Vivre Care Ltd

Stockwood 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?	Requires Improvement

Summary of findings

Overall summary

We carried out an unannounced inspection on 15 and 16 December 2016. The inspection was completed on 4 January 2017 when we received information we had requested from the provider.

The service provides specialist support and treatment for up to six people living with eating disorders. Some of the people receive care and treatment within the frameworks of the Care Programme Approach (CPA) and Community Treatment Orders (CTO) of the Mental Health Act 2007. There were four people being supported by the service at the time of this inspection.

During our inspection of the service in September 2015, we found the provider did not always have safe recruitment processes in place and they did not have a system to enable them to continuously assess and monitor the quality of the service. Additionally, robust records had not always been kept in relation to staff supervision and training. We checked these areas during this inspection and we found they had made the required improvements.

There was a registered manager in post, who was also the provider of 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.

People were safe because there were risk assessments in place that gave guidance to staff on how potential risks to people's health and wellbeing could be minimised. There were systems in place to safeguard people and staff knew what to do if they suspected that a person was at risk of harm. The provider now had safe recruitment processes in place and there was sufficient staff to support people safely. People were supported to take their medicines safely.

There was now evidence that staff received regular supervision and they had been trained to meet people's individual needs. Staff understood their roles and responsibilities to provide people's care and treatment as set out by the Care Programme Approach (CPA) and Community Treatment Orders (CTO). Everyone supported by the service had mental capacity to make decisions about their care and treatment and therefore, the requirements of the Mental Capacity Act 2005 were not applicable.

People were supported by staff who were kind and caring, and their privacy and dignity was promoted. People were supported to meet their nutrition needs in a sensitive way and in accordance with their treatment plans. They had access to other healthcare services when required to maintain their health and wellbeing.

People had care and treatment plans that took account of their individual needs, preferences, and choices. They were fully involved in planning and reviewing their care, and were supported to manage their health

conditions. People were supported to pursue their hobbies and interests, and were able to pursue a variety of activities outside of the home without staff supervision.

The provider had a system for handling complaints and concerns. They sought feedback from people and commissioners of the service in order to improve the quality of the service. The provider's quality monitoring processes to enable them to assess and monitor the quality of the service had improved. However, they did not always keep robust records in relation to people's medicines and staff recruitment processes.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safe and there were systems in place to safeguard them from avoidable harm.

The provider now had effective recruitment processes in place and there was enough skilled and experienced staff to support people safely.

People were supported to take their medicines safely.

Is the service effective?

Good

The service was effective.

People were supported to manage their health conditions by staff who had been trained and received regular supervision.

Staff understood people's care needs and provided the specialist support people required to maintain their health and wellbeing.

Staff understood their roles and responsibilities to provide people's care and treatment as set us out by the Care Programme Approach (CPA) and Community Treatment Orders (CTO).

Is the service caring?

Good

The service was caring.

Staff who supported people were caring and showed passion towards ensuring that people made progress towards independent living.

People were supported in a way that protected their privacy and dignity.

People had been given information about the service to enable them to make informed decisions about their care and treatment.

Is the service responsive?

Good

The service was responsive.

People's care plans took into account their individual needs, preferences and choices.

The provider worked in partnership with people and other health professionals so that people's needs were appropriately met.

The provider had an effective complaints system.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Robust records were not always kept in relation to people's medicines and staff recruitment processes.

People who used the service and professionals involved in their care were routinely asked for their feedback about the quality of service.

The provider's quality monitoring processes had improved to ensure that they could make continuous improvements to the service.

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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 inspection took place on 15 and 16 December 2016, and it was unannounced. The inspection was carried out by one inspector and completed on 4 January 2017 when we received information we had requested from the provider.

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 reviewed this, as well as other information we held about the service including notifications they had sent us. A notification is information about important events which the provider is required to send to us. We also reviewed the report of our previous inspection in September 2015.

We did not speak to any of the four people who used the service during the inspection because the three people present at the time chose not to speak with us. We left the inspector's telephone number and email address in order for them to provide feedback that way, but none of them contacted us. We spoke with three staff, the clinical lead and the registered manager, who was also the provider of the service.

We reviewed the care records and risk assessments for three people who used the service. We checked how medicines and complaints were being managed. We looked at the recruitment and supervision records for five staff, and training for all staff employed by the service. We also reviewed information on how the quality of the service was assessed and monitored and we observed how staff interacted with people who used the service in communal areas of the home.

Good

Is the service safe?

