Zeno Limited

Zeno Limited

Inspection report

18A Riverview
The Embankment Business Park, Heaton Mersey
Stockport
Cheshire
SK4 3GN

Tel: 01617960360

Date of inspection visit:
15 November 2017

Date of publication:
01 January 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection visit took place on 15 November 2017 and was announced.

Zeno Limited is registered to provide personal care and support for people living with mental health needs and/or living with a learning disability or autistic spectrum disorder. This service provides care and support to people living in 12 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. The Care Quality Commission does not regulate premises used for supported living; this inspection looked at people's personal care and support. At the time of the visit there were 37 people who used the service.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

This inspection was the first inspection since the service was registered with the Care Quality Commission in September 2017. The service was previously registered at a different address where we inspected on 15 April 2014. We found the service to be compliant with regulations at that time.

During this inspection in November 2017, we found the service to be in breach of three regulations under the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. The breaches were in relation to a failure to deploy sufficient numbers of suitably qualified, competent persons to deliver care, a failure to ensure staff received appropriate support, training, professional development, supervision and appraisal. The quality assurance systems were not effective in identifying and generating improvements in relation to the shortfalls in staff training, staffing levels and safeguarding processes. We also made recommendations about staff awareness of safeguarding protocols and record keeping for mental capacity assessments. You can see what action we told the registered provider to take at the back of the full version of the report.

The service had a registered manager as required. A registered manager is a person who has registered with the CQC 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 registered manager was not present on the day of the inspection visit however; we spoke to them following the inspection visit. We were supported by the deputy manager and the nominated individual who is also one of the directors of the company.

The registered manager had systems in place to record safeguarding concerns, accidents and incidents and take appropriate action when required. During the inspection we received allegations of abuse from a former staff member. We informed the local safeguarding authority. They are undertaking enquiries. There was a lack of guidance and awareness on how to raise safeguarding concerns outside the organisation. We have made a recommendation about staff knowledge and awareness of safeguarding protocols.

People and their relatives confirmed people were encouraged and supported to maintain and increase their independence. Some people who used the service had limited ability to provide us with feedback on the service due to their needs. Feedback from relatives about care staff was positive.

Recruitment checks were carried out to ensure suitable people were employed to work at the service.

Feedback from staff demonstrated that there were concerns about staffing levels in three of the properties managed by the provider.
Staff had received induction, supervision and training. However we found a significant number of staff had not updated their training.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service supported this practice.

Risk assessments had been developed to minimise the potential risk of harm to people who used the service. These had been kept under review and were relevant to the care and support people required.

Care plans were in place detailing how people wished to be supported. People who received support, or where appropriate their relatives, were involved in decisions and consented to their care. People's independence and choice was promoted. However, mental capacity assessment records were not always provided to staff who provided care. We made a recommendation about following best practice in record keeping for mental capacity records.

Staff responsible for assisting people with their medicines had received training to ensure they had the competency and skills required.

People's care needs were discussed with care commissioners before they started using the service to ensure the service was able to meet their assessed needs. Care plans showed how people and their relatives were involved in discussion around their care. People were encouraged to share their opinions on the quality of care and service being provided.
Where people's health and well-being were at risk, relevant health care advice had been sought so that people received the treatment and support they needed. People's nutritional needs were met.

There was a variety of meaningful activities to keep people occupied and to promote social inclusion.

People who used the service and their relatives knew how to raise a concern or to make a complaint. The complaints procedure was available and people said they were encouraged to raise concerns.

There was a policy to support people at the end of their life to have a comfortable, dignified and pain-free death.

We received mixed feedback from staff regarding the management and culture in the service. The registered manager understood their responsibilities, and were supported by the provider and other managers to deliver what was required. They used a variety of methods to assess and monitor the quality of service provided to people. These included regular internal audits of the service, surveys and staff and relatives meetings to seek the views of people about the quality of care being provided. The quality assurance systems were not always effective to identify the shortfalls we found during the inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

This service was not consistently safe.

People and their relatives told us they felt safe. Feedback was positive.
Risks to the health, safety and well-being of people who used the service were assessed and plans to minimise the risk had been put in place.

There were concerns about the staffing levels in the service and safeguarding processes in the service needed to be improved.Staff had been safely recruited and disciplinary measures were in place.

People's medicines had been safely managed. Staff had been trained and competence tested for safe administration of medicines.

Is the service effective?

Requires Improvement

This service was not consistently effective.

The rights of people who did not have capacity to consent to their care were protected in line with the MCA principles. The use of physical restraint had been considered as the last resort and used proportionate to the risks posed.

Staff had received induction and supervision however there were shortfalls in training that the provider had deemed necessary for the role.

People were adequately supported with their nutritional needs.People's health needs were met and specialist professionals were involved appropriately.

Is the service caring?

Good

The service was caring.

Relatives spoke highly of care staff and felt their family members were treated in a kind and caring manner.

