concerns raised.

During the inspection we spoke with two people and three relatives. We also spoke with five members of staff, including the managing director, the registered manager, one co-ordinator and two care workers. We looked at four people's care records and five people's medicine records. We reviewed four staff files, including records of the recruitment process. We reviewed supervision and training records as well as

records relating to the management of the service.

Good

Is the service safe?

Our findings

At the last inspection in July 2015 we found the registered provider did not have sufficient suitably qualified, competent and trained staff to ensure an effective delivery of their contractual requirements. The service had received a number of complaints from relatives regarding staffing levels and changes in staff supporting their family members. Relatives had also informed us that some support had not been provided with calls being missed due to staffing levels.

During this inspection we found improvements had been made. The provider had recruited more staff and put plans in place to ensure people had consistent teams of care workers to support them with their specific needs.

The registered manager explained how rotas were organised in line with people's needs. They explained how small groups of staff were deployed to individual people and how they were committed to continuity of staff, based on skills set and familiarity. People and relatives confirmed staff were reliable. One person said, "They always arrive on time, they are fine." A relative told us, "[Family member] has had the same carer for a long time and I feel she knows him inside out." Another relative explained how the provider had recruited enough staff to support their family member's needs and that there were only a small number of care workers who were allocated to provide care and support. They said, "We're up to four carers and they are now introducing a fifth carer as a back-up (to cover holidays, sickness etc.)"

The managing director explained staff were predominantly recruited to support specific people. A process had been implemented where people and their relatives were invited to take part in the recruitment process if they wished to. Potential care workers were introduced to people and their families to guage whether they felt the match was appropriate. The managing director explained they met with both parties following the introduction to see if they were happy. They told us if either the person, relative or potential staff member didn't feel the position was appropriate, they would seek an alternative care worker.

People's care records contained service failure plans which were agreed with people or their relatives. These plans included information about alternative care workers who could provide care and support to the person in the absence of the usual staff members. Plans included essential skills, training and knowledge staff members would need to have to provide effective cover.

The provider had recruitment and selection procedures to check new staff were suitable to care for people. We viewed the recruitment records for three members of staff. We found the provider recruited staff in a safe way. Staff files contained job application forms, interview score sheets and references from previous employers. The provider also checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people.

At the last inspection in July 2015 we also found people's medicines were not always being managed in a safe way. This was due to their medicine records being incomplete and having noticeable gaps. Audits were also not carried out on medicine administration in the home and competency checks were not completed

routinely.

During this inspection we found improvements had been made to the management of medicines. Medicine administration records (MARs) we viewed were mostly complete. A small number of gaps were noticeable on MARs. These had been identified during routine medicine audits and investigated to establish whether medicines had been missed or if it was a recording issue. The gaps were due to cancelled calls and refusals. The provider took appropriate action including discussing the issues with individual members of staff as well as in staff meetings.

People and relatives told us the service was safe. One relative said, "When I go out I don't worry about [family member]. It makes a big difference."

Staff demonstrated they had a good understanding of safeguarding. Staff were able to name and describe different types of abuse and gave examples of signs people may show if they were being subjected to abuse. One staff member said, "If someone had bruising or if they became aggressive, perhaps other marks on the body." Staff explained the reporting process for safeguarding concerns. One staff member said, "I would report this to the team leader or the manager. We record everything in daily notes as well."

Safeguarding records were held electronically and included details of specific safeguarding issues. Records also included alerts to local authorities, statutory notifications to the Care Quality Commission, investigations, outcomes and the subsequent action taken. For example, disciplinary action against staff. Staff we spoke with were also aware of the whistleblowing procedure and how to use it. One staff member told us this was included in their induction training.

Risk assessments were completed for people receiving support from the service. We saw all areas which had been assessed were clearly linked to care plans which documented how the risk should be avoided. For example, someone assessed with a high risk of developing pressure sores had been supported to obtain an appropriate air pressure mattress and encouraged to complete daily passive exercises.

There were personal emergency evacuation plans (PEEP) in place for each person. Plans detailed each person's needs and included support they required to evacuate their homes, any equipment needed and identified exits. This meant staff had access to relevant information to be able to evacuate people safely from their homes in an emergency.

