92 Higher Drive Limited

# Highfield House

## Inspection report

92 Higher Drive
Purley
Surrey
CR8 2HJ

Tel: 02087632060

Date of inspection visit:
23 November 2017
27 November 2017

Date of publication:
01 February 2018

## Ratings

| Overall rating for this service | Outstanding ☆ |
|---|---|

| | |
|---|---|
| Is the service safe? | **Good** ● |
| Is the service effective? | **Outstanding** ☆ |
| Is the service caring? | **Good** ● |
| Is the service responsive? | **Outstanding** ☆ |
| Is the service well-led? | **Outstanding** ☆ |

# Summary of findings

## Overall summary

Highfield House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Highfield House can accommodate up to 45 people across three floors, each of which have separate adapted facilities. People were able to interact across the floors. Highfield House specialises in providing care for people who are medically highly dependent due to their complex physical and/or neurological disorders. At the time of our inspection 37 people were using the service.

At the last inspection on 9 October 2015 the service was rated 'Good' overall and for each key question. At this inspection on 23 and 27 November 2017 the service had improved their rating for the key questions 'Is the service effective' 'Is the service responsive' and 'Is the service well-led' to 'outstanding'. This meant the service was now rated 'outstanding' overall.

People, relatives, staff and healthcare professionals were very complimentary about the management team at Highfield House. They felt the management team were approachable and interested to hear from them their experiences and any suggestions to improve practice. Healthcare professionals felt there was a drive within the staff team to improve and develop their practice.

Since our last inspection the provider had developed their corporate values. The provider had updated their policies and procedures linking them to their values and adopting the five CQC key questions as their desired outcomes. The provider's values and behaviours underpinned their governance framework and there were robust procedures in place to review and improve the quality of service delivery. Staff worked in partnership with other agencies, this included liaison with their local NHS trusts, Clinical Commissioning Groups (CCGs) and the local authority. The service followed public health England guidance and implemented NHS initiatives at the service. There were systems in place to enable staff to continuously learn, improve, innovate and ensure sustainability of service. The provider issued safety alerts in response to any incidents that occurred. They had also developed a staff newsletter which was themed on the 5 CQC key questions to further enhance staff's understanding of the five questions about how the care they provided fitted into these and the provider's values.

Staff were very passionate about their roles and working at Highfield House. Staff, people and relatives were keen to share with us their experiences of Highfield House and staff were very proud of the work they did. There was an obvious drive and commitment within the team to provide high quality personalised care. All of the healthcare professionals we received feedback from were very positive about the quality of service delivery and joint working arrangements.

Staff stayed up to date with and delivered care, support and treatment in line with best practice guidelines. This included guidance from the National Institute for Health and Care Excellence (NICE) and Royal College

of Physicians (RCP). The management team organised for authors from recently published guidance to come to the service to speak to staff and families about the new guidance available. There was a comprehensive training programme in place and robust processes to ensure staff were competent to undertake their allocated tasks. Training drop in sessions were held daily for staff to update their knowledge on the provider's mandatory training topics as well as 'skills sessions' held for staff to update their clinical knowledge.

The service provided healthcare support in line with the principles of the NHS England's vanguard initiative for enhanced models of care which ensured proactive review of people's healthcare needs and streamlining processes to ensure accurate and complete information was available in the event people required emergency hospital admission. The chef worked with specialist healthcare staff to ensure meals provided met people's complex dietary requirements. An accessible environment was provided which took account of people's physical and sensory needs. Staff adhered to the Mental Capacity Act 2005. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People, relatives and healthcare professionals were extremely positive and complimentary about the care and support provided to people. Care was person-centred and met people's individual needs. Assessments were regularly undertaken to review people's needs and any changes in the support they required. Detailed support plans were developed instructing staff about how to support the person. Care staff worked with the therapy team to support people's rehabilitation and help people to develop their independence. A range of devices were used to support staff to assess and improve people's cognition, memory and attention span, as well as using rehabilitation computer games to incorporate fun into people's recovery. Staff followed the 'six steps to success' programme to ensure high quality end of life support was provided. An annual memorial event was held to remember those that had died. A range of activities were provided at the service and in the community. There were different sessions available which targeted different groups of people depending on their needs. One to one activities were provided as well as a group activity programme.