People's personal information was managed in a way that protected their privacy and dignity.Staff knew people and spoke respectfully of the people they supported.

The service supported people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible.

Is the service responsive?

Good

The service was responsive.

People had well written plans of care which included essential details about their needs and outcomes they wanted to achieve. Records were comprehensive and detailed.care was reviewed regularly with people and their relatives involved.

Staff and management had a strong emphasis on community involvement and keeping people active and engaged to reduce social isolation.

There was a complaints policy and people's relatives told us they felt they could raise concerns about their family member's care and treatment.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a registered manager in post and people gave positive feedback about the manager and the provider.

Feedback from staff was mixed regarding management and the culture in the service. There were shortfalls in staff training and staff deployment. Oversight and systems for identifying shortfalls were not always effective.

People and their relatives had been consulted about the care provided.Policies for assessing and monitoring the quality of the service were in place and visions and values were shared with people and their relatives.

Zeno Limited

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 site visit took place on 15 November 2017 and was announced.

We gave the service 24 hours' notice of the inspection visit because it is a domiciliary care service and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection team consisted of one adult social care inspector, one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert accompanied us on our visits to people's homes and also undertook telephone interviews with people and their relatives on 16 November 2017.

Before our inspection visit we reviewed the information we held on Zeno Limited. We gained feedback from health and social care professionals who visited the service. Feedback we received was positive. We also reviewed the information we held about the service and the provider. This included safeguarding alerts, information from whistle blowers and statutory notifications sent to us by the registered provider about significant incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us.

Prior to the inspection we had received allegations of abuse from a former employee of the service. We passed the concerns to the local safeguarding authority and the provider started their own investigations in line with their own safeguarding policy. We also explored how safeguarding concerns were managed in the service.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the

service does well and improvements they plan to make.

We visited two properties with people's permission to observe how people were supported in their own homes. We were unable to speak to some people due to their communications needs. We met four people and four care staff, we spoke to four staff and four relatives via telephone interviews. In addition we emailed all staff who worked at the service and received feedback from nine staff. We spoke with the nominated individual who was also one of the directors, the deputy manager, the human resources manager, a development manager, two service managers and the registered manager.

We looked at care records of five people who used the service, training and three recruitment records of staff members and records relating to the management of the service. We also contacted the safeguarding department at the local authority and Healthwatch.

Requires Improvement

Is the service safe?

Our findings

We looked at how the service made sure that there were sufficient numbers of suitable staff to support people to stay safe and meet their needs. We looked at the rotas and received mixed feedback from care staff regarding the staffing levels in three of the properties where people lived. Comments from five of the staff we spoke with indicated that there were times when there were not sufficient numbers of staff to ensure people's needs were safely met. Comments included; "Our staffing levels could be better...we definitely need two on sleeps in staff." Another staff member said, "There definitely isn't enough staff in the mornings. One person may wake up early in the morning and wake others up; both need someone to be with them to keep them separate and safe. When they are all awake it's very difficult to manage and you definitely need two staff to get them ready."

A further two care staff from different properties told us they had experienced difficulty meeting people's needs effectively and safely due to staff shortages. They added that a review of the staffing levels would reduce safeguarding incidents in their services. They also reported that there were times when people had regularly failed to go out on activities due to staff shortages. People who used the service were unable to give us their view on the impact due to their communication needs. The feedback from care staff demonstrated that the staffing shortfalls were having an impact on people's ability to receive the care they required.

We looked at the staff rotas for the service and the provider had planned the staffing requirements for each property ahead, however; in some instances staff sickness had resulted in shortages being inevitable. During and after the inspection visit we spoke to the nominated individual, the registered manager and their deputy about our findings and comments from staff. The registered manager informed us that the staffing arrangements were based on the level of care commissioned by the local authority. They also advised us that they would review staffing levels in the properties where there were concerns. This would ensure that people's needs would be met in a safe and timely manner.

There was a failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons in order to meet people's needs. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

People we spoke with and their relatives told us they felt safe using the service because they trusted the staff that supported them. Comments from individuals who used the service included, "Yes, I feel safe here, there's no problem. I definitely feel that the place is clean and tidy." Relatives said they felt their family members were kept safe by the service. Comments from relatives included, "I definitely think [my relative] is safe there. I don't visit very often. I've never had to raise any concerns as such. They are more like queries that I ask.", "I think [my relative] is safe yes. They went through a blip where they were unwell and the care was fantastic." And "Yes, my lad is safe and I have no concerns whatsoever. The Staff do a marvellous job and it is always very clean and hygienic when I call." And "I do go at different times of the day; there is no restriction on visiting."

One member of staff told us; "To help people stay safe, we keep an eye on them. We lock the doors, follow the care plan closely…We've had training on challenging behaviour, health and safety."

A community professional felt people were safe at the service and that risks to individuals were managed so that people were protected. They commented, "I have placed three people with Zeno this year and have been very happy with the support provided. I have found they provide a very professional and thorough service. They take time to get to know the person fully before compiling detailed care plans and risk assessments."

