Zero Three Care Homes LLP

Massenet

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 16 January 2017 and was unannounced.

Massenet 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 five people using the service.

A registered manager was not 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. The previous manager had left in the last year and we met the new manager who was in the process of applying to be registered with the Care Quality Commission.

Massenet is a new service which opened in April 2016, with people moving in a month later. In addition to the management changes, there had been some disruption as the staff team came together and people with complex needs settled into their new surroundings. Despite this, the organisation had worked hard to support people and staff to settle in and the service was gradually becoming established. Senior staff and area managers had provided continuity during this period of change.

People were supported to stay safe and staff had the skills and guidance needed to effectively minimise risks to people. Staff were recruited safely and worked well together to enable people's needs to be met. Medicines were safely administered by appropriately trained staff.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. Management and staff understood their responsibility in this area. Staff were committed to ensuring all decisions were made in people's best interest.

Staff supported people to eat and drink in line with individual needs and preferences. Health needs were well managed by staff with input from relevant health care professionals.

Detailed assessments had been carried out and personalised care plans were in place. People were supported to have an active life and to maintain relationships with family members. Staff had access to specialist training and guidance. The providers clinical psychologists helped staff reflect and learn about how best to work with individual people.

Staff created a stimulating environment where people felt accepted. People were treated with kindness, dignity and respect by staff who knew them well. Staff had the skills to support people to communicate their

views in a variety of ways.

Staff were enthusiastic about their role. The provider had systems in place to check the quality of the service and made improvements, where necessary.

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 knew how to protect people from abuse and risk was minimised across the service.

There were sufficient skilled staff to meet people's needs.

People received their medicines safely.

Is the service effective?

Good

The service was effective.

Staff were well supported and were skilled at meeting people's needs.

There were measures in place to ensure decisions were made in the person's best interests.

People were supported to eat and drink in line with their needs and preferences and to maintain good health.

Is the service caring?

Good

The service was caring

There were positive relationships between staff and people.

Staff had the skills to communicate with people and enable them to make choices.

People's privacy and dignity was respected and they were treated with fondness.

Is the service responsive?

Good

The service was responsive.

People received support which was personalised around their individual needs. They lived full lives and enjoyed taking part in activities of their choosing.

Care plans provided staff with detailed advice about how best to meet people's needs.

There were processes in place to deal with any concerns and complaints appropriately.

Is the service well-led?

Good

The service was well led.

There was a new manager in post who was being supported by the area manager to provide a smooth transition.

Staff were committed and worked well as a team.

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

Massenet

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 16 January 2017 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. A significant number of the people at the service had very complex needs and were not able verbally to talk with us, or chose not to, so we used observation as our main tool to gather evidence of people's experiences of the service. We met with four care staff, the deputy manager, the new manager and the area manager. We had contact with three family members by phone or by email. We also spoke with one health and social care professional to find out their views about the service.

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

When the service was first set up, the provider had to manage high levels of risk as people with complex needs and a new staff team were brought together in a new setting. Whilst there was some disruption during this period, the provider managed the situation effectively, so that by the time of our visit we found the service was settled and people were being supported safely.

Family members told us people were safe with the staff who supported them. One relative told us, "We are confident that he is safe, cared for by competent, well trained staff." Another family member said, "We believe our son is safe, there are usually sufficient staff in evidence and his medication is carefully monitored." We observed that people felt comfortable with staff and looked to them for reassurance and comfort when distressed.

We saw that staff had received training in safeguarding and were knowledgeable about the types of abuse people might be exposed to and how to report any concerns that they might have. Measures were in place to ensure people were not at risk of harm, for example from financial abuse. There were strict rules for recording what had been spent and audits were carried out to check people's money was safe.

As well as being aware of how people might be vulnerable to abuse, staff also had a good awareness of the need to supervise the people they supported whilst they were in the community. Staff knew which people required two staff to take them out into the community to ensure they, and the people they met, remained safe. Staff had assessed to minimise any potential risks where children might visit, for example a person's sibling.

A member of staff said they knew who to go to if they were concerned about the safety of the people they supported. They told us something would be done about their concerns and said, "I feel the managers would listen." The organisation's safeguarding policy and a poster in the office contained advice on how to report concerns.

