Voyage 1 Limited

60 Cobham Road

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected 60 Cobham Road on 21 June 2016, the inspection was unannounced. Our last inspection took place on the 20 May 2013 where we found the provider was meeting all of the regulations we checked.

Cobham Road is registered to provide accommodation and personal care for up to six people with a learning disability and who are neurodiverse. The home is located in the village of Fetcham, between Cobham and Leatherhead in Surrey, with convenient access to local shops. On the day of the inspection there were four people living in the home.

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

Information about the home was accessible and understood by people who used the service. People had communication plans in place and staff followed these. People were listened to and their rights were respected and staff provided person-centred care.

Recruitment checks were completed to assess the suitability of the staff employed. Staff received suitable training and good support from the registered manager to enable them to carry out their roles. There was a suitable number of staff to meet the needs of the people who used the service.

The provider ensured the administration, storage and disposal of medicines were managed safely.

Systems were in place to effectively improve the quality of care delivered. However impartial feedback was not sought from people to obtain their views and comments regarding the service.

Suitable arrangements were in place to ensure people received good nutrition and hydration. Good food hygiene practices were followed by staff working in the home.

Staff had a good understanding of safeguarding procedures and followed protection plans to minimise the risk of harm to people. Prevention measures had been put in place to minimise future re-occurrences of any incidents.

People were supported by staff to attend health care appointments when there were changes to their health care needs or associated risks to their health. Staff did not always follow the legal requirements in relation to the Mental Capacity Act 2005. Staff understood the MCA and presumed people had the capacity to make decisions first. However, where someone lacked capacity, best interests decisions about whom else could make the decision or how to support the person to be able to make the decision was not sought.

People were supported to maintain positive relationships with their relatives and friends. Relatives were complimentary regarding the care and support provided by staff. People had access to activities that were important to them and were encouraged to be active in the community.

Relatives knew how to make a complaint and were confident any concerns would be resolved. There was an easy read complaints policy available for people.

We found one breach of regulation relating to consent. We have also made a recommendation about obtaining the views of people who use the service. You can see what action we asked the provider to take at the back of the full version of this report.

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.

Staff understood what abuse was and knew how to report concerns if required.

Staff were aware of the risks to people and how to manage them.

There were enough qualified and skilled staff at the service to meet people's needs.

Staff followed safe practices for the administration, storage and disposal of medicines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always follow the legal requirements in relation to the Mental Capacity Act 2005.

Staff received the appropriate training and support to deliver good standards of care to people.

People received good nutrition and hydration and people were involved in the choices regarding food preferences.

Staff supported people to visit health care professionals to ensure their health care needs were met.

Is the service caring?

Good

The service was caring.

Relatives told us staff were welcoming and caring, and involved in making decisions about their care.

People were encouraged to be active in the community and take part in the hobbies and interests that mattered to them.

Staff treated people with dignity and respect and helped people

to remain independent when supporting them with care.

Is the service responsive?

Good

The service was responsive.

People had access to activities that were important to them. These met people's individual needs and interests which promoted people's well being.

People's individual religious, cultural and lifestyle needs were met. The service had a strong commitment to providing person-centred care.

People and their relatives were given the opportunity to raise any concerns, and were confident if any concerns were raised, these would be resolved.

Is the service well-led?

Good

The service was well led.

Staff were kept informed about matters that affected the home and gave positive feedback about the support they received from the registered manager.

The registered manager carried out regular audits and continually strived to improve the service.

Systems were in place to monitor the quality of the service provided. However, we found that impartial feedback was not always sought from people who used the service.

60 Cobham Road

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.

We visited Cobham Road on 21 June 2016 to undertake an unannounced inspection of the service. The inspection was carried out by one inspector.

We checked information that the Care Quality Commission (CQC) held about the service which included a Provider Information Return (PIR), previous inspection reports and notifications sent to CQC by the provider before the inspection. The PIR is a form that asks the provider to give some key information about the service, including what the service does well and any improvements they plan to make. The notifications provide us with information about changes to the service and any significant concerns reported by the provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with three relatives and spent time observing the care people received. We contacted the local authority and Healthwatch and spoke to two health and social care professionals who confirmed they had no concerns about the service. Healthwatch are a consumer group that gathers and represents the views of the public about health and social care. We did not receive a response from Healthwatch.

We looked at four people's care records including their medicines records. We also spoke with two senior support workers, one care worker, an aromatherapist, the operations manager and the registered manager. We also looked at five staff recruitment and training records, minutes of meetings with staff, quality assurance audits, complaints, staff rotas and some of the provider's policies and procedures.