Before this inspection we received concerns from one whistle-blower regarding the quality of care provided in one of the properties where people lived. They raised concerns regarding staffing levels and allegations of abuse against one member of care staff employed at the service. During the inspection we also received additional concerns from a staff member regarding the quality of the care in relation to another property. These also related to staffing levels and the impact on people's safety.

We reported the concerns to the local safeguarding team. We also spoke to the nominated individual and the registered manager who informed us that they had been aware of some of the concerns raised by the whistle-blower and had took action to address the concerns. However; they informed us they were unaware of the concerns about allegations of abuse against one of their staff. They also added that they would now take action in line with their own policies to investigate the concerns and take appropriate action. The concerns are still under consideration by the local safeguarding team at the local authority.

Staff had received safeguarding training at the beginning of their employment and undertook refresher training. We found safeguarding procedures took into consideration wishes and feelings of people and their relatives. Staff we spoke with knew how to report safeguarding concerns within the organisation, however; they were not aware of how to report concerns outside of the organisation for example to the local authority. We spoke to the nominated individual and the registered manager who informed us that staff report safeguarding through the head office who in turn report to relevant safeguarding authorities. They assured us that staff would be provided with details and procedures for rising safeguarding outside of the organisation. This would ensure staff are able to report concerns timely and confidentially.

We recommend that the service finds out more about improving staff knowledge on how to report and share safeguarding concerns based on current best practice, local and national safeguarding protocols.

Before the inspection we had received a number of notifications for incidents including altercations between people who used the service. We reviewed the records relating to these concerns and action taken with the provider. We found appropriate action had been taken. For example observations had been increased to monitor people and in one property the property had been adapted to separate people and reduce the risk of incidents between people.

Risks to people were assessed and their safety was monitored and managed so they were supported to stay safe and their freedom was respected. The provider's risk management policies and procedures showed the ethos of the service was to support people to have as much freedom of choice in their lives as possible. We found examples of positive risk taking approaches. Staff we spoke with demonstrated a positive risk taking approach which was underpinned by a desire to ensure people's freedom was not limited due to risks around them. One staff member told us; "I am most proud of how we as a team have supported people with very complex needs to fulfil lifetime challenges and special experiences including holidays with support staff and outdoor activities such as hikes and getting out and about in the community regularly."

Records we checked and conversations with staff demonstrated that the provider had systems for ensuring the proper and safe use of medicines. Staff designated to administer medicines had completed a safe handling of medicines course and undertook competency tests to ensure they were competent at this task. Staff had access to a set of policies and procedures which were readily available for reference.

We noted the medicines administration records for medicines were well presented and organised. Medicines audits (checks) were in place and we saw daily and monthly checks carried out by the service managers, senior staff and management. Concerns and errors had been identified during the audits and actions had been taken to ensure people continued to receive their medicines safely. Where errors have been found, staff had been provided support such as further training in medicines management before they could be allowed to administer medicines unsupervised.

We found there were suitable arrangements for the management of creams such as topical creams and temperature was monitored in rooms where medicines were stored. This ensured that the integrity of the medicines was not compromised.

Evidence we saw showed that there was a system to allow the organisation and staff to learn and make improvements when things went wrong. For example there were de-briefing meetings after physical intervention and where errors such as medicines errors had occurred. Staff had received supervision and discussed ways to improve their practices. The management team also met monthly to discuss any issues arising, areas of improvement and best practice.

We looked at the records of three staff members employed at the service. We saw that all the checks and information required by law had been obtained before staff had been offered employment in the service. Staff files were well organised, which made information easy to find. All the files we looked at contained evidence that application forms had been completed by people and interviews had taken place before an offer of employment. At least two forms of identification, one of which was photographic, had also been retained on people's files. Staff members we spoke with confirmed they had been checked as being fit to work with vulnerable people through the Disclosure and Barring Service (DBS). This meant the provider had taken appropriate steps to ensure only suitable staff were employed to work in the service.

There were policies in the service to protect people from risks of infection. Staff had received induction training on infection control and prevention. Staff who supported people with food preparation had received food and hygiene training. In addition staff had completed infection control audits and were provided with person protective equipment. However; we noted some shortfall in the training. 42 staff out of 123 had not renewed their training. This would help to ensure people would be protected from risks of infections. We report further on training in the Effective domain of this report.

Requires Improvement

Is the service effective?

Our findings

We looked at how the service made sure that staff had the skills, knowledge and experience to deliver effective care and support. Relatives of people who were supported by Zeno Limited told us they felt the staff were appropriately trained and had the necessary skills and abilities to meet their needs. Comments from relatives included; "I think Staff have the skills they need.", "The manager always rings if there are any concerns and they also listen if I have questions for them", "They are anxious to train staff as soon as they start. They may not know much when they start, but they soon teach them and have them learning the job." And; "Staff really do have skills above and beyond the call of duty."

