Mrs Josefa McLeod

Highbray Residential Care Home

Inspection report

84 Mount Pleasant Road Exeter
Exeter
Devon
EX4 7AE

Tel: 01392980846

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Highbray Residential Care Home is a residential home registered to provide accommodation and personal care support to three people with learning disabilities, autistic spectrum disorder or mental health needs. They were in the process of expanding the service user group to include people living with dementia. At the time of the inspection there were three people living at the home. The home was managed and staffed by the provider's immediate family.

The registered manager lived on site, and was the main member of care staff. 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.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

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Why the service is rated Good.

People remained safe at the home. There were trained and experienced staff available over a 24 hour period to meet people's needs and to spend time socialising with them. Risk assessments were carried out with people which promoted their independence while minimising risks. People received their medicines safely.

People continued to receive effective care because staff had the skills and knowledge required to effectively support them. Their communication needs were recognised and met. People lived in a service which had been adapted to meet their needs. Their healthcare needs were monitored by the staff and they had access to healthcare professionals according to their individual needs. 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.

The home continued to provide a caring service to people. One person said, "The whole thing has a real warmth about it. Its very comforting. Very relaxing." Staff promoted people's independence and treated them with dignity and respect. They were familiar with people's history and backgrounds, respected their choices and acted in accordance with their wishes. People were accepted for who they were regardless of their sexuality, faith or culture. The service was able to provide effective support to people at the end of their lives.

The service remained responsive to people's individual needs. Care plans were person centred and provided

detailed information about people's needs and preferences. As the main carer the registered manager had current and detailed knowledge of people's needs. People could choose to participate in a range of activities, both in the home and out in the community. There was a complaints policy in place, and concerns or complaints were managed effectively in line with the policy. There had been no formal complaints since the last inspection.

The service was well led, although improvements were needed to quality assurance processes to simplify them and ensure their relevance to the service. The provider and registered manager had a strong value base, and worked to promote a person centred, open and empowering culture. They had an ethos of honesty and transparency, reflecting the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service has improved to Good.	**Good**

Highbray Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 05 and 06 November 2018 and was unannounced. It was carried out by one inspector.

Prior to the inspection we looked at information we held about the service such as notifications and previous reports. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. At our last inspection of the service in April 2016 we did not identify any concerns with the care provided to people.

During the inspection we met the three people who lived at the service and spoke with them about their care. We met the provider, and spoke with the registered manager, one person's advocate, a relative and a visiting professional. We requested feedback from three health professionals by telephone but no feedback was provided. We looked at records relating to individual's care and the running of the home. These included two care and support plans and records relating to medicine administration. We also looked at the quality monitoring of the service.

Good

Is the service safe?

Our findings

The service continued to provide safe care to people. People told us they felt safe with the staff who supported them. A relative commented on how quickly their family member had built a trusting relationship with the staff. One person said, "It's very nice and homely. I feel safe here." A visual monitor had been installed in their room as they were at risk of falls. They had given their written consent for this and told us it helped them to feel safe.

The registered manager lived on site and was the main member of staff, with part time support from another employed family member who also lived on the premises. This was sufficient to meet people's needs and keep them safe. Additional cover was provided if required by other family members who had relevant training and experience, and knew the people living at the service because they visited regularly. This ensured continuity of care and minimal disruption for the people living at the home.

The registered manager had detailed knowledge about the care needs of people including any risks. This meant they recognised when people required extra support, for example if they were drowsy and more confused due to their dementia. People identified as being at risk had risk assessments with clear information on the level of risk and the action required to keep them safe. These included risks related to nutrition, smoking, mobility and skin breakdown. One person, new to the service, did not yet have a written risk assessment in place. They were living with dementia and enjoyed spending most of their time out and about in the community. The registered manager was working with them to identify any risks and develop strategies for staying safe while respecting their freedom. For example, they had agreed the times the person would return for meals, so their nutrition and hydration would be maintained. The person had a mobile phone with the manager's number on it, and was in regular contact while they were out. This meant the registered manager was also able to prompt and reassure the person by text message. Emergency information was being printed on a card for the person to carry, should they need it. The registered manager had arranged to sit down with the person to develop a formal risk assessment and care plan now that the risks had been identified and the strategies established.