The service had systems for ensuring concerns about people's health and welfare were managed appropriately and care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. People felt safe at the service and told us they received prompt support from staff. People's dependency levels were reviewed daily and there were sufficient staff, with appropriate skills and knowledge, to meet people's needs. This included providing one to one support for people with high risk complex care needs and recruiting specialist clinicians required to provide people with safe care and treatment. Staff assessed risks to people's safety and systems were in place to minimise risks to people and to alert staff as people's risk levels changed.

Safe medicines management processes were adhered to. Staff followed best practice guidance to prevent and control the spread of infection. Systems were in place to report incidents and learning was shared in response to any errors made, including issuing safety alerts to all staff about how to prevent similar incidents from recurring. Staff followed best practice in regards to safeguarding people from avoidable harm.

Staff had developed therapeutic and caring relationships with people. Staff were aware of people's preferred name and their preferences in how they were supported. Staff respected people's individual differences, their religious preferences and their culture and provided any support people required with these. People's privacy and dignity was maintained. A dignity champion was nominated who held various events to promote dignity and explore people's understanding of what it meant to maintain people's dignity. Staff were aware of people's communication methods and provided them with any support they

required to communicate, including use of technology, in order to ensure their wishes were identified and they were enabled to make decisions and choices about care and service delivery.

A complaints process remained in place and complaints received were investigated appropriately. Many of the complaints received since our last inspection focused on the building work that was previously carried out and this had now been resolved. The service received many compliments about the staff and the care and support people received whilst at Highfield House.

## 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 remains good.

### Is the service effective?

Outstanding ☆

The service provided outstanding effective care.

The service stayed up to date with good practice and ensured all staff and families understood good practice guidance. There was a holistic approach to care delivery and the service supported implementation of evidence based techniques.

Staff training was developed and delivered around the individual needs of people using the service. There was a proactive support system which continued to develop staff's knowledge and skills, offering easily accessible support structures for staff to refresh their knowledge and clinical skills.

Staff were aware of people's individual preferences and patterns of eating and drinking. There was flexibility in order to meet people's complex and unique eating and drinking requirements.

There was a thorough approach to planning and coordinating people's health needs through the delivery of ward rounds by the GP and neuro-rehabilitation consultant to ensure people's complex and continuing health needs were met. Practices reflected new models of care in regards to preventing and streamlining admissions to hospital care.

### Is the service caring?

Good

The service remains good.

### Is the service responsive?

Outstanding ☆

The service provided outstanding responsive care.

People, relatives and healthcare professionals were extremely positive and complimentary about the care and support provided to people.

Care was extremely person-centred and met people's individual

needs. Care staff worked with the therapy team to support people's rehabilitation and develop their independence.

The service had an innovative approach to using technology. A range of devices were used to support staff to assess and improve people's cognition, memory and attention span, as well as using rehabilitation computer games to incorporate fun into people's recovery.

The staff work closely with healthcare professionals and provided outstanding end of life care through implementation of the 'six steps to success' programme. An annual memorial event was held to remember those that had died.

A range of activities were provided at the service and in the community. There were different sessions available which targeted different groups of people depending on their needs.

## Is the service well-led?

**Outstanding** ☆

The service provided outstanding leadership and management.

People, relatives, staff and healthcare professionals felt there was exceptional leadership and management which was committed to providing high quality care in line with best practice. There was a strong organisational commitment to the provider's vision and values which were outcome based and put people at the heart of the service. The provider's values and behaviours underpinned their governance framework and there were robust procedures in place to review and improve the quality of service delivery.

There was consistent engagement with staff and people who use services and constructive challenge from people, their relatives and healthcare professionals was welcomed and used to improve practice.

There was a particularly strong emphasis on continuous improvement and staff were proud of the quality of service delivery.

# Highfield House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 and 27 November 2017 and was unannounced. The inspection team included an inspector, a specialist professional advisor specialising in nursing and care home management, and an 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 care service.

Prior to the inspection we reviewed the information we held about the service, including statutory notifications submitted about key events that occurred at the service. We also reviewed the information included in the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with five people, five relatives and 20 staff including members of the management team, care and nursing team, the therapy team and the chef. We reviewed seven people's care records, eight staff records, records relating to medicines management and other records relating to the management of the service. We undertook observations throughout the inspection including at mealtimes, attendance at a multi-disciplinary staff meeting and during a music therapy session.