Good

Is the service safe?

Our findings

Relatives described the service as safe and told us, "My family member is content and it's very obvious he/she approaches staff very comfortably." Another relative told us, "I turn up at the home unannounced, and every time I do I can see [my family member] is very well cared for. I always leave the home very happy, because I know my [family member] is happy."

People were safe as there were systems in place to reduce the risks of harm or potential abuse. There was a safeguarding policy that guided staff as to the correct steps to take if they had a concern and staff knew how to access this. All of the staff had received training in safeguarding adults. Staff understood how to whistle blow if they had a concern that they wanted to report about the workplace. Any outcomes following safeguarding concerns showed that the agreed preventative measures had been put in place and the guidelines had been followed by staff to minimise further harm to people. For example, we saw that there was intervention from the behaviour support team following concerns where people's behaviour had become challenging to the service.

Risk assessments for people were detailed and informative and included measures that had been introduced to reduce the risk of harm to people. This included assessments on the environment, personal care, communication needs and medicines management. One senior support worker had worked in the home for 13 years and explained because people communicated with their body language, staff recognised people's triggers that may cause their behaviour to become challenging to the service and knew what actions should be taken, such as taking the person for a short walk or not changing people's routines. We saw there were risk assessments in people's care files' to help staff understand behaviour that challenged and identify ways of supporting behaviour change, these were called antecedent, behaviour and consequence (ABC) charts. The aim of using an ABC chart is to better understand what the person's behaviour is communicating. People's care plans contained a missing person's procedure and included the relevant information to give to the police; such as a photograph and a physical description of the person. This showed that the provider had systems in place in the event that a person needed to be reported as missing.

Staff rotas demonstrated there were enough care staff to provide care and support to people during the day and night; with the right qualifications and skills to keep people safe. The registered manager told us they used bank staff to cover any shifts in the event staff had taken planned leave. We saw records to show that the staff had worked in the home for a number of years including the registered manager who had been in post since the service opened.

Staff recruitment files contained documents that had been obtained before each person started work. The registered manager told us staff references were held at the head office and sent us the documents after the inspection. We saw that the documents included two references, evidence of the person's identity and a full employment history. Staff told us that before they started work at the service they went through a recruitment process and had to provide evidence of their identity and background checks. Criminal records checks were carried out for all staff before they commenced working in the service to ensure that they were

suitable to work with people using the service.

We looked at medicines and found there were safe practices for the administration, storage and disposal of medicines. The medicine cupboard was locked and only appropriate staff had the key to the cupboard. We looked at the medicines administration records (MAR) charts for people and found that administered medicines had been signed for. Repeat prescriptions for people provided a four-week cycle that showed medicines were being prescribed, ordered and administered in a timely fashion. There were photographs of people in the front of each chart to identity who the medicines had been prescribed for and we saw staff followed the appropriate guidance when administering 'as required' medicines. There was guidance in place on best practice and where people had refused their medicines this was recorded on the MARs. One person had epilepsy and we saw there was a comprehensive plan in place. We found that when the person had a seizure staff had administered medicines and recorded the length of the seizure and that two care workers had signed the epilepsy chart.

There was a separate lockable cupboard for the storage of controlled drugs (CDs) and a CDs register. The CDs register showed two care workers had signed for controlled drugs and other records demonstrated that any surplus medicines were disposed of safely. There were homely remedies such as topical creams stored in the medicines cupboards. We found good practice when regarding the guideline for homely remedies, for example, we saw written records which showed this had been signed and verified by the GP. People's medicines were reviewed regularly and staff were knowledgeable about the importance of administering medicines for people. Training records demonstrated staff had completed medicine training and regular audits of medicines had been completed by the registered manager.

We found the environment safely met people's individual needs. Following a fire safety inspection in November 2015 we found that the provider had completed the actions that were recommended by the Fire Safety Officer. Fire tests and drills were carried out and individual personal emergency evacuation plans (PEEPS) were completed and kept in people's care records.

During our tour of the home we noticed a malodour from one person's bedroom. The registered manager informed us that flooring had been replaced throughout the home apart from one person's room and had reported this to their maintenance department, however this had not been actioned by the provider. We spoke to the operations manager who told us they were aware of the concern and would seek to resolve this issue with immediate effect.