Our findings

When we inspected the service in September 2015, we found the provider did not always have robust recruitment procedures in place because thorough pre-employment checks had not always been completed for all staff. During this inspection, we looked at the recruitment records for five members of staff who had been employed after our previous inspection and we found safe recruitment procedures had been followed. This included a review of the applicants' employment history, skills and experience; obtaining references from previous employers; and completing Disclosure and Barring Service (DBS) checks. DBS helps employers to make safer recruitment decisions and prevents unsuitable people from being employed.

Although we were unable to speak with people who used the service, we had no concerns about whether they were safe living at the home because they were all able to raise any concerns they might have with provider or the commissioners who funded their care and treatment. The provider had systems in place to safeguard people including up to date safeguarding and whistleblowing policies. Whistleblowing is a way in which staff can report concerns within their workplace without fear of consequences of doing so. Staff had been trained on how to safeguard people. They told us that people were safe and they showed good understanding of how to keep people safe. One member of staff said, "Service users are safe, there is always staff here. We check how they are doing and we make sure the environment is safe too." Another member of staff told us, "I 100% feel service users are safe and well cared for."

Potential risks to people's health and wellbeing had been assessed. We saw that each person had personalised risk assessments in place which identified the risks they could be exposed to and the support they needed to minimise the risks. As well as specific risk assessments in relation to people's health conditions, there were generic assessments for risks associated with self-administration of medicines and the use of kitchen appliances. We saw that the risk assessments had been discussed with people who used the service and that they were reviewed regularly or updated if their needs changed.

There were systems in place to ensure that the physical environment of the home was safe. A member of staff told us that they took a lead in monitoring health and safety issues and they ensured that checks were done in a timely manner. We saw records that showed that the safety of the home was assessed regularly and prompt action taken to rectify any identified hazards. For example, a gas cooker was replaced when it was found that it was no longer safe. An environmental risk assessment was reviewed in August 2016, as well as risk assessments for fire, business continuity and the Control of Substances Hazardous to Health (COSHH). External contractors also completed various refurbishment work, including redecoration of the home during early 2016, rewiring of the boiler, and the call bell system was replaced in October 2016.

Staff told us that there was always enough of them to support people safely. One member of staff said, "Service users are quite independent, but there is always at least two staff when everyone is here during the day." Another member of staff told us, "We definitely have enough staff." We saw that there were 23 members of staff who worked across the two services run by the provider on the same road. The rotas we looked at showed that there were sufficient numbers of staff to support people who used the service. The manager told us that they had used regular agency staff to cover night shifts during the summer months due

to staff taking leave. However, they ensured that they had previous experience of supporting people who used this type of care service so that they were able to provide effective support.

The provider had a three-stage system to assess whether people were able to manage their own medicine regimes. One person managed their own medicines and the other three people required some prompting by staff to take their medicines. People who took their own medicines had locked drawers to keep them safely in their bedrooms. Medicines for those who needed prompting or support and stock medicines were kept in the home's medicine trolley. We found some people had excess stock of medicines which made it difficult for the provider to account for the amount of medicines at the home. We discussed this with the lead nurse and they sent us evidence that they had audited all medicines held at the home and returned what was not needed for that monthly cycle to the pharmacy that supplied the medicines. This meant that they could easily check if people were taking their medicines as prescribed by their doctors.

Good

Is the service effective?

Our findings

Although we were not able to ask people if staff had the right skills to provide effective support and treatment, we saw that staff had been trained in a number of areas relevant to their roles. Most of the training was done online, but the manager told us that they were trying to introduce more 'face to face' training from 2017. Staff were complimentary about the quality of the training they had received. A member of staff told us, "We get enough training. When we encountered a challenging situation in the past, we had a lot of support and training on how to deal with it. It was very positive because we learnt from the situation and we always try to improve." Another member of staff said, "Training is really good. We always think of issues along the Care Quality Commission (CQC)'s five key questions to make sure we are doing what we need to for service users. I recently trained to administer medicines and I found it interesting as I had not done this before." A third member of staff said, "Training is good. If you want more training you can ask and [manager's name] is happy to look into it. I've just finished my online training and I also check if other staff are up to date with theirs."

In order to provide more specialised treatment, the service employed nurses although this was not a requirement of their registration with CQC. The manager told us that they always ensured that the nurses they employed had opportunities to develop their skills and knowledge and had the support necessary for them to meet the 'revalidation' requirements of the Nursing and Midwifery Council (NMC). A nurse told us that they were able to maintain their clinical skills and knowledge. They explained the benefits of a national workshop in eating disorders they attended in June 2016 in making sure that the service's treatment programmes followed current good practice guidance.

There was evidence that staff received regular individual and group supervision and staff we spoke with confirmed this. One member of staff said, "We have a lot more supervision now which is fantastic. It's amazing how much you can get out of your chest during supervision. I 100% feel supported by the senior staff." They further told us about the benefits of group supervision. They added, "We have become a much closer team since the group supervisions started." Another member of staff said, "The support is good. [Named staff] is my supervisor."