Similarly we received positive feedback from the professionals who worked with the service. Comments included; "We have found them to be a responsible agency who contact us appropriately and have the interests of their clients central to their focus." Another professional told us; "The support staff all appear competent and are able to answer questions which indicate that they have good person-centred knowledge of the people they support."

Staff feedback about training and development was mixed. Four of support workers we spoke to informed us the training was valuable and gave them the correct skills. However; four other support workers informed us they felt they had not received adequate training in specific areas such as safeguarding adults and mental capacity.

We reviewed the training records for the whole service and found staff had received regular supervision and a number of training courses had been provided. There was a four day induction training programme that was offered to all staff before they commenced their role. This included an introduction to the Care Certificate, mental capacity and safeguarding. The Care Certificate is a nationally recognised set of standards that health and social care workers are expected to adhere to in their daily working life. Records showed that staff had started the Care Certificate at the start of their employment.

Following their induction staff were required to complete training that was specific to the needs of people they supported. For example staff had received; training in areas such as autism, managing and supporting people who display behaviours that challenge and positive behaviour support. In addition staff were required to complete refresher courses online using e-learning. 50 staff had obtained a Level 2 or above National Vocational Qualification or a Diploma in Health and Social Care. There were plans for staff to complete accredited training in positive behaviour support.

We spoke to the registered manager who informed us that safeguarding training mental capacity, and care certificate were offered on the first day of induction. They added that staff were expected to complete e-learning refresher as part of their ongoing training in areas that the provider had deemed necessary for the role, also known as 'mandatory training' in the organisation. They also informed us that they had delegated other managers to ensure staff completed the e-learning. The records of e-learning showed a significant number of staff had been enrolled to complete their e-learning. For example 39 staff had enrolled but not completed e-learning in safeguarding. 45 staff had also enrolled but not started or completed their e-

learning in mental capacity. These shortfalls were evident in all areas of training that the provider had deemed necessary for the role.

We discussed with the registered manager the need to ensure oversight of staff's completion of training and to ensure they were completing the booked e-learning timely. The organisation's training policy needed to be reviewed as it did not provide guidance on how often staff were required to complete training. This would ensure that people can be assured that staff supporting them have the right skills and knowledge to deliver safe care and treatment. We spoke to the registered manager who informed us that all staff would be reminded about timely completing their e-learning. They also informed us that some of the staff were new to the service and yet to complete their training.

There was a failure to ensure that all staff had received such appropriate support, training, professional development as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedures for this in supported living and are called the Court of Protection Deprivation of Liberty Safeguards (DoLS). The nominated individual informed us that they had routinely notified the local authorities if they felt the care they provided resulted in restrictions on people's freedoms. None of the requests had been authorised due to backlogs at the local authority. The registered manager was regularly checking progress of the other applications.

People and their relatives informed us that staff sought consent and considered people's mental capacity while providing care support. Care files demonstrated staff had ensured that people or relevant relatives and professionals who acted on their behalf were involved in and agreed to the care delivered. Relatives we spoke with during the inspection confirmed this had happened.

We found mental capacity assessments had been completed for when people were required to make significant decisions about their care. Best interest decisions had been completed where people lacked mental capacity. Consent to photographs and medicines management had been completed. Consistency was required to ensure that all mental capacity assessments were completed in the people's files to provide staff with guidance on people's ability to consent. For example in three of records we checked the mental capacity assessments had not been filed. We spoke to staff in the service and they could not locate the mental capacity records in the houses where people lived. However, the nominated individual located some of the records at the head office. They informed us this was due to the recent change of offices. However, records of people's consent should be available at the point where care is delivered. This would ensure that staff have the up to date guidance on people's ability to make specific decisions.
We recommend that the service consider current guidance on mental capacity and effective records keeping.

There was an up to date policy in relation to seeking consent and mental capacity. Staff we spoke to were knowledgeable and shows awareness of MCA principles. They also informed us that there were on-going discussions with in team meetings and supervision around mental capacity principles. However, not all staff had received up to date training in mental capacity.

We looked at how the provider ensured that people's needs and choices were assessed and care, treatment and support delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes. Records we reviewed showed that people's physical, mental health and social needs

were holistically assessed, and their care, treatment and support delivered in line with legislation, standards and evidence-based guidance. For example, staff had been trained in positive behaviour support, which recognised how people can communicate through their behaviour and how staff should respond. Behaviour was seen as a form of communication which staff needed to understand.

We saw evidence of staff following best practice to support people. For example, staff explored different way of facilitating communication with people who had limited verbal communication skills. They were utilising the picture exchange communication system (PECS) to ensure people could express their needs. The picture exchange communication system, or PECS, allows people with little or no communication abilities to communicate using pictures. People using PECS are taught to approach another person and give them a picture of a desired item in exchange for that item.