After the inspection we contacted health and social care professionals who worked with staff to provide care to people. We received feedback from four professionals.

Good

# Is the service safe?

## Our findings

All the people we spoke with felt safe at the service and this was also confirmed by the relatives we spoke with. A person said, "Definitely, the carers are good, conscientious - I don't feel in any danger." Some people received one to one care and they told us there was always a staff member present to support them. For those that did not require one to one care they told us staff regularly checked on their safety. One person said, "'Yes, it's secure everyone checks me out. They are very nice people, very kind'." People had call bells in order to get staff assistance. Some people had different bells for different circumstances to help staff understand whether the person required urgent assistance. One person told us, "I have a safety bell and when I press that everyone comes running quite quickly… I press my emergency bell which I keep under my t-shirt. I have two - one for if I want a cup of tea and one for emergency the black one."

Staff were aware of their responsibilities to safeguard people from harm and were aware of the reporting procedures if they had concerns about a person's safety or the quality of care they received. The registered manager had raised concerns with the local authority safeguarding team when they had concerns about a person returning from another care provider, for example in regards to pressure ulcers obtained whilst receiving care in hospital. The registered manager liaised with the local authority about the concerns raised so they were aware of the outcome of the investigation and any learning. At the time of our inspection there were no ongoing safeguarding investigations.

The service had systems for ensuring concerns about people's health and welfare were managed appropriately and care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. Clinical risk assessments were in place which were outcome led, including use of the National Early Warning Score (NEWS). Care records included the plans to manage the risks identified and minimize the risk of harm. There were plans for risks associated with needs such as respiration, risk of malnutrition or dehydration, those at risk of falls, moving safely around the home and skin care. One person's relative told us about the risk management plans in place to support their family member with their epilepsy and when they had a seizure. Also about the care and attention provided whilst supporting them with personal care as they were at high risk of injury when being moved. They said the physiotherapy team had helped staff to undertake safe moving techniques. Staff were able to demonstrate clearly how they managed risk and we saw members of staff were competent in using the required equipment.

Checks were undertaken to ensure a safe environment was provided and that equipment remained in a safe working order. This included electrical safety, gas safety, legionella checks, monitoring of water temperatures, fire equipment checks, servicing of lifting equipment including hoists and lifts, bed rails and mattress checks, calibration of specific medical equipment and checking window restrictors.

There was a large multi-disciplinary team providing support to people. Many of the people using the service required one to one staffing because of the high risk complex care they needed. This one to one support was rostered and staff were dedicated on each shift to provide this level of support. There was a daily review of people's dependency levels and staffing levels were adjusted to take account of changes in people's needs. The registered manager also took account of staff's experience and skills when developing the staffing rota

to ensure staff with the required competencies and skill mix were on each shift to provide the specialist care people required.

The provider directly employed a number of therapy staff including physiotherapists and occupational therapists. The provider had identified there were difficulties accessing certain community healthcare professionals due to a lack of resources available. They were aware they could not safely meet people's needs without this specialist input and therefore had made arrangements to buy in sessional support from dieticians and speech and language therapists. There were also arrangements to have input from respiratory specialists and a neurorehabilitation consultant.

During 2017 the service increased their bed numbers from 27 to 45. The service was gradually increasing the number of people they supported and were undertaking continuous recruitment to ensure they had sufficient staff to meet people's needs. Safe recruitment practices were followed to ensure skilled, experienced and knowledgeable staff were employed. This included checking staff's eligibility to work in the UK, obtaining references from previous employers and undertaking criminal records checks. At the time of inspection there was not a process in place to undertake criminal records checks throughout employment, however, the HR manager told us there were plans to implement this and undertake criminal record checks every three years in line with best practice. We will check implementation of this at our next inspection.

Medicines continued to be stored securely. For the majority people received their medicines as prescribed and accurate records were maintained of the medicines administered. On the first day of inspection for two people we identified minor medicines administration errors. By the second day of inspection all errors had been reported through the incident reporting process. It had been investigated as to why they occurred and what practice changes were required to prevent recurrence. Safe practice was followed in regards to the storage, administration and recording of controlled drugs. Protocols were in place in regards to medicines people required on a 'when needed' basis and in regards to medicines people required in an emergency, for example if they developed an infection. Information was also included about homely remedies (medicines that can be obtained without a prescription) and when it was appropriate to administer these medicines.