Good

Is the service effective?

Our findings

At the last inspection in July 2015 we found staff had not received regular supervisions and annual appraisals. We also found that staff training was out of date for some staff and they felt they hadn't received enough training to carry out their roles effectively and efficiently. Staff training records were held on two systems which held conflicting information. Staff competencies were not assessed on a regular basis.

During this inspection we found improvements had been made. Staff we spoke with told us they received a robust induction when they first started with the service. Records showed that inductions covered areas such as safeguarding and whistleblowing, concerns, complaints and compliments, reporting and record management, confidentiality and information sharing. The registered manager told us the new staff members undertook training around moving and handling and basic life support training face to face as part of the induction. This was then followed by completion of the care certificate through e-learning, shadowing and the successful completion of workbooks.

Staff told us they received enough training to carry out their role. One staff member said, "All training is up to date. We do e-learning, but moving and handling is done in the office or a care home. First aid as well." They went on to say, "I have my NVQ level two." Training records showed that staff had received up to date training in relevant areas such as safeguarding adults at risk, child protection, moving and handling, Mental Capacity Act (MCA), medicines management and nutrition. Staff also received training in other areas relating to conditions such as dementia and epilepsy awareness.

The managing director explained how staff recruited to support specific people also received additional training in areas around the person's complex needs. They explained this was to ensure staff were trained and equipped with the correct knowledge and skills to effectively support individual people. Specific training included tracheostomy care, oxygen saturation monitoring, nebuliser and tracheal suction.

Staff underwent competency assessments in medicines administration as well as person specific areas such as catheter care and tracheal suction. Each competency assessment looked at the staff member's understanding as well as their ability to demonstrate competence with different tasks within each area assessed. The assessor signed off different levels of competency for individual staff members. This included whether they had completed initial training, were competent to practice and for some staff member whether they were competent to teach others.

People and relatives we spoke with said they felt staff had the skills to do their job. One person said, "Yes they are trained, but don't need much training to look after me." Another person told us they were "extremely impressed by staff". They went on to tell us they felt staff were "well trained, highly qualified and competent staff". A relative said, "All the things we want them to do they do it." They went on to tell us about a specific member of staff and said, "[Staff member] just gets it, they get what [family member] needs, they're really calm with [family member]." Another relative told us, "They know exactly what you need them to do."

Staff told us and records showed they received regular supervisions. One staff member said, "We discuss any problems I have or if there is anything about my package. We get a letter about three weeks before hand so we get notice, they are normally after your shift so you don't need to come back specially. I don't usually go to the office only if there is training."

Discussions viewed in staff supervision records included updates on actions from previous supervisions, appraisals and observations, general wellbeing of the staff member, people support, and any issues or concerns. Other discussions recorded were in relation to maintaining people's dignity, respect, confidentiality and professional boundaries as well as safeguarding, MCA and training. Any agreed actions were recorded and followed up in the next supervision. For example, to complete specific training such as epilepsy training.

The provider had a policy and procedure in place for each staff member to receive an annual appraisal. Records showed that appraisal discussions covered achievements of objectives, job performance, personal strengths and development requirements, new objectives for the next 12 months and any training or support required. They also included specific goals that were important to individual staff members. Staff told us they received annual appraisals. One staff member said, "It covers if we need any more training, if you're happy, how you're doing."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

Staff told us they had received training in MCA and they had an understanding of MCA and people's capacity. When discussing decision making with one staff member they said, "The person I support is non-verbal but they can make their needs known through eye movements." Other people receiving care from the service had family members to assist with decision making. For example, for people under the age of 18 receiving a service, parents made decisions around their care and support. The registered manager told us about one person they felt may have fluctuating capacity. They said, "I went out and did the best interest assessment with him and he had capacity."

People were supported to meet their nutrition and hydration needs where required. We saw specific detailed care plans in place for people requiring support. People's likes, dislikes and personal preferences were included in their care plans. For example, details of preferred drinks including fruit teas, coffee with milk and two sugars and fizzy lemonade. Other information included specific times people preferred their snacks and meals.

Other people's nutrition care plans included information about nutritional supplements staff supported them to have to maintain their weight. Information included how staff needed to support people to have their meals. For example, one person was fed through a percutaneous endoscopic gastrostomy (PEG). This is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.