We found the service provided care and treatment to people who could display behaviours that can challenge others. Records we saw and conversations with staff and relatives demonstrated that there were instances where it had been deemed necessary for staff to use physical restraint and medicines to calm individuals where their behaviour had posed a risk to themselves, others and/or property. There were policies and guidance to ensure that where this was necessary, it was used in a safe, proportionate, and monitored way as part of a wider person-centred support plan. Staff had received training in the safe use of physical restraint known in the service as Management of Actual or Potential Aggression (MAPA). Staff had been instructed to use restraint as the last resort. There was guidance to use other strategies to de-escalate the situation before restraining a person.

We found regular analysis and management meetings had been carried out on to analyse the number of incidents and instances of physical restraint. We also noted that discussions were held with staff on strategies that they could use to reduce incidents and the use of restraint. Regular reviews had been undertaken to identify if the strategies were working and to find ways of improving them.

One of the office staff was employed as a positive behaviour worker who worked with the service to support them around managing the needs of people whose behaviours might challenge others. A positive behaviour practitioner is trained in specialist approaches, such as applied behavioural analysis and positive behaviour support. The practice is intended to enhance the quality of life and opportunities by establishing consistent supported approaches that complements the individual and reduces the potential for challenging behaviour. The positive behaviour support worker helped to write positive behaviour support plans that provided staff with guidance on supporting people effectively.

Care files were clear in their guidance to support the staff to meet the individual nutritional needs of people. Staff had clearly identified people who required support with their nutritional needs. Files had evidence that a nutritional risk assessment had been completed that identified what support people required. Where specialist nutritional support had been identified, for example; where there was a risk of choking, care plans and risk assessments had been developed. These were thorough and contained detailed guidance to support staff in providing safe care whilst minimising any risks.

Staff had ensured that people's individual needs were met by the adaptation, design and decoration of their properties. People's environments were appropriately adapted to safely meet people's needs. For example, access to the properties and to bathing facilities in some properties had been adapted to ensure people had easy access. Properties were decorated with people's own pictures and personal items.

We looked at how people were supported to live healthier lives, have access to healthcare services and receive on going healthcare support. The service had links with other healthcare professionals, which was

recorded in people's intervention and treatment plans. People had health care action plans and received regular health checks where required. For example, people living with conditions such as diabetes.

There was also clear evidence of the service seeking advice and support from other agencies. We saw that guidance from healthcare professionals had been incorporated in people's care plans. For example, we saw that one person had complex needs. There was detailed analysis of their needs with and the required interventions to include, learning disabilities nurses, psychologist and GPs. In addition the managers in the service had clinical background in areas such as nursing and psychology. There was guidance and contact details for specialist professionals to ensure people received seamless care. This demonstrated that staff within and across the organisation worked together to deliver effective care, support and treatment.

Good

Is the service caring?

Our findings

We received positive comments about the care staff and the service delivered to people. Comments from people included, "The staff are nice, they do help me when I need them to", Comments from relatives included "The staff do treat [my relative] with kindness and compassion, definitely." and "I have confidence in the staff they try their best." One relative added that they're a very caring staff and they help him [relative] to be independent.

Our observations and our conversations with people showed that people were treated with kindness, respect and compassion, and that they were given emotional support when needed. For example we saw a staff member directing a person away from harm by talking to them gently and asking them to follow them. We also noted people being sensitively supported to ensure they maintained their dignity. Staff spoken with and the registered manager had a sound knowledge and understanding of the needs of people they cared for. Staff members told us how they enjoyed working at the service. Comments from staff included, "With working so closely with people and for so many hours a week, you get to really know the person and what they like and don't like. I'd be happy for a member of my family to live here. We are a caring staff team and want the best for the people in our care" and "I like my job and I enjoy supporting people."

One social worker told us, "The people I have placed with Zeno have all had complex needs. Other providers had felt unable to manage their needs. It is heartening that Zeno appear to look at the reasons behind behaviours and try to work with the person, rather than viewing the person as a problem, as is the case with some providers." A doctor also commented, "I have positive feedback to make on the caring and positive attitude they have towards service users."

We considered how people's dignity was maintained and promoted. We noted people's daily records and care plans had been written in a way that took consideration of their choices and preferences. People had been asked about their likes and dislikes and this had been included in their daily support. Staff we spoke with talked about people in a respectful, confidential and friendly way. Guidance had also been provided on how to approach people and what to say when they appeared distressed.

People's privacy was respected. People's bedroom doors were fitted with suitable locks to help promote privacy of personal space. One staff member told us, "Having a female and two males, it makes sense to have half of the upstairs for the female and the other half for the males. We put the latch on when providing the female with help in personal care." Staff also described how they upheld people's privacy, by sensitively supporting people with their personal care needs and maintaining confidentiality of information. There was confidentiality policy which had been available to care staff. We observed staff knocked on bedroom doors before entering and ensured doors were closed when people were receiving personal care.