Staff worked well together to minimise risk and were always alert to the safety of both the people they supported and their colleagues. 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. Where guidance stated a person needed to be under constant supervision, staff were vigilant to make sure they were not left on their own. We observed a member of staff check their colleague was remaining with a person in the lounge before they went upstairs.

Staff were required to read about the risks involved with each person before they met them which helped staff be aware of any immediate risks they needed to be aware of. For example, one person's plan said, "I like to put things into my mouth" and another person's plan had advice on how to help them when they became anxious in loud places. Potential risk was considered when taking people out in a car. For example, there was guidance around the use of locks and what to do if a person undid their seat belt whilst out driving.

There was sufficient staffing available to manage situations when a person was putting themselves or others at risk. During one incident, we observed staff came from elsewhere in the service to support their colleague in supporting a person who had become anxious. A member of staff told us the majority of time there was enough staff and if there was an issue, such as if a colleague was off sick, staff from the wider organisation came in to fill the vacancy. This arrangement meant the staff who covered had the necessary skills, were aware of the organisations procedures and fitted in well to the service.

There was an effective recruitment process in place for the safe employment of staff. Checks were in place to confirm that staff were of good character and suitable to work with people who needed to be protected from harm or abuse. Staff confirmed they did not commence employment until the necessary checks such as, proof of identity, references and satisfactory Disclosure and Barring Service (DBS) checks had been obtained. A review of records showed the appropriate pre-employment checks had been made. The organisation also ensured self-employed professionals who visited the service, such as therapists, had also been checked.

Since the service had opened there had been a high turnover of staff but the staff team was now becoming more established. There was a mix of new staff and staff who had transferred from other services within the organisation. This meant there was a core staff group who were highly experienced and understood the way the organisation worked. A member of staff told us the staff group had much improved since the early months at the service and was working well together.

People's medicines were managed safely. People had risk assessments around the medicines they took. When people were prescribed medicines on an as required basis, for example for pain relief, there were protocols in place so staff understood when someone might need the medicine. We observed a person receiving medicine for a headache and noted that the member of staff followed the organisation's procedures.

Staff could only administer medicines once they had received training. They were observed by senior members of staff to ensure they had the necessary skills. Staff knew how to encourage people to take their medicines when they might refuse to do so. We observed a person was in bed as they were not well and the member of staff encouraged them to take their tablets in a gentle way, saying, "Sorry to wake you, mate, take this for me buddy and I'll leave you alone."

Medicines were stored in a locked room and staff could clearly explain the medicines signing in and out procedure. Regular medicine audits were completed by the manager to check that medicines were obtained, stored, administered and disposed of appropriately. We could also see a senior member of staff had regularly checked medicine records, highlighting if there were any gaps or errors.

Good

Is the service effective?

Our findings

We observed during our visit that the people at the service had very complex needs which were being effectively supported by a skilled staff team. A family member told us, "The staff we have come to know are caring, professional and have grown to understand our son's needs."

The service had been newly decorated and refurbished when it was opened. Due to the risks around people's behaviour, the décor in communal areas was neutral, uncluttered and rather stark. There were no pictures or soft furnishings and staff told us these would be removed or destroyed by people at the service. We asked about the décor and were told there had not been any attempt to incorporate colour or texture into these areas, for example, through painted or textured murals, in line with best practice. However, there were large picture windows overlooking the gardens and people's individual rooms were personalised in line with their preferences.

Despite the lack of ornamentation in the communal areas, the environment had been specifically and effectively designed to meet the complex range of need within the service. The doors were wide which helped people move around safely, with limited restrictions. Communal areas were large and allowed people to benefit from being in the same room as others but at a comfortable distance, should they become anxious. There were large internal windows, which meant people could have some level of independence, whilst still being observed by staff to ensure they remained safe.

There were measures in place to ensure staff had the skills to support people. New staff received a thorough induction. The organisation had a computerised system to track staff's training needs and enable the manager to support staff to develop the necessary skills. As part of the induction process, new staff were observed carrying out a range of tasks, such as personal care and preparing drinks. Before the service had opened staff spent time shadowing colleagues in other services within the wider organisation. In addition, staff who had transferred across from other services were known by senior managers and selected because they had the necessary aptitude and skills for the role.