People had access to a wide range of healthcare professionals and were supported to do so where necessary. From viewing people's records we noted people had received support from healthcare professionals such as GPs, paediatric consultants, physiotherapist, district nurse, specialist nurses, consultant neurologist and dieticians.

Good

Is the service caring?

Our findings

People and their relatives told us staff were caring and they were happy with the service. One person said, "They are very friendly." A relative told us they were happy with staff and said, "[Staff member] is trained and caring with [family member]. We have a couple of hours on a weekend as well, that really helps." Another relative told us, "[Staff member] is so bubbly and has a positive outlook on life." They went on to tell us staff always asked "can I do anything? We've got a lovely set of carers, we've been really lucky. We've never needed to change."

Staff supported people to help them with their learning and development and to maintain their emotional wellbeing. People's needs had been assessed by the service and appropriate professionals. Strategies and plans had been implemented to guide staff how to support people effectively. For example, one child had a play and activities learning and development plan. This included details of things the child enjoyed such as telling stories.

We viewed people's care files and noted staff recorded daily notes. Records included details of support provided as well as people's mood and conversations staff had with people.

All files containing confidential information including people's care plans, archived records and staff files were securely stored in locked cabinets. Keys to the locked cabinets were stored in another locked cabinet, located in a different room. We observed office staff using the keys to obtain specific files. This meant people's private information was stored securely and confidentiality was maintained.

People were supported to be as independent as possible. One person's personal hygiene care plan stated, 'I can wash and dry myself but the whole process can take me a couple of hours. I would like you to help washing my hair.'

People and relatives told us staff treated them with respect and maintained their dignity while supporting them with personal care. Staff had access to information in people's care records about their needs and preferences, including their likes and dislikes. For example, one person's personal hygiene care plan stated, 'I enjoy having a bath' and 'I would like to wear make-up.' A relative told us they were "quite happy" with the staff members who supported their family member. They said, "The staff come in and wear slippers in my home. They respect my home and my privacy. I feel comfortable."

The registered manager understood the importance of advocacy services and why people may wish to access them. They told us, if people required or appeared to require advocacy services they would support people to access appropriate advocacy services. A co-ordinator told us, "We currently have one person who receives support from an advocate for support purposes." The registered manager informed us they were currently awaiting an advocate for another person; they had made a request to the social worker.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs, wishes and preferences. One relative told us about their family member requiring a complex diet. They informed us the service were unable to prepare their family member's food due to the complexity around it, but they were able to support the person with their meal, once prepared. The relative told us, "They actually wrote a [complex diet] policy which really meant a lot to me as they weren't close off to the idea and they persevered (to be able to provide a level of support)."

People's needs were assessed prior to receiving support from the service. The assessment consisted of detailed information about each person, including their preferences. For example, what made them happy and sad. Assessments also included details around how to support people in different situations. For example, with epilepsy seizures.

People had personalised care plans in place to guide staff about how to support people to meet their complex needs. Care plans were robust, detailed and included information about people's specific preferences and wishes. Care plans also stated what support each person needed from staff. People had care plans in place to detail the support they received such as personal hygiene, nutrition and hydration, communication and medicines. One person's play learning and development plan contained phrases such as 'I love my sensory toys and lights' and 'I like to spend time in my B chair and watch television'.

Records confirmed care plans were reviewed on a regular basis, in line with people's changing needs. The registered provider completed regular reviews of care plans with the involvement of people and relatives to ensure they reflected people's needs and were up to date.

People and relatives told us they felt involved in the ongoing planning of their care and support. A relative told us, "I speak to [co-ordinator] at least twice a week just to touch base to see how everything is." Another relative said, "I have three monthly meetings with Voyage. We have a handbook and care plans in place. Very happy indeed."

Care plans we viewed contained consent forms signed by people or relatives. These were to confirm care plans had been discussed and agreed with people and to confirm their consent to the support detailed.

