Zero Three Care Homes LLP

Villeneuve House

Inspection report

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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

The inspection took place on 7 March 2016 and was unannounced.

Villeneuve is a small care home providing intensive support for up to six people who have a learning disability or who are autistic and have complex support needs. The service does not provide nursing care. At the time of our inspection there were six people using the service.

A registered manager was in post at the service. 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.

Staff supported people to keep safe. Risks were well assessed and steps were taken to minimise potential risks. There were sufficient numbers of staff to meet people's care needs and keep them safe. There were systems in place to manage medicines and people were supported to take their prescribed medicines safely. There were effective processes in place for when people chose not to take their medication. The provider had a robust recruitment process in place to protect people from the risk of avoidable harm.

Staff were focussed on making decisions in people's best interest, involving family and outside professionals as appropriate. Staff worked with people to keep any restrictions to a minimum.

People made choices when deciding what to eat and drink and were supported by staff to achieve a balanced diet and make healthy choices. Staff supported people to maintain good health and wellbeing with input from relevant health care professionals.

People were treated with kindness, dignity and respect by staff who knew them well. There were opportunities for people to be involved in making choices about their support. Staff worked closely with the providers' clinical team to develop personalised plans to help people when they were distressed or did not want to receive support. Staff supported people to enjoy their lives and develop their interests. The provider had an effective complaints procedure and felt able to raise concerns.

There was an open, supportive culture at the service. Staff worked well as a team and the manager demonstrated good leadership skills. The provider had systems in place to check the quality of the service and take the views and concerns of people and their relatives into account to make improvements to the service.

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 were aware of what to do to protect people from abuse.

Risks were managed well at the service.

There were enough staff on duty to meet people's needs. Staff had been safely recruited.

People received their medicines safely and as prescribed.

Is the service effective?

Good

The service was Effective.

Staff were supported to develop the skills to meet people's needs.

Where a person lacked the capacity to make decisions or had restrictions place on them, there were correct processes in place to ensure decisions were made in a person's best interests.

People were supported to eat and drink and to have a balanced diet.

Staff supported people to access health and social care services as required.

Is the service caring?

Good

The service was Caring.

People developed good relationships with the staff who cared for them.

Staff treated people with dignity and worked to improve people's quality of life.

Is the service responsive?

Good

The service is Responsive.

Specialist staff supported staff to meet people's needs.

Support was personalised and developed individually for each person.

Staff were creative in enabling people to engage in meaningful activities.

There were processes in place to deal with people's concerns or complaints and to use the information to improve the service.

Is the service well-led?

Good

The service was Well-Led.

There was an open culture, where people's views were respected.

The service was run efficiently and there was a committed registered manager in place.

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

Villeneuve House

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.

The inspection took place on 7 March 2016 and was unannounced.

The inspection team consisted of one inspector.

We reviewed the information we held about the service including safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law.

We focused on speaking with people who lived at the service and observing how people were cared for. Where people at the service had complex needs and were not able verbally to talk with us, or chose not to, we used observation as our main tool to gather evidence of people's experiences of the service. We spoke with two family members, four care staff and met with the registered manager. We spoke with one health and social care professional to find out their views about the service.

The provider owns a smaller service in close proximity to Villeneuve which is run by the same manager and staff team. As a result we inspected the linked services at the same time.

We reviewed a range of documents and records including the care records for all the people who used the service. We also looked at three staff files and documents relating to the employment of staff, complaints, accidents and incidents and the management of the service.

Good

Is the service safe?

Our findings

A person told us, "I am quite happy here." A family member told us, "As far as I am concerned they are safe, there is nothing which raises alarm bells." Another family member said, "I am very fussy about where [person] lives. I watch what goes on, they do a brilliant job." We observed that people were comfortable when in the company of the staff supporting them, for example they approached staff when they had any queries.

Staff were able to describe different forms of abuse and knew what to do if they felt a person was not safe. Where people were assessed as being vulnerable to abuse there was detailed guidance in place and staff recorded any changes in behaviour or injuries so that these could be monitored over time. Staff explained how they might recognise possible abuse where people were not able to communicate verbally, for example through observing changes in mood. Staff felt comfortable raising concerns. A member of staff gave us an example of how they had raised an issue with the manager when they felt a person had experienced potential abuse. There was information available to staff with advice on how to report concerns.