A clean environment was provided. One person said, "Very well maintained and very clean." Infection control was particularly important at this service due to the risk to people's health if they acquired an infection. All staff received infection control training and there were clear policies and procedures in place. Infection control and hand washing audits were undertaken to ensure staff were adhering to infection control procedures. We saw infection control was also addressed in the staff newsletter focusing staff on providing safe care. We observed staff using appropriate personal protective equipment. Staff were knowledgeable about what practices to follow in order to prevent and control the spread of infection.

All incidents, accidents and near misses were reported and reviewed by the registered manager and at the safety committee meeting. For significant adverse events, safety alerts were issued to all staff. In these safety alerts was information about the poor practice but also clear guidance about how to prevent these from recurring. This included guidance in response to the minor medicine errors we identified on our first day of inspection, reiterating that nursing staff should not be interrupted when administering medicines, unless there was an emergency. The provider was also updating their safety information leaflet for relatives and visitors informing them of the importance of not interrupting staff when administering medicines.

Outstanding ☆

# Is the service effective?

## Our findings

A healthcare professional told us, "The staff are knowledgeable regarding the patients' current clinical state…When, as is expected in this frail cohort, patients have deteriorations in their respiratory data [staff] are prompt to get in contact and reactive to advice given."

The implementation of national good practice underpinned service delivery and enabled staff to provide evidence-based care in line with current legislation and standards. This included guidance from the National Institute for Health and Care Excellence (NICE) for neurological and long term conditions as well as guidance from the Royal College of Physicians (RCP) for prolonged disorders of consciousness. These guidelines were followed in combination with the International Classification of Functioning, Disability and Health (ICF) biopsychosocial framework which enabled the staff to consider the disorder as well as people's psychological needs, their social needs, environmental factors and any other personal needs. This enabled the team to provide person-centred care which was tailored to the individual. In addition to these good practice documents, staff had also looked at the RCP guidelines for withdrawal of hydration and nutrition for people with prolonged disorders of consciousness. The head of therapy organised for one of the authors from this guideline to present at the service to staff and families so they were aware of the guidance. One of the families had expressed an interest in implementing this guidance and staff were liaising with the Clinical Commissioning Group (CCG) about achieving this.

There was a comprehensive training programme in place and the provider was committed to training and development. A staff member told us they felt the standard of care was excellent and felt this was due to the provider's commitment to training and development. A staff member said, "We have to be able to demonstrate knowledge and awareness following the training and we are encouraged to ask questions." We saw the training offered was well attended and a staff member told us they felt all staff were, "very keen to engage in any training". Staff were given real life examples during the training to aid understanding and apply this to their role. The training leads ran training sessions every day between 3pm and 4pm which enabled staff who wanted to update their knowledge in any of the mandatory topics prompt access to training.

There were two clinical trainers who delivered clinical training to staff and ensured they were competent to undertake their duties. For staff to work with people who had highly complex needs including those requiring the use of a ventilator and/or tracheostomy they had to complete a robust training and supervision programme. Staff were required to complete a learning log observing more experienced staff and complete a knowledge and competency assessment before being able to undertake certain tasks. They were then supervised undertaking these tasks and had to complete another competency assessment before being able to undertake their duties unsupervised. A further three month probation period was introduced for staff who had taken on these additional duties to ensure they were competent at their role.

The clinical trainers held regular 'skills stations' providing refresher training on clinical skills. There were also study days held throughout the year where the clinical trainers refreshed staffs knowledge on different topics including the respiratory system. Having the clinical trainers as part of the team enabled flexible,

responsive and robust training to be delivered, which was tailored to the specific needs of the people using the service. Other members of the multi-disciplinary team also delivered training, for example the physiotherapists trained staff in safe postural management for each person and took photos of people in a comfortable and supportive position so staff had visual reminders about how to support the person appropriately with their moving and handling needs.

The provider also made links with other providers to provide specialist training. This included training from staff at St Christopher's hospice on the six steps to success giving staff the knowledge and skills to provide personalised high quality end of life care.