People continued to be protected from abuse because staff understood and knew what action to take if they suspected someone was being abused, mistreated or neglected. They had completed safeguarding training, and there was a safeguarding policy in place. The registered manager knew where to access the contact details for the local authority safeguarding team should they have to make an alert or need advice.

Risks to people living at the home were reduced because the registered manager and other family members working at the service had been checked by the DBS (Disclosure and Barring Service). This included staff who worked on an occasional or voluntary basis. The DBS checks people's criminal history and their suitability to work with vulnerable people.

People did not face discrimination or harassment. People's individual equality and diversity was promoted. The registered manager had completed relevant training and was committed to putting their learning into practice. People had detailed care records in place with clear information about how they wanted to be

supported.

The registered manager looked after people's medicines for them, and they were happy with this arrangement. Medicines were kept in a locked cupboard and medicine administration records (MAR), were signed when medicines were administered. There were no drugs requiring additional security on the premises. People with prescribed medicines to be taken 'when required' (PRN), such as paracetamol, had records in place to provide information to guide staff in their appropriate administration. Training in medicines management had been completed by the registered manager and the family members who provided occasional support. Regular reviews and audits of the medicines and administration processes were carried out by the local pharmacist.

People were protected from the spread of infections. Staff understood what action to take in order to minimise the risk of cross infection, such as the use of gloves and aprons and good hand hygiene to protect people. There were safe systems in place for dealing with contaminated laundry. The taps in all the rooms were temperature controlled to avoid the conditions that favour the growth of legionella and other micro-organisms. A formal legionella risk assessment had not been carried out for some time. This had been arranged by the manager before the end of the inspection.

People lived in an environment which the provider continued to assess to ensure it was safe and secure. A security system had been installed to the outside of the property, as well as safety rails and a security gate. Guidance had been sought from the fire service and fire checks and drills were carried out in accordance with fire regulations. A fire safety self-assessment was completed regularly. People had personal evacuation procedures in place (PEEPs) which detailed how staff needed to support individuals in the event of a fire to keep people safe.

The registered manager was reflective, learning lessons and making improvements if required. For example, they described how they had improved their recording and documentation after a 'steep learning curve', when a person at the service had become extremely unwell. The information they had been able to provide about the person's deteriorating health had contributed to their assessment in hospital and forward planning.

Good

Is the service effective?

Our findings

The service continued to provide effective care and support to people. Staff were competent in their roles and had very good knowledge of the individuals they supported, which meant they could effectively meet their needs.

The registered manager was proactive in ensuring their knowledge and skills and that of other staff were up to date. This meant people were supported by staff who had received training to meet their needs effectively. The provider told us in the provider information return (PIR), "We employ a training provider for National Vocational Qualifications (NVQ) and general training to ensure that we are always aware of changes to legislation and law. Volunteer staff are pursuing higher NVQ levels and continue to train to keep current legislation and practice live." Annual training was completed in topics such as first aid, moving and handling, the mental capacity act, health and safety and infection control. The manager had also completed training in end of life care and was due to attend a workshop on pressure area care and training on new data protection legislation. When people had changing needs, separate training was organised to ensure they could continue to be met. For example, related to dementia, swallowing problems, or the use of a hoist.

People were supported to access external healthcare services as required to ensure their continued health and wellbeing. One person told us, "If I need to see a GP [the registered manager] will organise it all." Care records showed that people's health needs were monitored. The service had worked effectively with relevant healthcare specialists, such as the speech and language team (SALT) and older people's mental health team, to ensure their health needs were met. The service supported people to maintain their health, for example making links with local walking groups and swimming classes for a person new to the service.

People's legal rights were upheld. Consent to care was sought in line with guidance and legislation. Since the last inspection the registered manager had undertaken training in the Mental Capacity Act 2005 (MCA). This meant they were aware of their responsibilities under the act and how to apply its principles to their practice. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Throughout the inspection we heard staff consistently asking people to consent to their care and treatment, and ensuring they had the information they needed to make decisions. This was also evident in care records. Assessments of capacity were planned as part of the admissions process and in response to a deterioration in mental health. This ensured people's legal rights were protected.

People can only be deprived of their liberty so that they can receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). The service had referred people for an assessment under DoLS where required.

