

Voyage 1 Limited

Voyage (DCA) South 2

Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

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

The inspection took place on the 21 and 22 June 2018 and was announced, as visits to people in their own homes needed to be arranged with them. The service is registered to provide personal care to people in their own homes. At the time of the inspection the service was supporting 16 people with learning disabilities and/or mental health needs across Gloucestershire and Herefordshire. Not everyone using Voyage (DCA) South 2 receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

This service provides care and support to people living in four 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. People lived in a range of houses and flats, some located in ordinary residential streets. The two homes we visited during this inspection were three and four bedroomed homes, with shared communal areas and a room where sleep-in staff slept at night.

At the inspection in April 2017 we rated the service 'Requires Improvement' overall. This was because we found recruitment practices did not meet required standards and we had not been notified of all safeguarding incidents occurring at the service as required by law. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when, to improve the key question 'Is the service safe?' to at least good. The provider told us their action plan would be completed by 26 August 2017.

At this inspection on 21 and 22 June 2018 we rated the service 'Good' overall.

Why the service is rated Good:

At our June 2018 inspection, we found improvements had been made to recruitment practices but checks where staff had previously worked in care needed to be more robust. Despite this, there was no impact on people's safety as the systems in place to induct and monitor staff performance protected people from poor practice. Staff knew how to safeguard people from harm. We recommended that the service review recruitment processes for staff who had worked in care before. We found improvements to notifications to CQC had been met and sustained.

People's needs had been assessed and their support requirements and preferences were recorded in detail to provide staff with the guidance they needed to support people. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The service's policies and systems supported this practice. Effective systems were in place to manage people's medicines. When medicines errors occurred, staff underwent retraining and further competency checks. People were supported to access health care services and to maintain a healthy lifestyle.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. Outcomes for people were good and they were supported to live as fulfilling lives as possible. People described their home as, "a happy home".

Enough staff were available to ensure people's well-being and for people to participate in activities safely. Staff understood people's needs and completed appropriate training to enable them to meet people's individual needs. Staff felt supported and well trained and had access to the guidance they needed to support people effectively.

The registered manager had been in post since March 2018. 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. They were registered to manage the service on 22 June 2018.

Effective quality monitoring and improvement systems were in place. The service had an open and progressive culture to improve people's quality of life. People and their relative's views were sought and acted upon if any concerns had been identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

People were safeguarded from the risk of being supported by unsuitable staff, however recruitment checks for staff who had previously worked in care needed to be more robust.

Safeguarding incidents were reported in a timely way and appropriate agencies were involved.

People were protected against health related and environmental risks and there were enough staff recruited to meet their support needs.

People were supported to take their medicines safely and plans were in place to keep them safe in the event of an emergency.

Requires Improvement ●

Is the service effective?

The service was effective.

Staff had the skills and knowledge to meet people's needs and were supported to carry out their roles.

People's consent was routinely sought. Capacity assessments were completed when people may be unable to consent to the care provided or make specific decisions.

People received a balanced diet and were supported to have enough to eat and drink. They were supported to access health care.

Good ●

Is the service caring?

The service was caring.

Staff developed positive friendly relationships with people who used the service. People were treated with respect, kindness and compassion.

People were listened to and were involved in decisions about their care.

Good ●

People's dignity and privacy was maintained and their independence was promoted.

Is the service responsive?

The service was responsive.

People received personalised care and were consulted about the support they received. Staff knew people well and helped them follow their interests and realise their aspirations.

People were enabled to maintain relationships and communicate with those who mattered to them.

People could raise complaints and these were listened to.

Good ●

Is the service well-led?

The service was well led.

There was a positive culture within the service and the provider's vision and ethos were demonstrated by staff.

Staff, people and their relatives spoke positively about the management team.

There were effective systems in place to monitor the quality of the service.

Good ●

Voyage (DCA) South 2

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 was announced. We gave the service 48 hours' notice of the inspection because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. We also asked the registered manager to arrange for us to speak with staff and to seek consent from people to visit them in their own homes.

Inspection site visit activity took place on 21 June 2018. It included visits to two homes where we met seven people the service supports, observed people's interactions with staff, reviewed care records and spoke with staff. We visited the office location on 22 June 2018 to see the registered manager and office staff; and to review records and policies and procedures.