The safety of people and staff was prioritised within the service and staff knew how to minimise risk. Staff had carried out risk assessments which had action points to minimise risk and were reviewed as needed. The risk assessments were detailed and covered individual situations or activities. For instance, a risk assessment had been carried out when supporting a person with cooking and there was guidance for staff to supervise when a sharp knife was being used. These assessments were very detailed and required staff to take into account a number of factors before setting out, such as how the person's mood was and the exact nature of the activity. People were supported to make choices even when this may have threatened their safety. Staff were skilled in supporting them to consider their choices. For instance, staff would work with a person to help them understand how they could accept support from staff and other professionals when they were feeling anxious.

Risks were managed well within the service. There were evacuation procedures in place with individual plans set up for each person should they need to be supported to leave the building in an emergency. Adjustments had been made to the property in response to risk assessments, for example radiator covers and window restrictors had been fitted.

The provider had a safe system in place for the recruitment and selection of staff. The recruitment procedure included processing applications and conducting employment interviews, seeking references, ensuring the applicant provided proof of their identity and right to work and carrying out disclosure and barring checks (DBS) for new staff to ensure they were safe to work with vulnerable adults. We looked at recruitment files for three staff and noted that the provider's procedures had been followed. Staff told us that they had only started working at the service once all the relevant checks had been completed. The service did not use agency staff but sourced cover from the wider organisation where necessary. This means that disruption to people was minimised when replacement staff were required at the service.

Staff told us that there were enough staff on duty to meet people's needs and our observations confirmed

this. Where people had been assessed as needing checks during the night we saw that staff had recorded when they had carried out this task. Where people were assessed as needing one to one care this was in place and was detailed in people's records.

People received their medicines safely and as prescribed from appropriately trained staff. We observed people being given their medicines and the staff member told us they had only started administering medicines after receiving training. In addition, they received refresher medication training every two years and competency assessments took place to evidence they had the skills needed to administer medicines safely. Records of people's medicines were completed appropriately and we noted that they were accurate and legible.

In order to minimise possibility of errors in medicine administration from being distracted, staff ensured this support was provided in a quiet area or in the medication room. We saw that there was a protocol for medicines in place for each person. When people had been prescribed medicines on an as required basis, for example for pain relief, there were protocols in place for staff to follow so that they understood when a person may require this medicine. For example, staff were instructed to discuss with a person before making the decision to administer extra medicines.

There were clear guidelines in place to support a person who did not agree to take their medicines. Staff demonstrated a good understanding on how to manage this situation. For example, if they were due to administer medicines to a person who appeared unusually distressed they would leave the task for an agreed period of time and try again when the person was less anxious. There were clear processes in place for tracking surplus medicines where people chose not to take their medication.

Medication was stored in a locked medication room and the member of staff was able to clearly explain the medication signing in and out procedure. Regular medication audits were completed to check that medicines were obtained, stored, administered and disposed of appropriately. We saw records of observations carried out for staff who were administering medications, to ensure they were meeting the required standards and supporting people to receive their prescribed medications safely.

Good

Is the service effective?

Our findings

Staff were skilled in meeting people's needs. One family member told us, "I ring up now and there are no issues. I used to get a blow by blow account of what was happening; now [person] is just settled. The staff are fantastic."

Staff told us that they had received training and that this helped them understand people's support needs and to be confident in their role. New staff received a thorough induction and we saw that the registered provider's mandatory training was up to date. The organisation had a computerised system to track staff's training needs and support the manager in ensuring staff had the necessary skills. Staff told us that training was practical and relevant. The organisation had supported a person at the service to have input into the skill of the staff supporting them by involving them in filming a video for staff training.

The provider and the manager had a commitment to supporting the physical and mental health needs of staff. Staff were well supported with regular meetings, supervisions and annual appraisals. A supervision is a one to one meeting between a member of staff and their supervisor. Annual Appraisals were used as an opportunity for staff to reflect on their practice and consider different approaches to their work. The manager told us they observed staff at work and we were given examples of where they had supported staff to improve their skills or practice as a result.