People's relatives and friends told us they were made to feel welcome and were able to visit without being unnecessarily restricted. However; where it was felt a relative's visit may not be in the best interest of the person's welfare, staff had put measures in place to manage the visits and ensure people were not exposed to risk. This had been done in consultation with other professionals. We also found people were allowed to

be as independent as they could. For example people we observed people moving around their environment independently with no restrictions. In some cases people had been supported to make their own meals or to assist with house chores such as hovering and shopping. This meant that staff had supported people to use and develop their independent living skills.

The service supported people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible. We saw staff had sat down with people to discuss their preferences and choices and where this was not possible families and professionals had been involved. For example, we saw people being consulted about where they wanted to go on holiday. There was policy on advocacy which was made available to staff when they commenced their employment. The safeguarding policy also and the mental capacity policy also provided information on when staff should consider involving an advocate. In majority of the cases family had acted as advocates for their relatives.

Advocates support people to access information and make informed choices about various areas in their lives. Relatives that we spoke with informed us that they had been more involved in the care of their family members and that this had improved the quality of the care they received. The care staff we spoke with displayed a real passion in relation to the care of people and it was evident that the ethos of the service was based on the care and compassion of the people using the service.

Good

Is the service responsive?

Our findings

People received personalised care that was specific to meet their needs and they were involved in the planning, goal setting and reviewing of their care. People were supported to do things they enjoyed and follow their interests. Comments from people included; "I like to watch films. John Wayne and Sylvester Stallone are the best. I go out with Staff shopping...oh yes, today we went to the cinema to see a film, and it was very good. I enjoyed it."

Relatives were equally positive and felt the service was responding to people's needs.

People's care records demonstrated that the service had ensured that people's care plans fully reflected their physical, mental, emotional and social needs. They had been developed where possible with each person, family and professionals involved with them, identifying what support they required. Relatives told us they had been consulted about support that was provided before using the service. They told us they sat down with service managers and the registered manager regularly to discuss what had gone well and what could be improved.

During the reviews, people's outcomes were discussed and people given an opportunity to discuss what had gone well and what could be improved. We found review records called 'Care pathways to better outcomes' had been used. These records were well written and person centred. The process followed was holistic and looked at the whole person. In addition to this, a key worker produced a monthly family report which contained information about the person, their activities and achievements. The care planning approach in the service demonstrated how staff took into account people's strengths, their levels of independence and their quality of life. This was an example of best practice which was aimed at enhancing people's well-being and quality outcomes.

One relative told us; "My [relative] has a care plan and they ring every week and tell us what he has been doing. They also send out newsletters and are really good with things like that. He is out more or less every day bar Sunday and even then they try to do things around the house with him." A relative told us, "Yes, the care plan is reviewed all the time because [relative's] needs change." Another relative said "Yes, I always have quarterly meetings to discuss future goals."

A professional commented "There seems to be a strong ethos of wanting to get people out, to address problem areas and to see that they flourish. They have been pro-active in communicating with me, asking for additional reviews when they have had concerns. I observe good interactions with service users, and service users have appeared to be content in their services."

The registered manager, the deputy manager and the nominated individual explained to us that when written instructions are received by the service for a new care package, they would make the initial assessment. Following the completion of the assessment they would start transition work to ensure the person was compatible to live with others. One professional told us, "I have found they provide a very professional and thorough service. They take time to get to know the person fully before compiling detailed

care plans and risk assessments." The care records we reviewed confirmed this.

Staff completed a range of assessments to check people's abilities and review their support levels. For instance, they checked individual's needs in relation to mobility, mental and physical health and medicines. Any specific requirements for each individual had been identified, for example, people who required assistance with moving, personal care needs, people who were at risk of choking and people who were at risk due to their vulnerability.

We also found staff had completed separate assessments which identified any specific needs or risks. They had then developed 'situation specific support plans' as well as positive behaviour support plans. These support plans were well details and comprehensive. They contained guidance on how people would present in different situations and proactive strategies that staff could use to prevent certain the situations from escalating. They were plans of action on how to support people which were further supported by a series of risk assessments.

Staff we spoke with demonstrated that they had taken time to familiarise themselves with people's care records. This meant that staff had an understanding of people's needs and wishes, but also of their strengths and abilities.

People were supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them, including in the wider community, and where appropriate, have access to education and work opportunities. For example, one person had been supported to follow their education interest and the provider had started to work towards gaining accreditation to provide an accredited education programme for people they supported.

The service's values and ethos supported people's involvement in community activities and a positive risk taking approach which enabled people to explore and enjoy outdoor activities. There were weekly organised hikes and nature walks horse riding, and swimming among other therapeutic outdoor adventures. Some people had gone for walks in Snowdonia. People were supported by experienced outdoor staff and all staff employed had been provided with protective equipment as required.

In addition, the nominated individual informed us that the service owned its own horses which were accessible to people. The provider had also referred to research and best practice on how people can be supported in the community and how this would enhance their well-being. It was evident from the records we saw and conversations with staff and management that they valued the benefits of community involvement and the provision of therapeutic activities.