The Accessible Information Standard is a framework put in place making it a legal requirement for all

providers to ensure people with a disability or sensory loss can access and understand information they are given. Although there was no specific policy in place at the time of the inspection, the manager gave examples of how they had supported people with communication. One persons ability to communicate had deteriorated significantly. The service had made a referral for specialist support with communication and followed the guidance provided. Staff knew the person well, which meant they recognised if the person was distressed even when they could not verbalise it. They explained how they wrote down scenarios for them to point to, drew pictures or used body language to support their communication and help them to make choices. Pictures of faces showing different emotions helped the person express how they were feeling.

Staff had a good understanding of the communication needs of people living with dementia. They used technology to support communication, for example texting them on a mobile phone to prompt and reassure if they were out. People had clocks in their rooms with a large display which was easy to see. The clock told them the date, day, what part of the day it was and the time. In addition, the manager had, with consent, videoed a meeting between one person and their legal representative. This meant they were able to play the video back to the person after the meeting to remind them what had been discussed and agreed.

People continued to be supported to eat a nutritious diet and were encouraged to drink enough to keep them hydrated. The registered manager had a detailed knowledge of people's individual needs and preferences, and these were documented in the care plan. For example, one person had a small appetite and required additional support to maintain their weight. They were provided with small portions of high calorie foods which they liked and were easy to eat.
Any specific dietary needs were well managed, for example diabetes. Individual meals were made to order on the premises as requested. One person told us, "I can choose what I want to eat. I don't eat a lot." People were supported to prepare their own food if they wished. The home had a food hygiene rating of five.

People lived in a service which had been designed and adapted to meet their needs. The provider told us in the provider information return (PIR), "We have made several improvements to the premises, providing a stair lift and a level front garden. We have had a new walk in shower and bathroom installed with appliances to enable the service users continued independence." There was a pleasant, accessible outside space which people had enjoyed during the summer. Clear signage was in place to support a person living with dementia to find their way around the home independently. A large wall planner had been purchased to put on their bedroom wall to remind them about appointments and activities. In addition people had been provided with large screen televisions and remote controls with bigger buttons which were easier for them to use independently.

Good

Is the service caring?

Our findings

People continued to be provided with a caring service. People said, "The whole thing has a real warmth about it. Its very comforting. Very relaxing" and, "They are so respectful and always knock before coming in." The provider told us in the provider information return (PIR), "We pride ourselves on the personal approach we take to each individual service user in our home. " The registered manager had detailed knowledge of each persons likes and dislikes, and bought them Christmas or birthday presents according to their individual tastes, such as a specific perfume or pair of pyjamas.

People were supported by staff who treated them with patience, kindness and understanding. They were attentive to people's needs and understood when they needed reassurance or guidance. The registered manager told us, "We really do listen to what they are saying." For example, one person had recently needed to use a hoist for the first time and had found this frightening. The registered manager told us that although the person didn't like the hoist, they were now more accepting of it because staff explained what they were doing throughout, speaking in a soothing voice and offering reassurance. Another person was facing some significant challenges after a change in their health condition. The registered manager was aware of how this affected the person and was supporting them as they adjusted. They told us how they made video calls to the person on their mobile phone if they were away, as visual contact was important to them.

Staff told us, and we observed, that they treated people with dignity and respect. They knocked on doors before entering, and consistently asked people if they would like to be supported. People were able to make choices about how they spent their time, and were able to spend time in their rooms or go out if they wished. The registered manager told us, "Choice is very important for their psychological well being."

The staff team understood the importance of confidentiality. People's records were kept securely and only shared with others as was necessary. This was in line with the new General Data Protection Regulations (GDPR).

Staff spoke to us about how people would be treated and cared for equally regardless of their sexual orientation, culture or religion. We observed that people were treated as individuals, according to their needs and staff were proactive in ensuring they felt accepted and valued for who they were. The registered manager told us, "I will take them to church if they would like to go, or to the mosque if they are a Muslim." One person with a military background was being supported to attend a remembrance service, another to maintain their masonic links. People were welcomed as part of the family, for example spending time with the registered manager's young grandchildren and watching them grow up. Photographs of them with the grandchildren were displayed with the family photographs. One person, who chose to spend their time in their room, enjoyed the company of the family dogs at every opportunity.