One relative told us, "When visiting the home we were invited to see [our family member's] room, the home was totally tidy and [our family member's] room was very orderly." We saw that all other areas of the home were very clean and we viewed records that demonstrated the home was cleaned daily and room checks were carried out by staff to help support people to tidy their rooms. To ensure the home was kept safe for people, professional maintenance and servicing of equipment was routinely carried out, including regular water temperature and legionella checks to ensure the safety of people's health and well being.

Requires Improvement

Is the service effective?

Our findings

Staff did not always follow the legal requirements in relation to the Mental Capacity Act 2005 (MCA). The 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. We found that care plans held mental capacity assessments for people, and best interests meetings were held for people but these were not always completed for specific decisions. For example, we saw that where one person had been referred to a health professional for treatment a capacity assessment had been completed and a best interests meeting had taken place. However we found one person had no relatives and we saw their finances were managed by the provider. There were no records to show a best interests meeting had been held to discuss this aspect of the person's care, or that an Independent Mental Capacity Advocate (IMCA) had been sought for that person who required support with a particular decision. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. We looked at the provider's policy in relation to the Deprivation of Liberty Safeguards, which advised 'it is a legal requirement that the decision maker refer to the IMCA service those persons who lack capacity and where there is no family or significant other to support the person'. We found the provider's policy had not been followed.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The registered manager and staff had received training in understanding the principles of the MCA and DoLS. Following MCA guidance the registered manager had made four applications to the local authority for DoLS and we saw records from the local authority to show these were in the process of awaiting allocation for assessments.

Relatives were complimentary about the care and support provided by staff. One relative said, "They seem to be doing a really good job, they work with [my family member] to give him/her the care that's required, they look after [my family member] and make him/her comfortable and happy."

There were suitably qualified staff working in the home. Staff's compliance with the provider's mandatory training was managed electronically. The system sent alerts to staff when they were due to attend refresher training and staff then booked themselves on to available courses. The training courses which staff had completed included, epilepsy awareness, medicines administration, sexual health awareness, autism,

learning disabilities and mental health, first aid awareness, fire safety, equality and diversity, MCA and DoLS. Staff had also received specialist training on positive interventions to support people who behaved in a way that challenged. This was tailored to the individuals using the service and gave staff the skills to diffuse situations and reinforce positive behaviours when people behaved in a way that put themselves and/or others at risk. Staff told us they received regular supervision and appraisals, which encouraged them to consider their care practice and identify areas for development. The staff also attended team meetings that were held every month to give staff the opportunity to discuss best practice regarding how to support people and any areas of concern.

Staff supported people to maintain a balanced diet. People were involved in developing the menu and staff were aware of their likes, and preferred meals. There was a pictorial menu to show people the choices of food that were available that day and we saw in people's care files their dietary needs had been reviewed. Staff, on the whole, made the meals for people, but in addition people were encouraged to participate in meal preparation and some people were able to make drinks for themselves. Staff told us that one person had difficulty with eating and swallowing, and showed us the guidelines that were in place to support the person with their meals. These had been signed by all the staff to show they had read and understood the person's needs.

Staff had completed 'eating awareness training' provided by the speech and language therapist (SALT) to show how best to support people who had difficulty eating meals. We looked in the fridges and cupboards and found they were stocked with fresh foods, such as fruit and vegetables. Staff told us people had access to the kitchen to prepare snacks and drinks. People's favourite meals were recorded in their care plans, such as chicken curry. We observed an evening meal and saw that people were offered good sized portions of food. People were offered second helpings of the main meal and the care worker had taken the time to attractively present the food to show people they were valued. People were able to use the utensil of their choice and there were plate guards available if these were required. We observed drinks were readily available for people throughout the day.

We found that good food hygiene practices were followed, fridge and freezer temperature checks were completed daily, and food items were stored appropriately, sealed and labelled with the dates they were opened. Daily cleaning rotas were displayed on the kitchen noticeboards and signed daily by the care workers and there were concise records of food temperature probes documented by staff members. The service had received a '5 star' food hygiene rating which is the highest score.

One relative explained that staff knew how best to support their family member when attending health appointments , "I remember [my family member] had a terrible cold and they took him/her to see the doctor but he/she does not like doctors and my [family member] became challenging but the staff know how to manage his/her behaviour very well."

