Zero Three Care Homes LLP

Estoril

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 2 February 2016 and was unannounced.

Estoril is a small care home providing intensive support for up to five 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 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.

Detailed assessments had been carried out and personalised care plans were in place which reflected individual needs and preferences. However, there was a focus on supporting people with their behaviour needs and as a result; people's individual cultural and spiritual preferences were not always considered. Staff used on-going observation to establish people's views but had not considered alternate ways of finding out what people thought of the service they received. People enjoyed going out with staff but were not always supported to engage in meaningful activity when at home.

Staff had a good understanding in how to keep people 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. The provider had a robust recruitment process in place to protect people from the risk of avoidable harm.

Staff were focussed on ensuring all decisions were made in people's best interest, involving family and outside professionals as appropriate.

Staff supported people to have sufficient food and drink that met their individual needs and preferences. People's health needs were managed by staff with input from relevant health care professionals.

People were treated with kindness, dignity and respect by staff who knew them well. Staff had the skills to support people to communicate their preferences. The provider had an effective complaints procedure and people had confidence that concerns would be investigated and addressed.

There was an open culture and the manager demonstrated good leadership skills. Staff were enthusiastic about their work and felt able to express their views. The provider had systems in place to check the quality of the service and to make 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. There were enough staff to manage risks and provide people with safe care.

Risks to people's safety were thoroughly assessed and minimised.

Systems and procedures for supporting people with their medicines were followed, so people received their medicines as prescribed

Is the service effective?

Good

The service was effective.

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

Where people lacked consent, appropriate measures were in place to ensure decisions were made in their best interests.

People's nutritional needs were met by staff who understood what support they needed.

People were supported to maintain good health and access health services.

Is the service caring?

Good

Staff developed positive relationships with people and treated them with kindness.

Staff had the skills to communicate with people.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs arising from their behaviour were prioritised and staff did not always consider people's cultural and spiritual needs.

People enjoyed going out with staff but were not always supported to engage in meaningful activity whilst at home.

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

Is the service well-led?

Good

The service was well led.

The manager led by example and communicated the organisation's vision for the service.

Staff were well supported and the manager challenged poor practice effectively.

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

Estoril

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 2 February 2016 and was unannounced.

The inspection team consisted of two inspectors.

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 spoke with three family members, four care staff and met with the registered manager and the area manager. 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 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

The safety of people was prioritised within the service. We observed that people felt at ease with the staff supporting them, for example they approached staff when they wanted a drink or were feeling anxious. A family member told us that they always ask their relative if they want to go home after a family outing and, "[Person] is always pleased to go back, he puts two thumbs up to let us know."

Staff were able to describe different forms of abuse and were aware of 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. Staff recorded any changes in behaviour or injuries so that these could be monitored over time. Staff were able to describe how they might recognise possible abuse where people were not able to communicate verbally, for example through observing changes in mood. The organisation's safeguarding policy and a poster in the office contained advice on how to report concerns. Staff felt comfortable raising concerns. A member of staff told us, "If I had a concern I would go to the senior in charge or manager. If this was not resolved then I would go above their head." There were records in people's individual files showing that the organisation's procedures had been carried out when there were concerns regarding a person's safety, including contacting the appropriate professionals.

Staff knew how to manage risks to people and staff safety. 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 example supporting people when they were out in the community. These 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. The service considered the safety of staff. Staff told us they felt well supported, for example the team might come together in an emergency to discuss how best to manage a new risk. One member of staff gave a specific example of when they had felt concerned for their own safety in the course of their job. They had felt able to discuss it with the manager, who had put measures in place to support them and the person being supported.

The service managed risks well. During our visit maintenance was taking place in the service and an extra member of staff was on duty so staff could take out a person who would become anxious from the disruption. 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. Although staff supported people to take part in domestic tasks, appropriate safeguards were in place to minimise risks, for example any potentially harmful cleaning liquids were locked away.

Staff told us that there were enough staff on duty to meet people's needs and our observations confirmed this. One member of staff said, "There is always enough staff around to manage risk." Where people were assessed as needing one to one care this was in place and was detailed in people's records. A family member confirmed that there was sufficient staff to meet their relative's needs and that staffing levels would be adjusted for each activity and, "Depending on the mood of [person]."