One inspector carried out this inspection. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law.

As part of this inspection we got feedback from four people using the service and observed staff supporting another three people. We reviewed four people's care records. We checked medicines records for five people. We reviewed the processes in place for managing medicines and the use of 'as required' and emergency medicines. We spoke with the registered manager, their deputy, the operations manager and five care staff. We looked at the recruitment records for four staff, staff training records, policies, complaints, accident and incident records and quality assurance systems. Following the inspection, we spoke with the relatives of three people the service supports. We sought feedback from commissioners and health and social care professionals who regularly work with the service.

Is the service safe?

Our findings

At our last inspection in April 2017 we found a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 where recruitment practices did not meet required standards. The provider completed an action plan to show what they would do by 26 August 2017, to address the shortfalls. At this inspection we found improvements to recruitment practices had been made and the service was meeting the relevant regulation.

People were protected against the employment of unsuitable staff. Required recruitment checks had been completed, including those to ensure staff were of suitable character. Staff were subject to criminal record checks before starting work at the service. These checks are carried out by the Disclosure and Barring Service (DBS) and help employers to make safer recruitment decisions and prevent unsuitable staff being employed. However, we found checks on staff who had previously worked in care roles needed to be more robust. For example, evidence of conduct had been sought for one staff member's care role at the time of recruitment but not for a previous care role. There was no record the service had been contacted to request information about disciplinarys and reason for leaving which were not provided. We discussed this with the registered manager and their area manager who understood why this was necessary and told us how they would address this.

We recommend that the service review the processes in place for scrutinising evidence of conduct during recruitment of staff who have previously worked in care.

Despite a need for this part of the recruitment process to be more robust, the impact on people was minimal, due to the processes in place to support and assess the performance of new staff. All staff completed an induction, including completing required training and working alongside experienced staff to familiarise them with people's support needs. Staff worked a six-month probationary period, during which their performance was reviewed. Where staff did not meet the provider's expectations, including completing required training, following support plans and appropriate conduct, disciplinary action was taken.

Staff had completed training in the safeguarding of adults and understood how to recognise and respond to potential abuse. This included awareness of local safeguarding procedures. Staff told us they would escalate concerns to the provider's senior managers or external agencies if needed. Records were completed for any marks or bruising found and checks were completed to ensure any injury was consistent with the explanation. People sought support from staff when they had concerns. This was promoted through the provider's 'see something, say something' initiative. Information about this was found in communal areas within people's homes. One person said, "Staff listen to what's worrying me": They were aware of behaviours that were unacceptable from others and should be reported.

Risks to people had been assessed and people's support plans described action staff should take to reduce these risks. This included the support they needed to access and participate in community and home-based activities as well as support they needed to manage health related risks. For example, one person was prescribed a medicine used to control prolonged seizures. The staff member supporting them confidently

told us how they respond to keep the person safe, should they have a seizure. Their response was consistent with the actions set out in the person's support plan, which including timing the seizure and summoning emergency medical care.

When people's needs changed, staff responded appropriately to ensure people's safety. This included involving professionals to review their needs. For example, one person had become anxious the week before our inspection which resulted in some challenging behaviours that were out of character. Staff sought immediate support from the on-call staff member, kept others safe and helped the person return to a calm and relaxed state. Behavioural specialists and the community learning disabilities team (CLDT) were involved to identify the cause of the anxiety and update the support plan.

Staff told us expected staffing numbers were met. One said, "Very, very rarely there are not enough staff to do the planned activities. This happens when there are last minute changes (such as staff sickness at short notice)". All staff we spoke with were highly complementary of the support they received from senior staff on call. One said, "I've only got praise for the on call. They are always available to ring. They will always do what they can to help you. All three [registered manager and both field support supervisors] are straight on it, supporting you in any way they can".

People's medicines were managed safely. Systems were in place to reduce the risks to people, including regular stock checks and safe storage and return facilities. Accurate Medicines Administration Records (MAR) were maintained and clear protocols to guide staff in the use of as required [PRN] medicines were in use. Staff responsible for administering medicines completed competency checks before they were assessed as competent. When medicines errors occurred staff took appropriate action, seeking medical advice to ensure people's safety. Staff involved in a medicines error were routinely removed from this task until they had been assessed as competent following further training.