People were encouraged and supported to develop and maintain relationships with people that mattered to them, both within the service and the wider community, and to avoid social isolation. For example, we saw one person who used the service had been supported to regularly maintain contact with their, family and local community using public transport and to continue accessing facilities in the community. Another person was supported to have access to church where they had developed positive relationships with other people.

One staff member told us, "One of our service users loves music, so he has a weekly music lesson. He also enjoys watching videos of trams, so he has a membership at the Tram Museum in Crich, Derbyshire, and he takes the tram to Manchester every Monday." In addition, the provider organised family events for people, their families and staff and their families. This helped to maintain continuity and reduce social exclusion for people supported and to engage with families.

Another service manager told us "When drawing up our support plans we look at interests and options and build that into the plan so that support workers can enable participation in activities that people enjoy. As staff, we often complete an interest checklist with people to find out what they have done in the past, what they would like to do now and in the future."

The service had identified and met the information and communication needs of people with a disability or sensory loss. For example, each person's care file contained a communication plan which detailed how people needed to be supported with their communication needs. These were very person centred and sensitive. For example, in one person's file; staff were guided on the choice of words to use to support a person. Where people had specific communication needs, these had been identified. One staff member told us; "We use a total communication approach within the company, and we are trained in delivering as a group, a number of various communication intervention. Some of these include PECS, makaton, signing, and visual support. As well as person centred verbal and physical communications, which are set out in their communication passports."

Information about people was recorded clearly and respectfully, and shared with others when required. People's consent to share their information had been considered. We saw records for ensuring safe transfer to hospital or other care settings had been completed and filed in people's care records. This would be useful when people were transferred to other care settings.

The service had a complaints procedure which was made available to people and their representatives before they started to use the service. Copies were on view in the office. The complaints procedures had been written in an easy read format to enable people who used the service to understand the procedures. The procedure was clear in explaining how a complaint should be made and reassured people these would be responded to appropriately. Contact details for external organisations including social services and CQC had been provided should people wish to refer their concerns to those organisations.

We spoke with people who used the service and with relatives. They told us they knew how to make a complaint if they were unhappy. They told us they would speak with the registered manager or their service managers who they knew would listen to them. We looked at the complaints that had been received at the time of our inspection. Complaints had been dealt with in timely manner and in line with the organisation's policies and procedures. Where necessary the registered manager had contacted the complainant and discussed their concerns with them. We saw changes had been made following a compliant. For example, in one case family had complained about time keeping and consistency of staff. We saw this had been resolved and staff were reminded of their responsibilities. We also saw how concerns with neighbours had been responded to. Appropriate action had been taken when concerns had been raised.

Records we saw demonstrated that the provider and the staff had taken into consideration people's preferences and choices for their end of life care. For example, there was a policy which guided staff to record where people wished to die, including in relation to their protected equality characteristics, spiritual and cultural needs. There was also guidance on communicating with families and professionals to support people towards the end of their life. This showed that there were plans to ensure that people were supported at the end of their life to have a comfortable, dignified and pain free death.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager employed at Zeno Limited. 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.

We received positive comments from people about the organisation. Comments from relatives included; "I've met the service manager and she is very approachable. If I wasn't happy, I am the kind of parent who would say something and complain but I've had no reason to. I am really pleased for my [relative] that he gets good support from good staff.", "(name removed), the head boss has given me his personal mobile number. (name removed deputy service manager) and (name removed service manager) are also very good and the business all seems very transparent." And; "I feel that I can talk to the manager. The open days that they hold at the home are so useful and it's a really good service and my lad is very happy."

We received mixed feedback from staff. Comments included: "It's a good place to work and I would recommend it", "We work well as a team and have managed to overcome any tension or disagreement constructively. Constructive criticism is encouraged not only between staff members, but of management as well.", "The team is passionate, we do our job well, and the service users are inspiring."

However; four of the care staff we spoke with raised concerns regarding management's responses to the concerns in the service for example, staffing levels in three properties, the culture and the quality of training provided. Comments included, "There is a closed culture between head office staff and support workers.", "If I report concerns to my immediate seniors, I don't feel listened to, we are told head office are aware.", "Management are not always approachable and issues I raised regarding the quality of the service are not taken on board."

Following the inspection visit, we discussed the views from staff with the registered manager and the nominated individual. They informed us that they were not aware of the level of concerns raised however; some of the issues had already been raised with them by former staff. They added that they would review the staffing situation and provide staff and management with necessary support to ensure issues are escalated by service managers to the registered manager and nominated individual. They also informed us they engaged staff across the organisation and encourage open dialogue. This would assure staff that their concerns and views are listened to.

During this inspection we identified two breaches of regulation in relation to staffing levels and staff training. This demonstrated that the arrangements for assessing quality and safety required further improvements to ensure they were effective and robust in identifying concerns.