Training was provided by managers and the organisation's clinical psychologist. The provider used a training course called Studio III to equip staff to manage behaviour that could lead to physical violence. A member of staff told us they found this training invaluable. "It's very practical. The trainer acted out the behaviour then we had to respond. If you didn't have that training you'd be lost." Another member of staff said, "I'm pretty impressed with the training, compared to other jobs."

Staff were supported to develop their skills and progress within the organisation. A member of staff had been put forward for additional training, after discussions with a senior member of staff. Another member of staff had been promoted to a senior role and had used supervision sessions to discuss how they had settled into their new role.

A member of staff described how they had attended training to support people with epilepsy. They described the exact measures in place when they took a person who had epilepsy out into the community.

They knew what to do if the person had a fit and what medicine might be needed in this instance. A family member of a person with epilepsy said that staff, "followed the protocol" when supporting their relative.

A member of staff said that in addition to training, they received good advice from senior staff, particularly on how to diffuse situations through humour. For example, they described an incident where a person was about to throw a ball at someone and staff had turned the incident into a game of catch. We observed humour used effectively throughout our visit.

Staff were well supported by the organisation. Given the complexity of the needs of the people at the service, there was a risk to the safety of staff. We noted this was acknowledged throughout the organisation and measures put in place to minimise risk but also provide staff with opportunities to say how they felt. A member of staff told us, "100% the senior staff look out for you. There's a lot of debriefing and if we have an incident the senior will grab the worker and talk through it." We observed this support provided after a particularly difficult incident.

Staff had supervision meetings with senior staff, which offered them the opportunity to raise concerns regarding individual people and look at development and training needs. We saw that a member of staff had used supervision to discuss a concern around a specific behaviour a person engaged in. They were then given the opportunity to shadow other staff to see how they managed such incidents. Staff were due to have appraisals, once they had been in post for a year.

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. There were DoLS applications in place for all the people at the service due to the restrictions which had been put in place to keep people safe. The restrictions included people being under continuous supervision and locks on the front door, which prevented people from going out unsupervised.

There were personalised assessments in place regarding people's capacity to make decisions in a number of areas, such as engaging in social media and opening their own post. Where appropriate staff had involved professionals and family members to ensure decisions were made in the person's best interests. Staff had received training in the Mental Capacity Act (MCA) 2005 and DoLS legislation and guidance, and were able to demonstrate how they applied the principles of the Act in their daily practice. Although people needed support to make key decisions, staff described how they promoted choice on a daily basis. For example, a member of staff said a person pointed at one hand if they wanted blackcurrant squash and to another if they wanted orange.

People had personalised support to ensure they had sufficient to eat and drink and maintain a balanced diet. Staff were able to describe in detail people's food and snack preferences and needs. Where a person was allergic to milk, staff had substituted for rice milk. People were regularly weighed and any changes in

weight monitored.

People were encouraged to make their own choices about meals. For example, a person's notes said "Prepared a breakfast of cereal, crumpets and blackcurrant squash." During our visit, most people had cheesy pasta for lunch; however this was adapted to their specific taste. Therefore one person put mayonnaise on the pasta and another applied soy sauce and had a side salad, as staff told us they liked 'crunchy' food. A third person went out for lunch.

Meal times were informal but supervised. Staff knew which people might be at risk from sitting together and we saw a person who grabbed other people's food sitting with a member of staff next to them.

People were supported to maintain good health. The service worked alongside health and social care professionals to meet people's needs. 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.

Where people had a specific health condition, their care plan included information about any issues staff needed to be aware of. There was a health care check list, which indicted what area a person needed support, such as controlling weight and getting more exercise.

Good

Is the service caring?

Our findings

Family members told us staff were caring and treated people with respect. One relative said, "There is an excellent atmosphere in the house when we visit and we believe there is a high degree of respect and engagement with the residents. [Person's] clear affection towards a number of individuals makes us believe he is very well cared for and his complex needs understood and well managed." Another family member told us, "Whenever we visit, the staff are always engaged with the residents and seem caring and interested."