The provider had a safe system in place for the recruitment and selection of staff. Staff were recruited with the right skills and experience to work at the service. Staff told us that they had only started working at the service once all the relevant checks had been completed. We looked at recruitment files for three staff and saw that references and criminal records checks had been undertaken and the organisation's recruitment processes had been followed. The service did not use agency staff but drew from the whole organisations staff team when cover was needed. This means that disruption to people was minimised when replacement staff were required at the service. We met a member of staff who did not always work at the service and noted that they knew the people well; we observed interactions were familiar and positive.

People received their medicines safely and as prescribed from appropriately trained staff. We observed medication being administered 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, the member of staff responsible for this task told us they did not answer the phone when supporting people with their medicines. The staff member communicated well when giving people their medicines, for example lowering themselves to the level of the person when handing them some tablets. When people were prescribed medicines on an as required basis, for example for pain relief, there were protocols in place for staff so they understood when a person may require this medicine. Staff knew what to do when people refused medication, for example they might leave the person and come back in a few minutes and try again.

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.

Good

Is the service effective?

Our findings

During our visit to the service we observed people with extremely complex needs being supported by a skilled staff team. Staff knew what people wanted from minimal gestures and from changes in moods. A family member said, "[Person] is very happy and well looked after."

Staff told us that they had received training and this helped them understand people's support needs and to be confident in their role. New staff received a thorough induction and we saw 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 offered them opportunities to discuss situations they were struggling with. One member of staff said, "The training is fun, they make us laugh which helps us learn."

Staff received supervision and annual appraisals. A supervision is a one to one meeting between a member of staff and their supervisor. In addition to reviewing the quality of their practice we saw evidence of discussions around the physical and mental health needs of staff. This provided staff with support as they cared for people who used the service. We saw an example where a member of staff had discussed a concern regarding interacting with a person and the manager had identified a training course which would support them to increase their skills and confidence in that area. 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.

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 were focussed on ensuring all decisions were made in people's best interest, involving family and outside professionals as appropriate. 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. For example, they were able to tell us how they supported people to make everyday choices such as what to wear and what they would like to eat.

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, for

example where there were assessments in place where staff needed to open people's post with them. We noted that these assessments were reviewed and staff observations used to monitor any decisions made on the persons behalf, for example how a person was enjoying any items they had recently purchased with staff support.

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 home. For example, one application related to a person being restricted from leaving the building unattended.

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. People had meals when they chose and pictures of food and drink choices were used to help with communication where necessary. We saw that one person had their own specific set of pictures to meet their individual needs. People had separate folders with menu choices, which catered to individual choice and requirements, including allergies. One person's plan outlined the need to have small and frequent meals and another person was being supported by staff to increase their intake of fruit. People were supported to take part in meal preparation and we observed a person making a drink and a snack with the assistance and supervision of a member of staff.

People were regularly weighed and any changes in weight monitored. Staff and family members remarked on improvements in supporting people with their weight. A family member told us, "In the past there were too many takeaways, this has got better now and the staff encourage home cooking, though they do have fast food as a treat."

Staff were skilled at knowing when other professionals needed to be involved and making the necessary referrals. For example, we saw in a person's care plan that staff had made a referral to a speech and language therapist for a person to support them with their communication skills. 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. 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.

The property and décor at the property was had been adapted to suit the varying needs of all the people at the service, which meant a degree of compromise had been necessary. 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 no soft furnishings or wall decorations as these had been removed following incidents and risk assessments. Consequently people's preferences were not reflected in the communal areas. However, people had been involved in decorating their individual bedrooms, which were personalised reflecting their personal preferences. One family member told us their relative was not impacted negatively by the décor in the communal area as they spent a lot of time in their bedroom. The manager acknowledged that they had not explored more creative options, such as painted murals or different coloured walls in at least part of the communal area but agreed this was something they would trial and monitor in the future.

Good

Is the service caring?

Our findings

Relatives were positive about the service and expressed a high level of satisfaction with the care they received. A relative commented, "Staff know people very well, they have been wonderful to both [person] and me." Another person told us that when their relative became unwell, "Staff were absolutely superb, they are very fond of [person]." 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.