Assessments had been completed for each person to determine their ability to self-medicate and manage their medicines. Where possible, people were supported to become more independent with this and individual medicines storage cabinets had been purchased to allow people to store their medicines in their own room safely. The registered manager told us the number of medicine errors had dropped since this change had been introduced.

People were supported to maintain the cleanliness of their home. Systems were in place to protect people from the risk of cross infection. This included cleaning schedules for staff, fridge and water temperature monitoring, use of personal protective equipment and colour coded mops for different areas in the home. The registered manager had a system in place to monitor progress on maintenance requests made to landlords to ensure people's homes remained in a good state of repair. An Infection Prevention and Control Annual Statement had been prepared to show current best practice was being implemented.

Accident and incident records were entered into the provider's electronic record system. Incidents were graded according to their seriousness and those graded 'high' or 'very high' were flagged to the provider's senior management team for review. Direct changes to processes were made when improvements to the systems in place may prevent a similar incident from occurring. Similarly, the provider's 'behavioural therapist' monitored behavioural incidents and 'as required' medicines to ensure these were appropriate and the measures in place were effective.

Is the service effective?

Our findings

People's needs were assessed by a member of the management team, to determine whether the service could meet the person's needs, prior to offering to provide a service to them. These assessments were based on recommendations by health and social care professionals, information from existing care providers, the wishes of the person and their close relatives or advocate. People's spiritual, religious, sexual and cultural needs were included. A social care professional told us it had taken a long time for a person they commissioned care for to be placed. The registered manager explained the process could be lengthy as suitable accommodation was not always available and transitions were carefully planned to minimise the impact on people: Managers were aware of potential delays and had "met to discuss how they could manage the process more effectively, within a good time frame".

Staff were supported to meet people's needs in line with current guidance and standards. For example, the Community Learning Disability Team (CLDT) and the provider's behaviour support specialists assisted in understanding people's anxiety related behaviours and agreeing suitable behaviour support plans. The provider's area manager told us STOMP guidelines were being integrated throughout the organisation. STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines. It is a national project helping to stop the over use of these medicines.

A staff member told us how they had worked with a person's GP to reduce their medicines which staff believed could be the cause of mood swings. They said, "We kept on going to the doctor to review, they eventually decided [person] didn't need them anymore. [Person's] not having many behaviours now. I think it's to do with finally having a stable staff team that [person's] used to. We saw a really dramatic change." This person had experienced three to four anxiety related behaviours each week, this had reduced to one every three to four weeks. They told us, "When I get anxious, staff sit down and talk to me."

People were supported by staff who received appropriate training and support. A mandatory training programme was in place and staff had regular meetings with their supervisor where their individual needs were discussed. Mandatory training included first aid, infection control, equality and diversity, moving and handling and fire safety. Staff received training specific to people's individual needs, such as autism, mental health awareness, managing epilepsy and challenging behaviours. The provider monitored completion of training and above 92 percent of expected training had been completed in all areas.

Staff who were new to care completed the Care Certificate. This is a set of national standards that health and social care workers adhere to in their daily working life. All staff were encouraged to go on to complete Qualification and Credit Framework (QCFs) awards in health and social care. A staff member said, "I was happy with my induction. I had seven shadow shifts. You can have as many as you want until you're confident to lone work."

Two senior staff, in 'field support supervisor' roles, also undertook managerial level qualifications. We observed the supervisor's in action, supporting staff and making sure staff were confident and equipped to meet people's needs. Staff were very positive about the support they received within the organisation. One

said about the management team, "They notice that you're putting 100 percent in. They know I want to progress. I've signed up for my NVQ [QCF]."

People's weight was monitored monthly to ensure they stayed within recommended healthy limits. One person was encouraged to have a larger portion size as they needed to put weight on. Healthy food options were encouraged and a balanced meal was prepared each day such as a roast, sweet and sour chicken, stew or spaghetti bolognese. These included fresh or frozen vegetables and fresh fruit was available for snacks. On the weekends, people sometimes opted to buy themselves "special stuff" as a treat. People's food intolerances or allergies had been noted and support plans included helping to choose nutritious meals and stay hydrated.