Staff felt they had ample opportunities to discuss concerns on a daily basis. We saw examples in care and staff records where staff had discussed with their supervisor any concerns and queries they had about the needs of the people they were supporting. These discussions were very open about the challenges staff experienced when providing support and were also used as an opportunity to advise staff on how to resolve their concerns. For instance, we noted that additional clinical input was set up in response to staff concerns about an increasing area of risk. We felt that staff were enabled to carry out their daily tasks in a supportive working environment.

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.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff had received training in the Mental Capacity Act (MCA) 2005 and DoLS legislation and guidance. They had a good knowledge of capacity and giving people choice. One member of staff told us, "I try to use common sense. Although someone

might not be able to manage their money, they can be supported to pay for a purchase at a shop – it's nice for them as they get to pay for it." In addition, we observed that staff sought peoples' consent before providing care. The registered manager had completed personalised capacity assessments relating to a wide range of activities and support provided to each person.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). People who could not make decisions for themselves were protected. The manager had made the necessary Deprivation of Liberty Safeguard (DoLS) applications for people living at the service, for example one person had a DoLS in place due to the restrictions placed on them, for example from the locked front door.

Where staff had assessed that people may need to be restrained, for example for their safety, the correct procedures had been followed and there was detailed guidance and monitoring in place. Staff had completed a Mental Capacity assessment outlining any decisions made and there was a focus on using the least restrictive approach possible. Where decisions were made on people's behalf staff had consulted with professional and families to ensure decisions were made in the person's best interest.

Mental Capacity Applications and DoLS were reviewed to ensure any changes in people's circumstances were captured. The monthly audits tracked when DoLS had been submitted to, and authorised by, the authorising authority. There were triggers in place to highlight when the renewal dates were for each person.

People had personalised support to ensure they had sufficient to eat and drink and maintain a balanced diet. People had separate folders with menu choices, which catered to individual choice and requirements, including allergies. Staff were able to describe in detail people's food and snack preferences. At lunch time we observed people making a variety of meal choices. One person had beans on toast, another had bangers and mash, whilst a third person had their lunch at the local café. We were told that staff were cooking spaghetti bolognese that evening and that this had been decided in consultation with everyone at the service. Where people did not like this meal they could opt to have an alternative, for example one person had a preference for small snacks instead of one main meal.
We observed at lunch time a member of staff offer to prepare the food whilst a person sat watching television. We asked the member of staff whether the person had the ability to help prepare the meal. We were told that they did but that it could be difficult to encourage them to take part in domestic tasks as they were so engrossed in their own activity, such as watching a television programme or playing a computer game.

People were regularly weighed and any changes in weight monitored. We observed that one person had a chocolate drink and a chocolate snack for their breakfast. It was clear that this was their choice and they had the capacity to decide what they wanted to eat. Staff told us that they encouraged people to achieve a balanced diet, one member of staff told us, "We always offer options and put a few veg in there." Staff told us they had supported a person to go through recipe books and get involved with their cooking.

We saw from people's notes that staff liaised with people's health professionals as necessary. The service maintained regular contact with the GP and healthcare professionals that provided support and assisted the staff in the maintenance of people's healthcare. A family member told us, "Any health issues and its straight to the doctors." Where people had specific health needs there were details on their care plans which staff were required to read to understand how best to support them. Where people had a particular way of communicating, there were hospital information forms in place, outlining their needs and preferences, should they be admitted to hospital.

People's health and wellbeing was monitored regularly and there were specific arrangements in place where necessary, for example the dentist visited the service to support people with their dental hygiene. We saw that the organisations clinical team had met with the local authority's Behavioural Advisor Team and had made amendments to one of the people support in response to feedback.

People had been involved in decorating their individual bedrooms which were very personalised and reflected their personal preferences. There were a number of communal rooms which were light and airy, however due to some people's needs the furniture was largely functional and there were limited soft furnishings or wall decorations. The regular audit carried out had stated that the "internal décor and furniture" and "atmosphere and ambiance" was "fine." However, we found limited evidence that the people who used the service had been involved in personalising and designing the communal areas. A social care professional told us the provider, "Tends to provide good strong furniture but it's all the same and this has the effect of making the homes look more like hotels."

Good

Is the service caring?