We saw staff communicating in a friendly manner and people presented as being comfortable in their presence. The people at the service were young adults and staff promoted an environment which was fun as well as supportive. A family member told us, "The home has a nice vibe about it." We saw staff joking with a person about getting flat hair from their hat they had been wearing. Where possible, the language used was non-institutional, for example when a person was walking around without a shirt on, a member of staff said, "Shall we go and get a shirt on, mate."

Although people had been at the service for less than a year, staff knew them well. Care plans had detailed and specific information about people, for example, one stated that a person disliked the texture of sand but loved music. This meant staff could support people in a personalised way, helping them avoid anything unpleasant where possible and enhancing their quality of life.

Staff used a variety of communication techniques to communicate with people. People were being encouraged where possible to make choices about their care and to express themselves. A member of staff told us one person used pictures to communicate. They knew which picture to point to if they felt ill and then staff would point to parts of the body to find out where they were in pain. We observed that another person communicated with staff through a computer tablet. We observed the tablet was also used by staff to interact with the person.

Staff told us where there were difficulties in communication they would speak to family members for advice or look at the detailed communication plan. Although people might not be verbal, staff knew what signs to look for to find out how they felt. For example, staff described an incident where a person walked away from a horse one day, despite going horse riding every week. Staff knew from their response that they didn't want to go horse riding that day. The person's family member told us how well staff followed the advice they had given and how good they were at communicating with the person.

People's privacy and dignity was maintained. A member of staff was able to describe how they maintained people's dignity when supporting them with personal care. Staff knocked on people's doors before entering and assistance was provided in a respectful manner. When staff spoke with people they were courteous. We observed that if the person was busy staff apologised for disturbing them, for example to administer medicine. Confidentiality was maintained, for example people's care records were kept in a locked office.

Good

Is the service responsive?

Our findings

People were supported to have a good quality of life, which met their needs and preferences. Family members told us, "[Person] is happy and settled. They go out regularly and enjoy a variety of activities" and "It's always a busy house, it's not boring."

A member of staff told us, "People have a good life and are happy here. All of them are doing really well." Another member of staff told us they felt it was rewarding when people became settled at the service, and that they had been proud when a person had kissed their family member for the first time.

Staff were skilled at adjusting their support flexibly to best meet people's needs. For example, we observed a member of staff come up to a person and ask them if they wanted to do some art. The person ignored the offer. The member of staff then said, "Shall we do drawing before or after lunch," after which the person responded.

The organisation had recruited a clinical psychologist who supported staff to develop plans relating to people's behaviour. Each person had a detailed behaviour plan in place to support staff to meet their needs if they became anxious or distressed. Staff had opportunities to meet with the clinical team to discuss people's needs.

After each incident, where a person became anxious or distressed and displayed action such as hitting out, staff completed a form which was sent to the organisation's clinical psychologist. They analysed what triggered different behaviours and enabled the staff team to monitor what actions staff could take to support people to meet their needs. For example, staff were told a person did not like the word 'no', so staff were advised to word a sentence in a different way to avoid conflict. This information was reviewed regularly and any concerns were flagged up as necessary.

The main staff involved with each person's care met regularly to share information and discuss how best to support them. We saw records where a member of staff recommended using praise to encourage a person to take part in daily activities. The notes said "try using 'high fives' and saying 'well done mate." Our observations showed staff were following these recommendations.

People had their needs and risks assessed and the support needed was outlined in detailed in personalised care and support plans. People's strengths and dislikes were recorded. The information outlined in the plans reflected the discussions we had with staff about peoples' needs. The amount of information about each person was vast and often written in a clinical way. To ensure people's key needs did not get lost, there was a folder with vital information on each person, which was especially useful for new or temporary staff.

Care plans were reviewed on an on-going basis by staff and managers and included families and outside professionals. After each review there was an action plan with dates, for example on the plan it stated a person needed to be referred to a speech and language therapist.

We received positive feedback from families regarding the efforts by staff to develop appropriate activities both inside and outside of the service. Some of the people at the service had extremely complex needs, especially when out in the community. Staff had developed personalised timetables and tactics to ensure they were able to go out. We saw in a person's diary, "We went for a drive to costa coffee for a decaffeinated coffee" and another person's read, "I'm taking [Person] out for a massage then to Freeport for lunch."