Staff worked with others to ensure effective support was provided to people. For example, staff generally supported the same people on a regular basis but when requested they covered shifts at other group homes to ensure people's needs were met. Comments from external professionals included, "I've always found them extremely helpful. We work well together. They are quick to refer things to me" and "Staff work well in regard to communication. They act on our feedback". In their feedback to us, a commissioner raised concerns about the way one person's support had been provided. We spoke with the registered manager about this, who had since met the commissioner and explained why. An appropriate plan had been agreed to help the person adapt to their new circumstances and accept the support they needed.

People had health action plans which set out their support needs for maintaining their health and well-being. People were supported to attend an annual health check where their health and medicines were reviewed by a health professional. When one person declined to attend, staff involved the person's close relative to support them. People were supported to access dental, optical and specialist healthcare. People were encouraged to participate in exercise based activities such as swimming, mini golf and walking.

Records demonstrated that people's requests regarding improvements to the décor of their homes were communicated to the landlord. Action was taken to ensure the premises remained suitable for people's changing needs. One person found stairs difficult to manage; Their bedroom was located on the ground floor and they had a ground floor bathroom with toilet and a shower. People with more complex mobility needs were accommodated in ground floor flats. In one home we visited, drawers and cupboards were labelled to help people locate their personal and communal items.

Staff routinely sought consent when supporting people in their day to day activities. People's support plans included information about how to communicate effectively and support them in decision-making. For example, one person's support plan said they had full involvement in any decisions, needed time to absorb new content and important information should be given in advance of any action being taken. They required support with more complex matters and staff should avoid discussing too many topics at once. The person accessed the internet with support from staff to help spell words they used in searches.

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.

When staff were unclear about a person's capacity to make decisions, they involved social workers to review the person's capacity. For example, one person's capacity to consent to a sexual relationship had been assessed as this was in doubt. The person was found to lack capacity and had been supported to complete

a course about personal relationships to assist them in developing appropriate knowledge and awareness to give consent. Their capacity had been reassessed after the course and while they had benefitted from it, they remained unable to understand the risks to themselves. Further to this a best interest decision had been made about how staff should support them with personal relationships.

The provider's quality audit identified that some MCA assessments required review and this was included in the service's action plan. Some people required a level of continuous support and supervision that indicated a deprivation of liberty. Assessments by social workers demonstrated they understood the provider would provide this level of support to keep the person safe.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this are called the Deprivation of Liberty Safeguards (DoLS). In supported living services it is the responsibility of Local Authorities to apply to the Court of Protection for DoLS authorisation. No authorisations were in place for people the service supports. The provider's audit included ensuring restrictions or authorised DoLS were correctly documented; one shortfall had been picked up and was included on the service's action plan. The registered manager told us they would review all people to ensure any restrictions in place remained appropriate and the person's funding authority were aware of the restrictions.

Is the service caring?

Our findings

Caring relationships existed between people and the staff who supported them. Staff spoke fondly and respectfully about the people they supported. Their comments included, "The three girls [young women] are so lovely to work with. It's not a strict routine, it's down to the decisions of the people we support" and "I think of them as friends who just need helping out more than others". Staff understood what may cause people anxiety and were aware of things that may be emotionally challenging for them. We observed them supporting three people to manage their emotions, including communicating with others on their behalf and use of distraction to avoid escalation. People's comments about staff included, "very kind".

A staff member said, "The reward may take years but the reward is massive. To illustrate this, they told us how they had worked with one person over months, teaching them to recognise the time, (on the clock), when their taxi was due so they didn't need to rely on others for this. They added, "It's about the impact on somebody's life. You don't want them to be treated differently because they have a disability. I feel lucky because I can wake up and want to come to work, even if I'm tired".

People were supported to express their views and make decisions about the support they received. A staff member described how they supported one person who was non-verbal to express themselves through Makaton signing. If needed, this person also used a picture based 'mood states' board, using pictures of different faces to let staff know how they were feeling. Staff recognised that the other people living with them could understand this person well. One said, "These guys here are unbelievably helpful. When I first started here [names] would help me." We observed the four people living at this house interacting with each other. With lots of laughter and affection, they planned their activities for the coming weekend, putting pictures of the chosen activities in the right timeslots on the board.