Positive relationships were valued and promoted. For example people were given named workers within the service and were matched where possible with staff they got on well with. We observed staff singing with a person who seemed to enjoy the company of the member of staff. They shared friendly banter whilst the person was being assisted. When they needed to repeat something they had said staff were patient with people and each time they repeated themselves it was as though they were saying it for the first time.

Where people were not able to communicate verbally staff knew how to interact with them and understand their needs. For example, by pointing to an object of reference, or staff recognising what the person was referring to, or by the person's body language. When people became distressed staff had the necessary skills to communicate with people effectively and calmly. We observed staff providing physical reassurance by holding hands in an appropriate manner. A member of staff explained they support a person who was anxious by, "Communicating with them on their terms, for example chatting about people they used to know."

Staff told us they involved people in everyday decision making and used pictorial communication books and gestures to help them do this. For example, we observed that people had chosen what to wear and were dressed in their own style personal to them.

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, 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. Staff greeted each person by name as they encountered them. Confidentiality was maintained, for example people's records were kept in a locked room.

Referrals were made to advocacy services required 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.

Requires Improvement

Is the service responsive?

Our findings

The organisation had recruited a Clinical Psychologist and a clinical team was in place who 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 to support staff to meet their needs if they became anxious or distressed. Staff recorded what triggered different behaviours and enabled the staff team to monitor 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.

We met the company's behaviour advisor attached to the service. They provided on-going support to staff and people. This support was flexible and personalised, for example the advisor might take a person out to lunch, or visit them if they were in hospital to advise nursing care staff on how best to meet their needs. They told us that routines were important to the people at the service and staff had invested a long time in getting the routines to run smoothly. The routines were personalised to meet peoples' needs and preferences, for example people chose to go out when they wanted to.

With the focus on reducing risk and following behaviour plans, people's support had an emphasis on behaviour management. The service had not developed creative and specialist ways of enabling people to communicate their views and preferences. Decisions were predominantly staff led with input from families, or led by staff's views following observations of the people they were supporting. For example, staff would establish from a person's mood and behaviour their views regarding any subject. We saw from the annual audit carried out in the service that this issue had been recognised. Appropriate referrals were underway to speech and language therapy to support staff to improve how they established people's views.

People's records documented that prior to being at the service they took part in a variety of cultural and spiritual activities, for example at school or at church. Family members confirmed this. One family member told us, "Creative activities are important and could be better at the service." When we discussed a specific activity with a member of staff they acknowledged they had not tried the activity out with that person. It was clear that as the person was non-verbal then taking part in an activity would be the best way to assess their views regarding the activity.

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. A family member told us, "We always get involved in reviews." Staff were committed to monitoring people's changing needs and used observations to shape a personalised service around each individual. We felt however that the service had not always tried creative ways of seeking feedback from people about the service they received. Therefore, review forms had very detailed analysis of people's care needs based on staff's observations and professional input, but the section intended for people's views was often left blank.

We received positive feedback regarding activities outside of the service. Weekly schedules were in place to assist people to remember what was happening each day. A family member told us, "The manager is very

pro-active about getting people out and about." However, people did not have a consistently positive and person centred experience when at home, in particular when spending time outside their bedrooms, for example in the communal areas. Due to the possibility of items being picked up and posing a risk to other people in the service, people were not able to keep leisure activities, for example books, in the communal areas unless they were locked away. The communal area had one large television behind a plastic screen, and for safety reasons, there was no remote available for people to change channels. During our visit the television was on continually though no one appeared to be watching it and we did not observe any discussion on programme choice. The design of the television room meant anyone watching television would be disturbed by people walking through to the conservatory. We did note that there were televisions in people's rooms which they could watch in private. There was a summer house in the garden and we were told this was going to be converted into an activities room which would offer opportunities for greater personalisation within the shared areas of the home. We were not aware of any specific plans to do this, and it was not mentioned as a priority in the organisation's annual plan for the service.

Staff told us that there was no cleaner and one member of staff told us, "This means we all muck in, including the guys; it helps introduce them to new skills." A family member confirmed that their relative was involved in preparing meals and in sorting through laundry and we observed people in the kitchen being involved in meal preparation. We spoke with the member of staff leading on developing activities. They told us the service is reviewing what people do when at home to further increase the focus on developing skills and engaging in meaningful activities.