As well as the supervision provided by the clinical trainers staff received a mix of managerial and clinical supervision depending on their role, as well as an annual appraisal. We saw staff were supported to develop their knowledge and skills at the service and through internal promotion opportunities. If there were any concerns regarding staff performance these were addressed promptly.

People had very specific eating and drinking requirements which were often unique to their medical needs, and in response to this a personalised eating plan was available for each person.. Relatives told us specialists supported staff to ensure people's nutritional needs were met. One relative said, "The dietician monitors what he has." A number of people were unable to swallow and required food be administered by Percutaneous endoscopic gastrostomy (PEG) tube. Care staff worked with the speech and language therapists, dieticians and a visiting enteral specialist nurse to ensure they provided safe and appropriate care for people with specific eating and drinking requirements. The chef worked with the dietician and speech and language therapists to ensure people were provided with appropriate diets, this included fortifying meals for those that required additional calories. The speech and language therapist told us, "The chef, dietitian and I are working on…the consistency of different food thereby reducing the risk of choking."

People were provided with a choice of meals. In addition to the written menu, the chef had produced a picture book with photos of his meals to help people to make an informed choice about what they would like to eat. People were able to ask for specific meals and this was catered for. Many of the people at the service required support from staff to eat. We observed staff were assisting people in a way that acknowledged choice, the type of support they required and they made this a pleasurable experience. Family members were also invited to join meal times and be part of what was a therapeutic experience.

Staff worked with other healthcare professionals and organisations to ensure effective care, support and treatment was provided. The provider bought in support from a GP and neurorehabilitation consultant and weekly ward rounds were held, which were proactive in reviewing and identifying any changes in people's needs. A healthcare professional told us the staff seek, "timely effective communication both on the clinical issues and on seeking information on planning and advice." They also said any advice or guidance they provided was implemented effectively.

There was a multi-disciplinary team employed at the service. The team worked together and in liaison with medical professionals to ensure all of people's care and health needs were met and regularly monitored. The people using the service had complex health needs which relied on competent joint working across health and social care.

Support was provided in line with the enhanced models of care which were piloted through NHS England's vanguards initiative. As well as the regular ward rounds by the GP and neuro-rehabilitation consultant, staff had developed hospital passports for each person. This included ready prepared documentation about the person, their medical needs, their current medicines, a copy of their tracheostomy licence, their DNAR status

and information relating to their mental capacity and any restrictions authorised through the DoLS process. This meant all the required information was ready to pass to other healthcare professionals if the person required emergency hospitalisation.

A healthcare professional told us, "The environment is always extremely well kept and has a very friendly atmosphere." The service was well resourced and had a number of facilities to aid enjoyment, rehabilitation and nursing care. The building was fully accessible including people's bedrooms, bathrooms and communal rooms, and took account of any sensory impairments people had. Information was available in braille and through spoken word, as well as through written communication. Wifi was available throughout the building and for those that wanted it Sky was available in their bedrooms. For one person this was particularly important as they enjoyed watching sport.

Staff adhered to the Mental Capacity Act (MCA) 2005 and were knowledgeable about the principles of the Act. Staff ensured people consented to their care and treatment, where able. When people did not have the capacity to make certain decisions best interests' decisions were made on their behalf. There was clear information in people's care records regarding their capacity to make decisions and what best interests' decisions had been made. A healthcare professional said, "Often, the patients do not have either the capacity or the necessary communication to be able to state their needs, the staff are always working with families, advocates and come to joint decision making either formally at review/family meetings or informally on a day to day basis. I am able to contribute to these meetings."

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 MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager continued to apply for DoLS authorisation when they felt it was necessary to deprive a person of their liberty in order to maintain their safety.

Good

# Is the service caring?

## Our findings

One person told us, "I love staff and everybody likes me, they treat me well." People knew the staff by their first names and staff knew the people's name, including their preferred name. For example, one person liked to be called "mumma" as it was a sign of respect in their culture. Staff provided prompt support to people and people told us all you have to do is call a member of staff who is passing and they will stop and take you to where you want to go. For example, we observed after we finished speaking with one person they called a member of staff who happened to be passing, they immediately turned back and offered support. Staff were perceptive to people's needs. Whilst we were in the dining room we observed a physiotherapist was passing in the dining room and saw a gentleman resting with his leg hanging where it had fallen off the foot rest, they gently lifted his leg to put it back on the support area and ensure his comfort.