Our findings

People felt at ease with the staff caring for them. One person told us, "I'm all right; I just sit here chilling out with the staff." Staff told us that given the person's complex needs, it was a positive sign of how settled they were at the service and that this had been achieved following intensive support. Another person told me they were going to the café with their key worker. They said, "I like [staff member], he's my friend."

Relatives were positive about the service spoke with enthusiasm about the service. Our observations confirmed that people were cared for by staff that treated them with kindness and compassion. We saw staff communicating in a friendly, caring and calm way and it was clear they knew people well and people were comfortable in their presence. For example, we saw a member of staff interacting with a person about their sporting interest.

Staff supported people to make choices about their daily lives. We discussed with one person and with a member of staff the design and layout of their room and staff said, "It's like that because that is how [person] wants it." A family member told us the service had a homely, friendly atmosphere, "I am welcome at any point. This feels like [person's] home.

Positive relationships were valued and promoted. People were allocated named workers within the service and were matched where possible with staff they got on well with. Staff spoke with affection about the people they cared for. One member of staff said, "I get a lot out of it, we have a laugh and a joke and it's nice to see them happy." Staff were aware of the complexity of people's needs but still worked to develop a sense of wellbeing at the service. One member of staff told us, "Christmas is normally a good time. It's hard to have a meal together as they don't all get on but we had a nice turkey this year and a bit of music."

Staff displayed a humane approach to working with people who chose not to accept support which was vital to their wellbeing, for example, when taking their medicines. One member of staff said, "We try it loads of ways, we use banter, we encourage them, we leave it for a bit." We felt staff were not task focused and demonstrated a flexibility and compassion for the people they were caring for.

People's privacy and dignity being maintained. A member of staff was able to describe how they maintained people's dignity when supporting them with personal care, for example when they were having a shower. Staff knocked on people's doors before entering and were discrete when they required assistance. When staff spoke with people they were polite and respectful way. Staff greeted each person by name as they encountered them. Confidentiality was maintained, for example people's records were kept in a locked room.

We spoke to the manager about this she said that advocacy services would be provided if a person required these services and we saw examples of this in people's care records. Advocacy services are available for people who may need support from an independent person to speak on their behalf.

Good

Is the service responsive?

Our findings

Family members told us the support at the service met people's specific needs. One relative told us, "It's taken some time but over these last few months [person] has been happy for the first time since being a child."

The organisation had recruited a clinical psychologist and had a clinical team that supported staff to develop plans relating to people's behaviour. Staff received significant training in this area and had opportunities to meet with the clinical team to discuss people's needs. Each person had a detailed behaviour plan in place in relation to support staff to meet their needs if they became anxious or distressed. Staff recorded what triggered different behaviours and plans outlined what actions staff could take to support people to meet their needs. This information was analysed regularly and any concerns were flagged up as necessary. A family member told us, "There are statistics and charts showing what provokes [person] and what to do. It's working for them."

The advice to staff from the clinical team was practical, for example, staff supporting a person with autism were advised to, "Break things down into small steps if I don't understand or get confused." People were also supported to develop routines which would improve their quality of life. For instance, one person had a detailed plan in place to improve their evening routine to help them achieve their goal of having a good night's sleep.

People had individual sessions with the organisation's psychology team. We saw records where staff had agreed with a person to trial for a set period of time a different style of support in line with that person's wishes. This was agreed in a safe way and demonstrated a commitment to enabling people to have some control over the support they were receiving. A health and social care professional told us that the focus on clinical plans and on people's behaviour meant people were not always enabled to take risks and have contact with the outside world. Whilst we found the care people received had a clinical focus, staff at the service were nevertheless committed to supporting people to lead full and meaningful lives.

People had their needs and risks assessed and the support needed was outlined in detailed and personalised care and support plans. Staff were aware of people's needs and how to meet them. They described how some people had very established routines and gave examples of how they supported them to gradually do things differently . Where staff had not been present at meetings to discuss people's on-going needs, they were required to sign to say they had read the notes from the meeting. This meant that the manager could be certain that staff were aware of any changes in people's needs and any guidance available around the support required.

People were supported to engage in meaningful activities. One person told me about their hobby and how important it was to them. Staff knew about the hobby and were able to describe how they supported the person to develop their interests. We saw that staff were creative in helping people develop their interests, for example where people liked animals they were encouraged to visit local rescue centres and take the company dog, Enzo, out for a walk.