Staff we spoke with demonstrated they had a good understanding of their roles and responsibilities. We found the service had clear lines of responsibility and accountability with a structured management team in place. The registered manager and the nominated individual were experienced and had an extensive health

and social care background. They were knowledgeable and familiar with the needs of the people they supported. In addition to the registered manager, there was two directors one who had a clinical background in psychology as well as learning disabilities. They supported two deputy registered managers, a team of service managers, an activities coordinator, human resources manager, a business development staff, support workers and office staff.

Care staff had delegated roles including medicines ordering and catering and domestic duties. In majority of the cases each person took responsibility for their role and had been provided with oversight by the registered manager.

We looked at how staff worked as a team and how effective communication between staff members was maintained. Communication about people's needs and about the service was maintained. However; as noted in staff comments further improvement were required to ensure staff were confident to report concerns be confident that they will be passed to relevant managers and acted on. We found handovers, were used to keep staff informed of people's daily needs and any changes to people's care. Information was clearly written in people's care plans records showing what care was provided and anything that needed to be done. People's daily records were written in a respectful and dignified manner.

Staff and service user meetings were held on a regular basis. We confirmed this by looking at minutes taken of meetings and care files. In addition, staff surveys were carried out regularly. The registered manager analysed any comments and shared them with registered provider who had acted upon them. Feedback we saw demonstrated people and their relatives felt the service was of a good quality. We saw people and staff were consulted on the daily running of the service and any future plans.

The provider had undertaken quality assurance inspections in the service. These audits provided support with ensuring compliance and analysing information in the service such as accidents and incidents, as well as monitoring that the service was complying with regulations and quality requirements with other regulatory authorities. They also drew action plans for the registered manager and monitored that these had been completed in a timely manner. The registered manager met with the director on a monthly basis to discuss the quality of the service, progress and future plans. This also gave them the opportunity to discuss areas of concern and to share updates in requirements or any developments or changes in regulatory requirements.

We found regular audits had been completed. These included medicines, the environment, care records and accidents and incidents. However; audits had not always effectively identified shortfalls in the quality of the service. For example, we found significant shortfalls in staff training and staff deployment, record keeping for mental capacity records and concerns from staff regarding escalation of safeguarding concerns. These shortfalls had not been identified and acted on before our inspection. This meant that the quality assurance systems in the service had not always been effectively implemented to monitor compliance and the quality of the service provided.

The provider had failed to maintain good governance. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

In their PIR the registered manager wrote; 'Every Monday the registered manager and the deputy registered manager meets with a member of the development team, human resources manager, activity manager and director, at the meeting we complete a Red Amber Green (RAG) document, this document is updated if and when changes are made to the organisation. To review the RAG a monthly meeting is held with the directors to discuss the last month's changes. This is also an opportunity to share good practice, and a platform for

directors to inform of any changes within the organisation. At the registered managers' meeting held on a Monday, areas covered are safeguards, staffing , areas of development , health and safety, recruitment, supervisions, appraisals, general changes in the organisation. The meeting gives everyone an opportunity to have an in depth view of how the organisation is running and an opportunity to pre-empt any difficulties. Records we checked on inspection confirmed this.

We saw initiatives by the registered manager to demonstrate how they cared for their workforce. The nominated individual told us that they had achieved the Investors in People (IPP) recognition. IIP is an external accreditation scheme that focuses on the provider's commitment to good business and excellence in people management. However, as noted above staff had not always been monitored to ensure they were completing training.

The provider had obtained investors in diversity accreditation. This is an award granted to organisations that demonstrate fairness for all in the workplace by embedding equality, diversity and inclusion. There was also an employee of the month award for staff who had demonstrated exceptional performance. In addition, all staff had been provided with protective clothing for outdoor activities.

There were strong links with the local community and had strengthened their relationships beyond the key organisations. There were arrangements to ensure the service and staff kept up to date with good practice. There were staff nominated as champions in various areas of care. These staff would attend multi-disciplinary meetings with other stakeholders such as the local Clinical Commissioning Groups children service departments and adult social care services within the local authorities. They also shared information and best practice with other charitable organisations. The directors and managers attended and chaired provider meetings within their locality.

The service had sent statutory notifications for reportable incidents in the service as required by the regulations.

The service worked in partnership with other organisations. These included social services, healthcare professionals including General Practitioners, specialist nurses, dieticians and best interest assessors. The service also worked closely with the local special schools and local adult education providers to ensure people living at the home have a contribution in their local community.

During the inspection we found the nominated individual, registered manager and staff open and transparent with the inspection and keen to address the shortfalls we identified.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure governance systems were robust and systems or processes were not established and operated effectively to ensure compliance. Regulation 17 (1) (2)(a)(c) HSCA RA Regulations 2014 Good governance

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that persons employed by the service provider in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2)(a)(b) HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons in order to meet people's needs. Regulation 18 (1) HSCA RA Regulations 2014 Staffing