People's privacy and dignity was maintained. We observed staff knocking on people's door and obtaining their permission before entering their bedroom. Personal care was attended to in the privacy of people's bedrooms and/or bathrooms, and staff were observed offering support discreetly in order to maintain people's dignity. Staff were aware of the importance of ensuring information about people was kept confidential.

There was a dedicated dignity champion. This staff member promoted the importance of treating people with dignity at all times and educating staff, people and relatives on the 'dignity do's'. The 'Dignity do's' are a set of statements designed by the dignity awareness charity describing the values and actions that services should do to ensure people's dignity is respected. To promote dignity throughout the year that dignity champion organised different events for staff, people and relatives to attend. This included a 'digni-tea afternoon' where people came together for afternoon tea and discussed what dignity meant for them. Statements were produced about what people felt was meant by dignity and these were hung on a 'digni-tree'. The tree was displayed at the service so those that were unable to attend the event could read the statements and further promote dignity in care. The dignity champion had also arranged a 'dancing for dignity' event to continue their promotion of good quality dignity care. The dignity champion was planning to hold more events to celebrate dignity but also to celebrate other national awareness days and charity events. The next event planned was the national Christmas jumper day in support of Save the Children charity.

People were supported to make decisions and choices. One person's relative described how their family member indicated choice. They said, "He is very good with his eyes when I give him a choice he looks right or left and stays for example on the right to choose." A person told us, "Yes I make my decisions, if I want something I just ask them." Staff were aware of how people communicated and supported them to communicate whether this was verbally, through gestures or through use of technology, including eye gaze software. Staff communicated with people as they were supporting them irrespective of whether the person could respond verbally or not. One relative told us, "I told the staff please talk to him before you do anything. They talk to him as they are [supporting] him to help him relax." Staff spoke to people politely and patiently. Staff supported people who did not have English as a first language and there were a range of languages spoken by the staff team.

People were enabled to get involved in decisions across the service, including design and development of the menu. The chef told us, "I am very proud of what I do and believe my food to be of a high standard. I involve the service users in menu compilation but they can choose on a day to day basis what they want." Staff regularly involved people and their relatives in the service to ensure it met their needs. At the time of our inspection this focused around Christmas events and types of food they would like to have at their Christmas party.

Staff offered any support people required with their religious or cultural needs. Religious leaders visited the service and were available if people wanted to practice their faith. Staff were aware of people's backgrounds and their cultures. This was taken into account when providing support and care was provided in line with people's wishes and their individual differences.

Outstanding ☆

# Is the service responsive?

## Our findings

One person told us, "I'm always asked if I'm happy with things and in veritably I am. I feel lucky to be here." Another person said in regards to the service, "It's the best ever. When we came to visit I rang the discharge nurse and told her I loved it. It's a nice, friendly environment. I can't fault it in any way." A health care professional told us, "I have always been very impressed with the standards of care given to their residents… The standard of care they provide is in my opinion exemplary." Another healthcare professional told us, "Without [Highfield] many more patients with prolonged tracheostomy ventilation would have prolonged hospital stays waiting for discharge." A third healthcare professional said, "This is a brilliant service … the staff are like a breath of fresh air."

Staff supported people to have a smooth transition into the service. One person's relative told us, "When [their family member's] transition was happening, we wanted a smooth transition. The staff came from here for 12 days to see how they wash and change him and what they do with him." Pre-admission assessments were completed in all instances and contained relevant information such as likes and dislikes along with baseline observations, pre-admission weights, medical history and people's current medical and support needs. This helped staff to identify what support people would require when they came to Highfield and they could start preparing and organising for any specific requirements to be in place.

People's needs were re-assessed upon admission and at regular intervals. Care was planned in response to their identified needs. This included assessments in relation to people's general health, medicines, hearing and vision, dietary needs, communication, sleep, continence and mental health. Care plans were regularly reviewed to ensure they remained up to date in line with any changes in people's health. Detailed information was included in these records providing clear instruction for staff about how to support people. Daily staff handovers were held discussing people's needs as well as daily multi-disciplinary team meetings to go into detail about people's need with a holistic approach.