It was the criteria for admission to the service that people had mental capacity to make decisions and give informed consent to their care and treatment. Therefore at the time of this inspection, the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards were not applicable because people's care and treatment was managed under the provisions of either the Care Programme Approach (CPA) or Community Treatment Orders (CTO) of the Mental Health Act 2007. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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).

Staff demonstrated that they understood that they needed to seek people's consent before providing any support or treatment and they told us that they always respected people's rights. One member of staff said, "We encourage residents to do their best to support their own health, but we can't do that in a patronising manner."

People's treatment plans included them being supported to consume enough nutritionally balanced food and fluids. We saw that people had individual nutritional plans and these were reviewed regularly by the provider in their capacity as a trained dietitian. The service worked closely with people's GPs and other professionals to ensure that people were making good progress towards recovery. An occupational therapist and an art therapist were employed by the service to support people to develop independent living skills and to adopt positive ways of managing their health conditions in order to maintain their mental and physical wellbeing.

Good

Is the service caring?

Our findings

We were unable to ask people if staff provided their care and treatment in a caring and compassionate manner. However, we observed that staff interacted with people who used the service in a positive and respectful way. We also saw compliments from people that showed they found staff kind, caring and easy to get on with. A caring culture was embedded in the ethos of the service, with the manager and other senior staff demonstrating that compassion was central to how they supported people.

Staff spoke with passion about their roles in supporting people who used the service to achieve their individual goals. One member of staff told us of their previous experience in supporting people with complex needs within a hospital setting and their initial uncertainties about whether their skills would be transferable to this type of care service. They added, "I really like working here and I have been able to use my skills and experience to support residents. This is a unique service and I like that we have time to sit and talk with residents. I have built good rapport with the residents." Another member of staff said, "I really enjoy my job although it can be challenging sometimes. It is rewarding though when you can see the progress service users have made. I feel that I am doing essential work." They further told us how satisfying it was for staff when one person moved to their own flat and that they were supporting another person to move towards independent living in the near future.

We saw that people were actively involved in making decisions about their care and treatment. Care records showed that people's wishes and choices had been taken into account and as part of the service's aim to provide person-centred care. People who used the service were quite independent in meeting their day to day care needs and they made decisions about how they spent their time at the home. A member of staff told us that people mainly planned their day, but they gave them advice if any activities they chose to do had detrimental effects on their physical and mental wellbeing. They gave us an example of how they could discuss with a person if the amount of physical activity they engaged in meant that they were not maintaining agreed weight ranges, but they were not able to physically stop them from doing so. They further told us that they ensured that they prompted people in a way that respected their individual choices and upheld their privacy and dignity. Another member of staff told us, "I would never talk to a residence about their care where others could hear." They further told us that this was essential to maintain confidentiality and we saw that the importance of this was also highlighted in the service's 'Philosophy of care'.

The service encouraged people to maintain close relationships with their relatives and other significant people in their lives, but this had to be pre-arranged so that social activities did not interfere with people's therapeutic activities. We saw that sometimes people went away for weekends to visit their families and friends.

People were given a 'Service User Guide' when they moved to the home and this contained the information they needed to understand the ethos of the service, how it was managed and what they needed to expect from the staff that supported them. Staff told us that people who used the service were able to understand the information given to them without support. As part of their treatment frameworks, people had care

coordinators allocated by the commissioners who funded their care and treatment. The care coordinators acted as people's advocates to ensure that they received the care and treatment they required. Information was also available about independent advocacy services that people could contact if they required additional support and advice.

Good

Is the service responsive?

Our findings

The service provided specialist care and treatment in order to support people to manage their health conditions and we saw that they had assessed people's needs prior to them moving to the home. There were personalised care plans for each person that reflected what support they required to maintain their physical and mental wellbeing. For example, care plans we saw showed that people's needs had been assessed in the following areas: physical needs; weight and meal management; medicines; psychological needs; and occupational therapy. Although we were not able to ask people if they were happy with how their care and treatment was being managed, we saw that they had signed their care plans and they were involved in regular reviews. Staff told us that people's care plans reflected their current needs and these were reviewed in weekly clinical review meetings held on Tuesdays. One member of staff said, "We have a person-centred approach to supporting residents. There are weekly reviews and we always check what we can improve." Another member of staff told us, "Care plans are very well put together, simple and have information we need to support the residents. We get to know what to do to support residents and their preferences. It's good."