We looked at a person's care record and their profile stated that they liked helping with domestic tasks around the house. We saw staff cleaning the floor near their bedroom but did not observe staff involving them in the task. We discussed this with the member of staff and they said that when it was quiet the person would help mop the floor but that they would not do this if there was any disturbance, such as an inspection. Whilst we felt staff could have encouraged people to take a more active part in tasks we recognised that our presence meant this was difficult due to people's complex needs. We looked at people's notes and guidance was in place for staff to increase people's involvement in daily tasks. We felt assured that the manager was addressing this issue and our discussions with staff confirmed that they were being encouraged to support people to be more involved in the daily management of the service.

In addition to the on-going monitoring carried out by the clinical team, people's care needs were reviewed regularly, with professionals and families invited as appropriate. Staff responded to people's changing needs, for instance where a person struggled with managing money, staff were pro-active in setting up a budgeting plan with them. There were systems in place to ensure reviews took place regularly. A recent audit of care plans had highlighted the need for a review to be set up for a person at the service whose needs had changed.

Staff supported people to maintain relationships that mattered to them, such as families and friends. Families were involved the care of their relative, as appropriate. The manager held regular discussions with them and their views were expressed within people's care records. The manager demonstrated a commitment to involving families by holding reviews outside of standard working hours, where necessary.

The provider had a clear policy in place for responding to concerns and complaints. The manager had responded positively where concerns were raised and there was a record of the actions taken as a result. Where complaints were received they were logged and recorded. People and their families told us that they felt comfortable raising concerns and giving feedback.

Good

Is the service well-led?

Our findings

People told us they knew who the manager was and found them approachable. One person said to us, "She's the boss, she's a lovely lady." A family member told us, "[Manager] went above and beyond to get [person] settled, when they first arrived." Another family member said, "The manager is marvellous, they really know their stuff. I go directly to them if I have any problems."

The service had an open culture where people were treated with respect. Staff met in meetings called "cascades" to discuss and update on the support being provided to people. The service had a policy whereby people were able to attend meetings held with clinical staff to discuss their needs. Whilst these meetings were predominantly attended by staff, one person had chosen to become actively involved in discussing plans for their support. We felt this reflected the open culture at the service.

One of the people at the service was involved in the interview process. Records of the interview showed the questions they had asked which included, "Do you like to have fun?" We observed throughout our visit that the staff team understood that fun was an important part of everyday life. We felt this demonstrated that when choosing staff the manager had listened to what the people of the service had stated was important to them.

The service was well ordered and functioned efficiently, with clear structures put in place by the wider organisation. The manager described how care records had been improved and streamlined to enable staff to focus on people's day-to-day needs. Staff knew what their roles and responsibilities were, for example a member of staff was able to describe their role as key worker. The manager was involved in the day to day service and led by experience. They had a detailed knowledge of people's needs and we observed them speaking to a person with affection. The manager had invested a significant amount of time and effort into integrating people in the service into the local community and dealing with any issues which arouse.

The organisation rewarded good practice and had a "Hero of the Month" award where a member of staff in the organisation is awarded for good practice. We were also given examples where staff had felt able to share poor practice with the manager and this had been addressed effectively. Staff also told us that they had discussed poor practice as a team to work together to address their concerns. This demonstrated that the manager encouraged an open culture where people and staff were supported to speak out about their concerns.

A member of staff told us it was a good organisation to work for. The staff team worked closely to support each other as they managed with complex challenges and significant levels of potential risk. One member of staff told us, "If a colleague is having a bad day we look out for each other, we are a very strong team and we are improving." Another member of staff said, "The team is like a family."

There were effective monthly audits in place, for instance a recent audit had highlighted where some electrical maintenance which was required. There were records in the audits of discussion with people who used the service, demonstrating a commitment to involving them and gaining their views on the support

they received. People's views were taken into account, for example as a result of their input more board games were purchased. Relatives were involved in driving improvements at the service. The manager sought their views through an annual questionnaire, at peoples' reviews and through on-going contact. Managers also spoke with specific members of staff during audits to gather their views about the service and their jobs. Feedback was acted on, for example we saw in the annual plan that improvement in the quality of activities at the service was highlighted as a priority in response to feedback.