Staff supported people to set realistic goals and where able supported them to develop their independence. One person told us, "I spoke about going home in the hospital they said no but here they said we'll see. If I could walk a bit it will be much better, so back to the tilt table and the bike!" Activities were held to support people's rehabilitation. One person told us, "At the moment I am concentrating on physio. I am practicing my hand writing. Some staff came in for a chat and they went to get me an exercise book for me to practice in."

The team used assistive technology to assist in people's rehabilitation as well as to support communication and for those with cognitive impairment. The service had purchased equipment which enabled them to undertake the assessment process to establish who would benefit from use of assistive technology and what was the best package for them, rather than referring to a specialist service to do the assessment. By the staff at the service doing the assessment and enabling people to try different assistive technology devices this had cut down the time people had to wait for assistive technology to be assigned to them.

Assistive technology was also used for rehabilitation to assess memory and attention span, cognitive

assessments and also to bring some enjoyment and leisure into the rehabilitation process through the use of rehabilitation computer games. Staff introduced 'fun' into the rehabilitation process through adapting their approach depending on people's abilities and meeting the needs of the differing age groups of people using the service. This included supporting people to play computer games, where people were able to enjoy the activity and staff were able to assess attention span. There were also facilities available for people to watch videos of themselves undertaking their rehabilitation exercises so they could see the progress they were making and help promote their self-esteem.

A full activities programme was delivered at the service. This included a range of group and one to one sessions. The sessions were designed to interest and engage people with different needs. For example, one session was held for people with higher cognitive engagement. Another session focused around stimulating different senses. The activities team spoke to all people and/or their relatives to gather information about what they enjoyed, previous employment and hobbies so this could be incorporated into the activities programme. There were also opportunities for people to take part in activities in the community including accessing local amenities. The activities team had planned a number of events to celebrate Christmas. This included cheese and wine evenings, carols at the Royal Albert Hall and visiting Christmas markets. A brochure was produced and given to all relatives about the festive celebrations where they could indicate if they wanted to take part. Activities were also planned around other religious and cultural festivals so people who wanted to could celebrate these occasions.

In each of the care records viewed there was evidence of end of life decisions and this was completed with people, their families and the multidisciplinary team. Advanced care plans were developed and end of life support was provided in line with the 'Steps to success' programme delivered from St Christopher's hospice.

The service held a memorial event annually to remember all those that had died. Families and friends were invited to this event to remember and celebrate with staff their family member and reflect on the positive moments in people's lives. The service also had a memorial tree in their reception. The tree had silver dove decorations with people's names on to remember those that had died.

Support was provided to staff around death and dying. Staff commented on how they were previously anxious about supporting people who were dying but that with this additional support they now felt more comfortable and skilled to support these individuals and their families through the process. A reflective session was held with staff when a person died to give them time and space to grieve for the person and remember the positives that person bought to their lives.

A complaints process remained in place. The registered manager kept track of all complaints made and ensured they were investigated and responded to. Most of the complaints received since our last inspection were in regards to the building work that was undertaken to extend the service. This was now resolved. The registered manager also logged all compliments received and ensured these were shared with the staff team. Since our last inspection 28 compliments had been received. One of the comments included, "Thank you for looking after [family member] in her last days with consideration, love and dedication."

Outstanding ☆

# Is the service well-led?

## Our findings

A person told us in regards to the management team, "They are approachable, if I have any concern I can talk to them anytime." Another person said, "I think they are really good. They are approachable and they've got time for you." A healthcare professional told us, "The management team is very approachable, helpful and efficient. They lead and manage the home very well." They also said, "I am proud to be associated with this nursing home and the extremely safe, effective, caring, responsive and well led services that are provided."

The registered manager had been in post since 2014. 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. They were aware of the requirements of their CQC registration and submitted statutory notifications about key events that occurred at the service.

Since our last inspection the provider had developed their corporate values. These included; privacy, dignity, choice, independence, rights and fulfilment. The provider ensured all staff were aware of their values through completion of their core values training and we observed staff behaviour was in line with the provider's values which ensured people were empowered and respected. The provider had updated their policies and procedures linking them to their values. The provider had adopted the five CQC key questions as their desired outcomes for people and care delivery. From what was observed and heard throughout the inspection we found staff were aware of the values, behaviours and desired outcomes and these were integral to care provision. Duty of candour was also adhered to. An open and honest culture had been established. Staff discussed with each other, people and families when errors occurred and how this was learnt from and practice improved.