Care plans contained a record of input from health and social care professionals, such as GP, dermatologists, psychiatric and community nurses and occupational therapists. We found that people attended health appointments frequently and outcomes of the appointments were written in people's Health Action Plans (HAPs).This holds information about the person's health needs, the professionals who support those needs, and their appointments. The plan showed that people had full health checks and their needs were regularly reviewed. People had comprehensive oral hygiene plans in place that showed how staff should support people with their oral hygiene needs. Hospital passports were completed so people could show these to health professionals when attending hospital appointments. This contained information on, for example, how best to communicate with the person, how he or she shows pain, and the best way to give medicines. This meant that health services could make reasonable adjustments to ensure

that they were able to meet the health needs of people with multiple complex needs.

Good

Is the service caring?

Our findings

Relatives told us their family members were supported by staff that were caring. One relative told us, "We took some photographs of [our family member] when we recently visited the home, it's not often we find him/her smiling but we did. We are really pleased, the carers are very welcoming and caring."

Staff were observed to be supportive and caring when helping people in the home. Conversations with people were kind, respectful and appropriate explanations were provided when people needed these. We heard people being offered choices and we saw how people were encouraged to express their decisions. People were included in all discussions with staff whenever they were present, they were allowed time to reply in their own way. We observed staff communicating with people well. They understood the requests of people who found it difficult to verbally communicate. When asked, staff members knew how people communicated different feelings such as being unhappy or in pain so that they were able to respond to these.

People made their own informed choices about their care and a relative said, "If you ask [my family member] one word he/she will point to it, they are teaching [my family member] sign language." We found there were communication plans and these included the Picture Exchange Communication Systems (PECS) to help understand how best to support people. PECS is a picture-based communication system used to reinforce communication skills for people with complex needs. We saw PECS was used to better understand people's needs and listen to their views. Care plans recorded that staff must 'put the person in the centre of every decision made' and offer the best way to present choices, we saw this was acted on and family and health professionals were involved in these decisions also where appropriate.

People were encouraged to be part of the community. During our inspection people were taken out in the provider's minibus to lunch, and people regularly attended their local church where they were a valued member of the congregation. People were listened to and their rights were respected, for example, we saw that people were registered to vote and able to have a say on whom they would like to represent them in their local community. One relative explained how much their family member enjoyed football, and the staff had taken their relative to a football match to support their favourite team. We saw photographs of the event, and the person's room held a collection of books about their hobbies and interests.

Staff understood how to support people to be independent and there were discussions about people's needs. We saw people were allocated certain days to use the laundry room and help prepare lunch or dinner, this was displayed in a pictorial format on noticeboards so the information was accessible and understood by people who lived in the home. Daily records and care plans contained written records on the choices offered to people about what they would like to eat, drink and the daily routines they had completed in the home.

Relatives told us that their family members were treated respectfully and were always well presented in all aspects of their personal care and appearance. Care plans showed that people liked to be offered a choice of specific hair and bath products and when supporting people with their personal hygiene, advised staff

must ensure they maintained people's dignity and respect at all times. We observed staff respecting people's dignity and privacy. We saw that staff knocked on people's doors before entering their rooms and when people were being supported with their personal care needs this was done privately in their own rooms. There were spacious communal areas and a large well maintained garden where people could relax and enjoy time on their own if they wished.

People were supported to maintain positive relationships with family, friends and staff. Staff told us the importance of people keeping in contact with friends and relatives and placed this as an important aspect of people's well-being. We saw people had relationship maps in their files, there was a photograph of the person placed in the centre of the map and included the names of the relatives and friends who were important and special to them. We found written letters and birthday cards to one person from a former teacher and staff told us the teacher had kept in contact with the person for several years. Relatives confirmed they were invited to the home frequently, and we saw photos of where people had celebrated special events such as birthdays and religious festivals. This demonstrated that people's relationships and preferences were recognised, valued and celebrated.

Good

Is the service responsive?

Our findings

We asked people's relatives if the service was responsive to their needs and one relative said, "They walk [my family member] to the newsagents every day and gets a paper to read, this is an important part of their routine. They even know [my family member] at the shop. I have attended a meeting to see how he/she is getting on."

The care and support plans that we looked at showed that the provider had conducted a full assessment of people's individual needs to determine whether or not they could provide them with the support that they required. Care plans were in place to give staff guidance on how to support people with their identified needs and we found these were person-centered. There was information provided that detailed what was important to that person, how to keep people healthy and safe, how to give people recognition for an accomplished task and their likes and dislikes.