There were two cars available for use at the property. Although the location was rural people were able to walk to the local village. One person regularly went for lunch at the local pub, which had resulted in positive links with the local community. During our visit a person showed me a record they had bought when out shopping the previous day.

Each person had a schedule which was divided into half hour slots, which enabled staff to support people who benefited from a structured timetable. For example, they might have a specific time each week when they contacted their parent or an exact time each day when they had a bath. People were then shown this timetable, which assisted in reducing anxiety.

People were encouraged where possible to develop skills and increase their independence. Whilst lunch was organised by staff we were told people were supported to do cooking, either as part of their schedule, for example baking cakes or to make their breakfasts. This meal was chosen as it enabled staff to support people with a simple meal, one at a time, as they got up. During our visit a person was encouraged to help change their duvet and another to put their plate in the sink after lunch.

Staff supported people to maintain relationships that mattered to them, such as families and friends. Staff had taken time to consider how much families wished to be involved in the day to day lives of the people at the service. There was a questionnaire families completed regarding their contact preferences, for example whether they wanted to be contacted every time their family member had to have additional medicines. One person's family said they would like staff to visit with their relative to the family home and a member of staff confirmed this took place. The provider sent out yearly questionnaires to parents to find out their views about the service.

The provider had a clear policy in place for responding to concerns and complaints. There was a complaints log in place, though the manager told us the service had not received any complaints from or on behalf of the people using the service. Families felt the communication was good and as a result issues were dealt with at an informal level. One relative told us, "If I say 'this' or 'that', they will address it." Whilst another told us, "Whenever we make requests or enquiries they communicate freely and intelligently with us and replies to my emails are usually prompt, courteous and informative."

Good

Is the service well-led?

Our findings

On the day of our inspection we met the new manager who had only been at the service for a couple of months. Around the same time when the previous manager had left, the deputy manager also left the service as they had been promoted within the organisation. During this period an area manager had run the service and ensured the service had remained stable. We also met experienced staff who had been moved from other parts of the organisation over this period to help ensure the service continued to function safely and effectively.

Family members told us they felt the provider had managed this challenging situation well. One relative said, "As can happen with any provision there has been a turnover in the number of junior staff as well as the house and deputy manager. This latter change was particularly unfortunate but Zero Three management kept us well informed and the senior staff team rose to the challenge and in our view have emerged as a core strength of the provision." A second family member told us, "The home seems generally well run and managed."

The service was well ordered and functioned efficiently, with clear structures put in place by the wider organisation. The team worked well together and staff spoke with commitment and enthusiasm about their role. A member of staff told us, "I'm enjoying my job and it's got better as a company."

Good communication was key at the service. Staff and managers referred to the 'cascades' which were meetings held to discuss individual people's needs. They were attended by the clinical psychologist and other members of staff and were used to monitor on-going issues and provide guidance to ensure staff were working consistently and effectively.

Senior staff told us they were well supported by an on-call system where they could call upon a manager or deputy manager in an emergency. They could also call upon maintenance staff in an emergency relating to the property.

The provider held meetings for managers across their organisation where the managers could support each other and share good practice. At a recent meeting a manager of another service had described how they had met with their local fire service for advice, should the service need evacuating. This was now going to be rolled out to other services, including Massenet.

People benefitted from best practice and from the lessons in the other more established services within the organisation. Therefore, the design and location of the property had been influenced by the providers learning in relation to other properties they owned. Staff were now required to record people's positive achievements, which helped balance out the detailed recording of incidents of challenging behaviour and this was a central task carried out by staff.

As staff were working with people with complex needs, holding "resident meetings" was not practical. Whilst staff developed people's care and daily routines in line with their needs and preferences, there was potential

to involve people more creatively in developing the overall service, in line with best practice.

There were a series of audits carried out throughout the service by senior staff and managers, including managers from the wider organisation. The audits had clear dates by which any actions had to be completed. Audits had picked up when staff had not completed medicine forms correctly and this was discussed at team meetings where staff were reminded on how to improve recording. The organisation had its own maintenance team and so managers could prioritise effectively which repairs and improvements needed to be done.