People we spoke with knew how to raise concerns with the provider if they were unhappy with the service. They were confident issues would be resolved. One person said management was, "Good, but I had to complain once about a carer I did not want them to come anymore. They sorted it straightaway." Another person told us, "I needed to speak to the service some time ago now about one carer who just wasn't really listening to us, this was sorted. No problems at all now." A third person commented they'd "never needed to complain". A relative told us, "If I did have a concern I would ring the nurse."

We viewed the provider's electronic complaints log which contained seven complaints about the service in the last 12 months. We saw the complaints were recorded, investigated and outcomes were fed back to complainants and other relevant parties. Action the provider took was also recorded and included actions

such as raising safeguarding alerts, changing rotas and discussions during staff supervisions.

Good

Is the service well-led?

Our findings

At the last inspection in July 2015 we found the registered provider didn't have effective systems in place to regularly assess and monitor the quality of the service provided. The registered provider had a system in place for quality assurance checks and audits. But there was no evidence of those systems being used.

During this inspection we found improvements had been made. The registered provider had a robust quality assurance system in place that promoted best practice and identified improvements that were then acted upon. Audits regularly carried out related to medicines, falls, complaints, accidents and incidents and care diaries. There were also client specific audits carried out. For example, a person's bowel chart was audited to ensure it had been completed correctly and staff had been monitoring a person's bowel movements who was at risk of constipation. Any issues or improvements identified were communicated to staff and appropriate action was taken.

At the inspection in July 2015 people told us they never received visits from senior staff to carry out spot checks on care staff while providing support. During this inspection we asked people and relatives about spot checks and if they were taking place. One person said, "Yes they come in and I do have regular contact with the coordinator." Another person told us, "We just had one not that long ago." Records demonstrated spot checks were taking place on a regular basis. Completed checks covered staff appearance, timekeeping and quality of the support they were providing.

The provider sent out surveys to people, relatives and staff annually. Results were recorded, analysed and actions were generated from the feedback received. Records showed the registered manager also compared feedback and results with those received from the previous surveys sent out. All actions were then fed into the ongoing improvement plan for the service and signed off when appropriate action had been taken. The latest round of surveys sent to people and relatives were still being received at the time of the inspection. From those received we noted positive comments such as 'excellent, always excellent', 'carers extremely kind and reliable', and '[family member] is always treated with extreme respect in spite of them being unable to communicate'.

The service regularly sought views from people and their relatives in relation to the quality of the service. Supervisors met with people and their relatives face to face regularly to discuss the quality of the care and support they received. Specific questions included suitability of care and support, what was going well, any concerns or issues, suitability and approach of staff, medicines and moving and handling practices. We saw from records that any issues identified where people weren't happy or satisfied with a particular aspect of the service were recorded. The registered manager and senior staff signed off when planned action had been taken to improve the quality of service provision for individuals. Action taken included to observe new care worker and to revise staff rotas.

Relatives told us they had seen significant improvements in the service over the last eighteen months. One relative told us they'd "noticed a massive difference since [senior staff] have come on board. They went on to say, "It's gone from 'it's all right to a service I can really advocate for."

The home had an established registered manager who had been in post since December 2015. They were proactive in meeting their responsibilities in relation to submitting statutory notifications to the Care Quality Commission.

Relatives and staff told us the registered manager was approachable and supportive. One relative said, "[Registered manager] is fab. You can pick the phone up to speak to her about shift changes or anything." A member of staff told us, "I deal with [registered manager], is very nice if there is any problems it's sorted. I am really happy with my job."

Out of hours arrangements were in place for staff to be able to contact a senior member of staff if they had any issues or required guidance. People and relatives were also able to speak with a senior member of staff if required. The senior on cover duty maintained a log of calls received, what they entailed and any action taken. This was then handed over to other senior staff the next working day and logged on the electronic system. Actions included arranging staff cover and informing staff of cancelled calls.

The provider held regular staff meetings. From minutes viewed we noted discussions included people, medicines, accidents and incidents, safeguarding concerns and complaints. All discussions and agreed actions were recorded in the minutes and reviewed at the next meeting.

The service had received a number of compliments and thank you cards from people, relatives and health professionals. One email from a relative stated, 'Thank you for strong communication and listening to people's wishes.' Another compliment received from a health professional stated, 'Can you please thank your staff for the care they have shown [person] and their family since they were involved in the package.'