In addition to the provider's values, staff had been supported to sign up to the Social Care Commitment. This is a national initiative and asks employers and employees to commit to "I will..." statements to ensure people using care services are supported by skilled staff who treat them with dignity and respect.

The provider's values and behaviours underpinned their governance framework. Each element of the governance framework was related to the provider's values mentioned above and how they evidenced delivery of the provider's desired outcomes. As part of the governance framework there was an allocated auditor on each floor. They audited the quality of daily documentation maintained by care and nursing staff. This included an audit on ventilator care, national early warning score (NEWS) documentation, fluid balance records, tracheostomy care, emergency care procedures, bed side cleaning and people's hospital passports. These audits were also spot checked by the clinical trainers to ensure all clinical information was being robustly recorded and accurately completed. The management team also undertook a range of audits. This included on the quality of care records, infection control, hand hygiene, waste management, mattresses, antibiotics use, medicines management and in regards to health and safety processes. Where improvements were identified as required an action plan was produced. The provider's safety committee

had been expanded. The committee meet quarterly and identified key themes from service level data. This data was used to make improvements to the quality of service delivery.

There were a range of mechanisms in place to obtain feedback from people, relatives and staff about the service. The registered manager told us they had processes in place to help people who could not read or write or whose first language was not English to provide feedback and ensure their views were also considered. This included invitation to complete satisfaction surveys and regular meetings. We looked at some of the surveys returned which were very positive about the service, the care and support provided, training available for staff and support to staff. Family meetings were held regularly. Members of the multi-disciplinary team, the GP and representatives from the CCG were also present at these meetings to ensure all areas of care delivery could be discussed. For people that did not have relatives involved in their care, the service arranged for an Independent Mental Capacity Advocate to be present to support people and represent their views. The service also received feedback from the nursing students who completed their placement at Highfield House. From the feedback forms we viewed we saw students felt well supported, had access to the same training opportunities as other staff whilst at the service and felt the management team listened to any suggestions or comments they had.

There were a range of staff meetings held throughout the year and staff were encouraged to express their views at these meetings. Staff said they were supported by their managers, including the provider's senior management team. One staff members told us the senior management team were "very supportive" and "available and accessible at all times". Another staff member said, "Very good support from [staff member]. She's my backbone." In addition management meetings were held weekly and multi-disciplinary team meetings were held twice weekly to discuss the needs of each resident and to discuss potential admissions or discharges so all staff were kept up to date with people's needs and any changes in their health.

The provider had produced a staff newsletter which was themed on the 5 CQC key questions to further enhance staff's understanding on the five questions about how the care they provided fit into these and the provider's values. The information was outcome based and gave practical examples of how staff supported people to receive safe, effective, caring, responsive and well-led care.

The registered manager and management team had regular liaison with the managers from the provider's other service for advice and to discuss challenges, and learn from each other. We heard that if an adverse event occurred at either service a safety alert was issued to both teams for all staff to learn from.

Staff worked in partnership with other agencies, this included liaison with their local NHS trusts. The service followed public health England guidance and implemented NHS initiatives at the service, including following advice regarding flu vaccinations and undertaking antibiotic use audits. The service also learnt from other community or national disasters and how practice could be improved to ensure the safety of their people and staff. This included reviewing and improving fire safety practices. Personal evacuation plans were up to date and a summary was available for the emergency services in the event of a fire. This included information about how many oxygen cylinders were on site and where they were stored.

The registered manager informed us they had a good working relationship with staff at the local authority and from the clinical commissioning groups (CCGs) funding people's care. Representatives from the CCG came to undertake regular reviews of people's care and they were also invited to attend meetings with people's families. The registered manager also said the representatives were particularly supportive when working with families to ensure people's expectations of care delivery and the progress their family member could make were realistic.

Staff were very passionate about their roles and working at Highfield House. One staff member told us they, "loved coming to work" and another staff member said, "It's a brilliant service." Staff, people and relatives were keen to share with us their experiences of Highfield House and staff were very proud of the work they did. There was an obvious drive and commitment within the team to provide high quality personalised care. All of the healthcare professionals we received feedback from were also very positive about the quality of service delivery and joint working arrangements.