People's support plans included a 'decision-making profile' and guidelines for 'effective communication' which included use of the above tools for this person. It was noted this person could be easily influenced by others and may give different answers to different staff. Staff were asked to provide a quiet and peaceful environment and to remind the person about possible consequences of their choices, which they may not remember. Once written these guidelines were read out to the person to check their preferences had been recorded correctly.

People's privacy, dignity and independence were respected and promoted. When a person showed us around the home they shared with other people using the service, they told us some people preferred to keep their bedroom door closed. This was respected. One person had a notice on their door, reminding others to knock and wait patiently for a response before entering. They told us they had a key to their room and had set everything out as they wanted it. They added, "I always have private time. Staff knock on the door before they come in. I don't need to tell them what I'm doing."

People could invite friends or family over to visit but were asked to check with staff first, to ensure this would not impact on the other people they lived with. During the inspection one person received a call from a close relative who arranged to visit that afternoon. In another residence, we saw staff prompting a person to

respect another's privacy, when they had a visitor they wanted to be alone with. People were encouraged to be as independent as they could be for example when carrying out daily activities and household chores.

Is the service responsive?

Our findings

People were supported to participate in meaningful activities that added value to their lives. One person we spoke with told us about the job they had worked at for eight years. They said, "I enjoy it. I've been working there a while now. I get a taxi there and back". This role provided them with additional income, skills, purpose and self-worth. Staff understood how to support them, ensuring they had time to prepare and suitable transport was arranged to ensure they arrived at work relaxed and in good time. These needs were detailed in their support plan.

We observed people were supported to live normal lives, as far as possible. For example, during our visit, one person's relative called and arranged to visit. They arrived with their baby and dog and enjoyed time with their relative until the other house-sharers arrived home. We observed real camaraderie and friendship between the people living in both homes. People were clearly very fond of each other and happy: One person told us, "It's very nice. A happy home". In feedback to the service a relative said; I would just like to say how delighted I was to bump into [Name] in town recently. He was walking along St. George's Road, with a spring in his step, looking so happy and at ease with [Name], his carer, walking by his side."

Some people were supported to attend 'The Drop In Centre', run by the local authority; This provides support, advice and information about services for adults with disabilities, along with community based activities, educational talks and a place to meet friends. People benefitted from this, for example, learning about personal safety and healthy eating. One person told us they had met their girlfriend there adding, "She's a nice girl, she makes me laugh".

Support plans identified people's individual communication needs and identified how these needs were met in line with the Accessible Information Standard (AIS). AIS sets out a specific, consistent approach to identify, record, flag, share and meet the information and communication support needs of people with a disability, impairment or sensory loss. Two people's support plans detailed the support staff should provide to help these people use their phones to keep in touch with the people who were important to them. For one person, this included reading and typing text messages for them. We observed the staff member doing this to the letter, checking exactly what the person wanted to say was written before sending.

An easy read version of the complaints form was available to people, alongside information about external agencies and advocacy services. Two complaints had been logged since our last inspection. One of these related only to the support hours the person received, which was forwarded on the complainant's behalf to the local authority. The second complaint resulted from a last-minute shift change which had not been communicated effectively. Further to this, the person and their close family member received a verbal apology and improvements were made to the systems in place, to communicate rota changes and check staff had arrived as expected.

One person we spoke with told us they had previously written to a former registered manager of the service, with help from a staff member. They were happy to raise any further concerns. One person's relative told us of their longstanding attempts, involving "endless meetings" with the funding authority and provider, to

ensure their relative received the service they felt they should receive. While this was ongoing, the provider remained engaged with this process throughout.

Nobody had required end of life care since our last inspection as the service had been provided to a small group of younger adults who were not at this life stage. People and their families had been consulted about their wishes for end of life and this information was recorded in people's end of life plan. Our discussions with senior managers demonstrated the provider had appropriate policies and procedures in place. The service had good relationships with GPs and district nursing services, which were available to provide medical and nursing support to staff in managing any symptoms including pain relief. Appropriate training and support for staff was available, including access to the employee assistance programme.