People had their needs and risks assessed and the support needed was outlined in detailed and personalised care and support plans. People's strengths and dislikes were recorded, though plans did not always outline how people's cultural and religious needs were going to be met and reviewed. Where possible care plans were in place to meet people's communication needs, for example we saw a health care plan with pictures to illustrate a variety of health needs and activities, such as going to the GP. The information outlined in the plans reflected the discussions we had with staff about peoples' needs.

Staff supported people to keep relationships that mattered to them, such as families and friends. Staff also supported people in relationships with their neighbours and local community. For example, one person was supported to regularly go to the local pub which provided them with important community links. Communication with family members was positive and appropriate. A relative commented, "Staff know people very well, they have been wonderful to both him and me. The staff involve me in care planning, nothing goes on without the service letting me know." Staff knew family members well and spoke with compassion about them, for example, when they became unwell. One relative noted, "Staff are wonderful always ready to help, questions that I ask are always answered respectfully." Where families could not visit people, staff supported other ways of keeping in touch, for example by helping people send greeting cards

The provider had a clear policy in place for responding to concerns and complaints. The manager 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. A family member told us, "I feel happy to say anything, they will always try and put things right." Another family member told us, "I only had one issue and when I raised it with the manager we had a heart to heart and it got put right." We were told that the organisation carried out annual parental questionnaires to gather views on the service being provided. A member of staff told us that when a relative had made a complaint, as well as responding and acting on the complaint they had also sent them another questionnaire to fill out to give them the opportunity to comment on the service as a whole.

Good

Is the service well-led?

Our findings

The service had an open culture where people were treated with respect. A family member told us, "Staff are wonderful, always ready to help, questions that I ask are always answered respectfully." There was a positive atmosphere amongst people, families and staff, and we received feedback that this was a service which was improving." A member of staff told us, "We have such a good team, right now."

The service was well ordered and functioned efficiently, with clear structures put in place by the wider organisation. We discussed the vision of the organisation with the senior manager and were told that they aim to provide specialist residential services with a clinical input. The senior manager said that the registered manager of the service understood this central vision and had a happy staff team who have, "A passion for the guys (at the service)." The registered manager was involved in the day to day service and led by example. We observed them speaking to a person in a soft tone of voice and held their hand to reassure them. A staff member told us, "[Manager] is firm but fair and has emotion where she needs to."

Staff said the there was an open culture where information was shared between all staff. This was both informally and through "cascades." One member of staff explained, "We have cascades where we meet to discuss with other staff where we are going with people." For example, a member of staff might suggest a specific way of communicating with a person which they felt worked well. Another member of staff said, "I can discuss whatever I want with my manager, who works around my strengths."

A member of staff told us it was a good organisation to work for and that, "They care about the staff, not just the "guys"." Staff told us that the provider and manager supported them to develop their careers through training and by promoting opportunities for progression within the company.
The organisation rewarded good practice and had a "Hero of the Month" award, when a member of staff in the organisation is awarded for good practice. Staff knew what their roles and responsibilities were, for example a member of staff was able to describe their role as key worker.

We saw from staff supervision records that they felt able to raise poor practice and staff had confidence that the manager would deal appropriately with any concerns raised. We were given examples of where the manager had been effective when challenging poor practice and supporting the whole staff team to resolve any issues which occurred.

The organisation was committed to improving systems to ensure they run more effectively. For example the manager described how care records had been improved and streamlined to support staff to focus on people's day-to-day needs. Throughout our inspection the manager had an enthusiasm to learn about best practice and improve the service people received.

We looked at what the manager and provider did to check the quality of the service. We saw that the manager was committed to improve the service people received. Feedback from surveys was acted on, for example we saw in the annual plan that improvement in the quality of activities at the home was highlighted as a priority in response to feedback. Monthly audits were carried out by a senior officer in the organisation.

Checks related to the general management of the home, such as maintenance checks plus more detailed audits relating to staffing and to the care of the people at the service. Many of the issues raised in our inspection had already been identified in the audit, for example the need to improve how staff communicated with the people at the service and improve the range of meaningful activities within the home. We did note however that audits had not highlighted the issues we raised regarding the lack of personalisation of the communal areas. The most recent monthly audit had stated that "internal décor and furniture" and "atmosphere and ambiance" were "fine." Having discussed this with the manager we were assured that this was an area which would be addressed by them following our visit.