People were encouraged to keep a daily reflective diary in order to chart their progress. They were able to review this with staff so that appropriate support could be put in place when required. We saw that the provider worked closely with the commissioners of the service to regularly review the effectiveness of the care and treatment provided to people. People's care and treatment was also reviewed regularly during the Care Programme Approach (CPA) meetings arranged by the commissioners. The provider sent progress reports to these meetings.

People chose to engage in a range of educational, therapeutic and recreational activities. Each person had an individual occupational therapy assessment and had been supported by the occupational therapist to plan how they wanted to spend their time when they were not taking part in therapeutic activities. For example, we saw that some people liked to go for walks around the local area, enjoyed cinema trips and they had visited a theatre in London to see, 'The Lion King'. One person had also recently started voluntary work at the local hospital. One member of staff told us, "Residents have therapy groups that they attend and they do other activities too. Today, they are going to the cinema. We went to the theatre in London last week and most residents are happy to go out in groups." Another member of staff said, "Service users are provided with opportunities for an active social life. It's good." The occupational therapist planned and ran a 'Skills development group' for people who used the service from September to December 2016. The sessions included increasing motivation; reflective recovery; coping strategies in managing emotions or distress; assertiveness; confidence and self-esteem; lifestyle re-design; and goal setting. However, we were not able to ask people if they had found these useful.

The provider had a complaints procedure in place and we saw that this information had been included in the 'Service User Guide' given to people when they first moved to the home. There had been complaints raised by a person who was no longer supported by the service and we saw that the provider took appropriate action to investigate the issues raised. They had also provided feedback to us and the relevant commissioners.

Requires Improvement

Is the service well-led?

Our findings

When we inspected the service in September 2015, we found the provider did not have a system in place to enable them to continuously assess and monitor the quality of the service. Additionally, robust records were not always kept up in relation to staff employed by the service because they did not have up to date records of staff supervision and training. During this inspection, we found there was now evidence of staff training and supervision. However, records relating to staff recruitment were not always organised in a way that made them accessible during the inspection. Not all records of references and Disclosure and Barring Service (DBS) checks were in staff files as some were still in emails that could only be accessed by the provider. This meant that we would have not been able to check this information if they were not available on the days we inspected the service.

The provider told us that they had entrusted the organising of staff's files to a manager they had recruited in early 2016, but this had clearly not been completed to a satisfactory level. They showed us a form they had developed so that they could audit staff's files twice a year. They also said that they would work with other senior staff to make sure improvements were made. Following our inspection, the provider sent us evidence that they had audited all staff's files and the progress they had made to ensure that these contained all the information as required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Additionally, the medicine administration records (MAR) had unexplained gaps which made it difficult for us to determine whether people were consistently taking their medicines. Staff had explained that gaps were mainly when people took their own medicines during day or weekend trips away from the home. However, they could not explain why they did not use the suggested codes on the MAR to record this. The provider sent us information to show that this recording issue had been addressed with staff via an email and they had been asked to confirm that they had re-watched the training video provided by the pharmacy that supplied medicines to the home.

The provider was also the registered manager of the service, but they planned to employ a manager who will register with the Care Quality Commission in the future. At the time of the inspection, they were supported in their management and leadership roles by a clinical lead and a member of staff who was recently promoted to a deputy manager role. Staff we spoke with found the provider and other senior staff very approachable and supportive. They also said they worked well together as a team and that the service was good at providing appropriate and effective support to people who used the service. A member of staff described feeling part of the team and they told us they could speak with any of the staff if they needed support. They added, "I feel appreciated here." Another member of staff said, "This is a unique service and there is not many around. I find it a privilege that I have been able to work here."

Staff had opportunities to contribute towards the development of the service and they held regular meetings where relevant information was shared. They also used these meetings to share learning and to facilitate group supervision. The clinical lead and the deputy manager told us of a plan to develop a 'skills improvement folder' by January 2017 so that they could use it to train staff on specific topics during team meetings and handovers. They said this was essential to ensure that they were continually developing staff's skills and knowledge. There was a communication that staff were expected to use to promote effective

communication. We saw that staff signed to indicate that they had read and understood each message recorded in the book.

As well as the provider completing regular audits of the service, we saw that commissioners of the service regularly checked if it was still appropriately meeting the needs of people who used the service. The provider told us that a commissioning team had visited the service the week before our inspection and two others had also visited since our previous inspection. Although we did not get feedback from people who used the service, we saw that they had given compliments about how they were supported by staff. The provider had asked for feedback from people who used the service using an online survey in October 2016, but only one response had been received. However, we saw that the person had responded positively to the ten questions asked about the home environment; whether staff respected their choices about how they lived their lives; whether their concerns and complaints were acted upon; their legal rights were protected; and whether staff were kind, understanding and courteous. Also, people had regular meetings with staff where they could provide feedback about the service and make suggestions for improvements.