People were encouraged and supported by staff to engage in leisure activities outside of the home. We were shown photographs of activities and holidays that people had attended, with support from the staff team. This included events and entertainment, visiting farms and local parks, a trip to Brighton, an outing to the theatre including an open top bus ride, a trip to the zoo, a holiday to Paris and meals out at local restaurants. People's religious, cultural and lifestyle needs were identified and met. People were supported by staff of the same or opposite gender if requested, and took part in religious celebrations and the interests that were important to them. Some people had identified they liked nice clothes and different styles of music. Their care plans showed how staff supported them to meet their needs, through individual activities or group outings with other people that shared their interests. Staff explained that the activities were flexible depending on what people wanted to do.

On the day of our inspection we saw that planned activities were available and that people attended the local day centre three times a week. We spoke to an aromatherapist who visited the service once a week and had worked with people in the home for nearly 16 years. The aroma therapist explained that people in the home thoroughly enjoyed the relaxing hand and foot massages. The registered manager was complimentary about the service people received from the aromatherapist, and explained that the service had a positive effect on their well being.

We observed that staff were responsive to people's needs. They provided them with drinks when people indicated that they were thirsty, food when it was requested and provided personal care in a timely manner. Staff members described the needs of people they cared for and what they needed to do to make sure people were helped to meet their needs. We looked at one person's care records and found that staff members had carried out the actions, such as assistance with tidying their rooms and supporting people with activities in the community.

Relatives we spoke with told us the registered manager and staff were approachable, listened to their concerns and acted to resolve them. One relative told us, "I have never had a cause to complain my [family member] is living the best quality of life." We saw systems were in place for recording and managing

complaints. The provider had received one complaint since the previous inspection which had been resolved. There was an easy read complaints policy available for people. The procedure gave information about external organisations that people could take their complaint to if they were not satisfied with the provider's response, such as the Surrey Partnership Board.

Good

Is the service well-led?

Our findings

All the relatives we spoke with told us they thought the service was well run. One relative said, "[Registered manager] is absolutely lovely, when I first met him years ago he was the main carer for [my family member]. He told me anytime you want to chat just give me a call."

Staff described the registered manager as supportive and said he treated them as a valued member of the team. One care worker told us the culture of the home was like being part of a large family. Staff members told us that the registered manager had an open door policy, maintained a visible presence around the home and was always willing to step in and assist when needed. We observed this during our inspection. Staff were aware of the management structure within the provider's organisation and who they could contact if they needed to discuss any issues. The registered manager had completed training that was reflective of the needs of the people who lived in the home. This included a higher national vocational qualification in health and social care, promoting independence and leadership programmes.

Daily handovers were recorded by staff after each shift and included the handover of keys, medicines and finance checks, staff observations and tasks staff were allocated to complete during their shifts. Staff said that they were kept informed about matters that affected the home through team meetings and talking to the registered manager regularly. They told us about staff meetings they attended and that the registered manager fed back information to staff who did not attend the meetings. The most recent staff meeting minutes were available and detailed any changes regarding the home. Included in this was a discussion regarding the budget for activities for people and property and maintenance, which had been identified as needing improvements.

The registered manager completed audits of medicines, health and safety, and care plans amongst other areas. We found that annual service reviews had been sent to the key people involved in their care. These were passed to the registered manager and operations manager for collation and analysis for trends and themes which produced the quality development plans. The plans highlighted what improvements needed to be made and what is working well. For example we saw that a former teacher had provided feedback on the experience of working with a person, including how the person likes to follow and memorise words and their dislike of loud noises. We saw the service had developed a comprehensive care plan based on the feedback and this was included in a review of the person's needs.

The operations manager visited the home monthly to check on how the home was running and that audits were carried out quarterly, for example on peoples' finances to ensure accurate receipts and records were signed by care workers and authorised by the registered manager. Quality and compliance visits were carried out in the home and we found that these were based on the five key questions embedded by the Care Quality Commission (CQC).

Formal questionnaires had been sent to people and their relatives and health and social care professionals involved in their support in May 2015. The registered manager told us surveys for May 2016 had been sent out but they were waiting for responses. However, we found that surveys sent to people using the service

were completed by staff based on their views of how they thought people saw how the service was run. We spoke to the registered manager and explained that feedback must be impartial and conducted in a way that people understood. The registered manager agreed with this and said he would seek to resolve this.

We recommend that the service seeks advice from a reputable source about obtaining the views of people who use the service, based on current and best practice, in relation to people with complex needs.

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 11 HSCA RA Regulations 2014 Need for consent How the regulation was not being met: Consent was not always sought where people lacked the capacity to make an informed decision, or give consent in accordance with Mental Capacity Act 2005 and associated code of practice. Regulation 11(1)(3)