People were supported to maintain ongoing relationships with their friends and families, and could see them in private whenever they wished. The provider told us in the provider information return (PIR), "Friends and relatives are welcome at the home when they wish. We do not mind people popping in unannounced, though most pre arrange a visit and generally have a meal with their loved one." We spoke with a visitor who

had popped in during the inspection. They were offered a cup of tea and made to feel welcome while being updated about the well being of the friend they were visiting. They said, "It's fantastic. There is a nice, homely atmosphere."

People and their advocates were supported to express their views and be actively involved in decisions about their care and support as far as possible. Annual questionnaires were given to relatives asking for their views about the service. The registered manager told us they continually sought people's views, completing their care plans with them or consulting them about how they would like their room decorated. They ensured people were kept informed about topics they were interested in, for example related to the management of their health condition or events and activities in the community, researching them and sharing their findings.

Good

Is the service responsive?

Our findings

People continued to receive care and support which was responsive to their needs. One person told us, "It's so friendly and relaxed, and they are really supportive. I have had no anxiety at all. I know I can talk to them about any problems or worries."

Where possible, prior to moving into the home, the registered manager met the person to gain an understanding of their needs and whether they could be met by the service. People were invited to visit and spend time at the home if they wished to help them make an informed decision about whether they would like to live there. This had not been possible for one person new to the service due to their personal circumstances. The registered manager was therefore working with them, their GP, and advocates to gain an understanding of their needs and risks, and agree their care plan. They were also supporting them to make links with relevant health and social care professionals, community services and activities and maintain contact with friends and family.

The registered manager completed people's care plans with them to ensure their accuracy. This meant the care plans were person-centred and held detailed information about how they wanted their needs to be met. For example one person's care plan stated, "[Person's name] enjoys a coffee with two sugars. Before retiring to bed [person's name] enjoys a hot chocolate." People's records also held information on their social and medical history, as well as any cultural, religious and spiritual needs.

Staff monitored and responded to changes in people's needs, seeking appropriate specialist advice and guidance. This was evident in care records, for example when one person's health deteriorated rapidly and they had needed specialist support. The service aimed to review the care plans monthly, but they had not been formally reviewed for some time. The registered manager told us, as the main carer, this had not been necessary because they had current and detailed knowledge of people's needs. They therefore planned to complete a formal review every three months unless there was a change in the person's support needs. When handing over to the occasional or volunteer staff they provided an up to date written handover sheet, detailing each person's needs and the support they required.

The service had a complaints policy which was shared with the people at the service. There had been no complaints since the last inspection. One person did raise some minor concerns during the inspection and we fed these back to the manager. They acted immediately to clarify the concerns with the person and ensure they were resolved to their satisfaction.

People were supported to express how they wanted to be cared for at the end of their life and these wishes were documented. This would help ensure people's wishes were respected. One person had already organised their funeral. The registered manager was working with another person, with no family, to document who they would like to be contacted at that time.

People took part in activities according to their interests. A beauty therapist was visiting one person during the inspection. A person, new to the service, was being supported to explore what was available in the

community, for example walking groups or a memory café.

Good

Is the service well-led?

Our findings

When we inspected in April 2016, the service was rated 'Requires Improvement' in this key area, because a comprehensive audit of the service had not been completed. At this inspection we found medication audits had been completed, environmental safety assessments had been carried out, people's views were sought, and accidents and incidents documented and reviewed. However, much of the audit paperwork was unnecessary because it had been adopted from a different kind of service and was therefore not relevant to the actual service being provided. The registered manager undertook to review the quality assurance processes to make them less complicated, in response to feedback given during the inspection.

There was a registered manager in post. 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. Since the last inspection the registered manager had completed a course to improve their leadership and management skills. They managed the day to day running of the service and delivered most of the hands on care. They kept the provider informed of developments as required.

The registered manager was proactive in keeping their skills and knowledge and that of other members of the staff team, up to date. They had responded to changes in legislation and people's needs by seeking out and attending relevant training events, or requesting guidance from specialist health care professionals.

The registered manager had a strong value base, and worked to promote a person centred, open and empowering culture, for the benefit of the people living at Highbray. People at the service spoke highly of them. Comments included, "The manager is fantastic in a gentle unassuming way " and, "[The manager] is more than kind." A relative described them as 'open and transparent', adding, "They are a cracking person."

The manager promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment. They acknowledged the areas in which the service needed to develop and improve, and were proactive in making this happen. Any issues raised during the inspection were addressed immediately.