Is the service well-led?

Our findings

The provider's vision was to, "make a lifelong difference to the people we support, and their families." Their purpose was, "to deliver great quality care and support" by "enabling people to live as independently as possible where, how and with whom they choose." This was displayed on their website and reflected in their Statement of Purpose. Our conversations with staff and managers supported this ethos. For example, at a recent meeting, managers agreed "to support each person to achieve something for the first time". A staff member had enabled one person to recognise the time they left for work, which meant they could get ready for work, in their own time, without relying on staff. This had reduced their anxiety and increased their independence. Staff and the management team spoke openly about areas for improvement within the service. They were highly positive and respectful when speaking about each other and the people they supported and demonstrated a caring and committed approach.

People were enabled to live rewarding lives and outcomes for them were good. The people we visited had good friendships with the people they house shared with, evidenced by them laughing and joking together. We heard them agreeing plans for the weekend, which they looked forward to, such as a "girls shopping trip to Cardiff" and mini golf. People socialised in their local community and were supported with personal relationships and maintaining family relationships. People were supported to apply for and/or hold down a job when this was appropriate for them.

People were supported at a pace that was right for them. For example, in feedback to us, a social care professional raised concerns about things that were not going as well as they anticipated for a person they had recently placed with the service. We discussed this with the registered manager who explained this person did "not identify themselves as needing support" and could be "difficult to engage with". Staff were working with a non-challenging approach and to avoid "overwhelming" them, priority areas had been agreed. These included establishing healthy eating and drinking habits and developing a structured activity plan with exercise and community access. Other goals and increasing the person's independence would follow.

The provider ensured they met CQC's registration requirements by continuing to meet all necessary regulations, by displaying the home's current inspection rating and completing and forwarding all required notifications to support our ongoing monitoring of the service. The registered manager had been in post since March 2018. 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. They were registered to manage the service on 22 June 2018.

The registered manager is also registered manager for a small supported living service in Wales for this provider. They divided their time between both services and were supported at Voyage (DCA) South 2 by two 'Field Support Workers' who formed the management team and provided on-call support to staff. Managers were highly visible around the service, they knew people well and were informed of any changes in people's needs. We received mixed feedback from people's families, some highly complementary about the

management team and some saying communication could be improved. The registered manager had met with some families but had been unable to find a date that suited others thus far. Those they had already met with were satisfied and two families had recently written to complement the service.

There were effective systems in place to monitor the quality of services and care provided to people. Policies, procedures and guidance information was up to date and available to staff. Audits were completed on a regular basis and in accordance with the provider's quality monitoring arrangements. This included quarterly 'fresh eyes' audits by a registered manager from another of the provider's services, health and safety, infection control and medicines audits. An extensive provider audit was carried out annually by the provider's quality team. These checked that safe practice and processes were followed and ensured the home remained compliant with necessary regulations. Improvements had been made to the provider's systems for monitoring the service since our last inspection. When the new registered manager came into post an extensive action plan was in place and they were making good progress in completing this. Progress was monitored closely by the provider's quality team who verified completion of actions on a weekly basis.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. This included communicating with people and their relatives about notifiable safety incidents. The service worked openly and in partnership with external agencies, including the Local Authority safeguarding teams and education providers.

Feedback about the service was sought in an annual service review, this was due to be completed for 2018. This included views from people who used the service, their friends and relatives, health professionals and social workers. Feedback was also sought through informally through social events and meetings with families. After a recent meeting with a relative wrote to say, "We very much appreciated your pragmatic approach to a number of situations we discussed - refreshing." House meetings were held to enable people to say what they wanted to happen in their home. For example, at one house people said they would like to do a fire drill and suggestions for new activities and meals were put forward. Staff meetings were held at regular intervals.

The provider's quality audits were underpinned by national guidelines including those by the National Institute of Clinical Excellence (NICE) and Social Care Institute of Excellence (SCIE). The registered manager participated in local forums, including the Gloucestershire Care Providers Association (GCPA). A senior administrative staff member also attended national events for the public and care sector professionals such as FestABLE at the National Star College.