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Highbury House Nursing Home

Inspection report

Highbury House Nursing Home
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Date of inspection visit:
30 August 2016

Date of publication:
19 October 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

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 and associated Regulations about how the service is run.

People told us that they were happy with the support they received with their medicines. One person told us, "The nurses here give me my tablets. Everything runs just as it should." Systems in place ensured that medicines were managed and recorded appropriately. However, not all nurses had completed an annual competency assessment. We have identified this as an area that needs improvement.

Risks associated with the fire safety of the environment were not always identified or managed appropriately. Staff had not received appropriate fire drill training. We have identified this as an area of practice that needs improvement.

There were sufficient numbers of staff to ensure that people's needs were met and that they received care and treatment promptly. People commented they felt safe living at Highbury House Nursing Home. One person told us, "Staff are quick to respond to the call bell and we can always find staff around." Staff were aware of what actions they needed to take to raise a safeguarding concern. A staff member said, "By being a friendly home, I think people have trust in you as staff and raising any concerns becomes so much easier. I have done the safeguarding training and we have talked it over in meetings and I can assure you that I would report anything straight away, but it's never come up." Policies and procedures were in place to safeguard people. Essential training, as well as additional training to meet people's specific needs, had been undertaken. Staff were encouraged to take further qualifications to develop their careers.

Care and treatment focused on the needs of the person and acknowledged their individuality and identity. There was a focus on meaningful activities to ensure people's social and emotional well-being was fully promoted. There was an activity coordinator in post who led on the provision of meaningful activities. The importance of sharing this responsibility was understood by staff. One member of staff said, "We all have a role in the activities. So for example, I know that people like to get out and about so we go to Rudyard Kipling garden in the village or down to the seafront, anywhere they want to go."

People spoke highly of the food. One relative said, "The food is absolutely delicious. Mum enjoys a lovely tart made with goats cheese. She let me taste it and it was good." Any dietary requirements were catered for and people were given regular choice on what they wished to eat and drink. A relative told us, "[My relative] wasn't eating very well when she first arrived. The cook made a point of coming over and introducing themselves and said, 'If there's anything you like I will make it.' They send out an extra jug of gravy or cream out with the meals, as my relative doesn't like their food too dry." Risk of malnourishment was assessed and where people had lost weight or were at risk of losing weight, guidance was in place for staff to follow.

People told us they were happy living at Highbury House Nursing Home. One person told us, "It's nice and homely here. It suits me very well." People's privacy and dignity was respected. Staff had a good understanding of people's needs. They treated people with respect and protected their dignity when supporting them with personal care. One person said, "Staff here have love, care and compassion in abundance." Relatives told us they could visit at any time and they were always made to feel welcome and involved in the care provided.

Care plans and risk assessments for people were in place and reflected people's individual health and social care needs. Staff knew people well and were knowledgeable about their care needs.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider, manager and staff understood and could demonstrate application of their responsibilities and processes of the Mental Capacity Act 2005 and DoLS. People's consent was gained and staff respected people's right to make decisions and be involved in their care. The registered manager was aware of the legal requirements with regards to ensuring people who lacked capacity had mental capacity assessments and that they were not deprived of their liberty unlawfully.

People's healthcare needs were met. People were able to have access to healthcare professionals when they were unwell and relevant referrals had been made to ensure people received appropriate support from external healthcare services. A healthcare professional told us, "I am impressed with the care offered at Highbury House. The home has a loyal and committed staff team. The manager has embraced the support we can offer and works proactively with us."

The registered manager was described as approachable and supportive. A relative told us, "The registered manager] has been very helpful. Take finances. It has always been a concern but [the registered manager] has kept the accountants at bay. They have been wonderful." They were visible and proactive and this had helped to create an open culture at the home. Residents meetings provided an opportunity to discuss issues with other relatives and staff. Handover of care meetings were held to discuss people's changing needs and plan how staff could meet these. Management, departmental and whole staff team meetings were held. Participants were able to contribute to the meetings and make suggestions to improve practice.

Audits were undertaken regularly and included care plans, medicines and health and safety. There was a record for the monitoring and maintenance of the environment and equipment used in the home such as hoists and the lift. Policies and procedures had been reviewed and updated and were available for staff to refer to, as required. Pre-employment checks for staff were completed, which meant only suitable staff were working in the home.

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

Highbury House Nursing Home was not consistently safe.

Medicines were managed and administered safely. However, not all nursing staff were assessed as competent.

Staff had not received appropriate fire drill training.

People said they felt safe and there were enough staff on duty to care for them.

Staff received safeguarding training and knew how to take action in response to any concern that may arise about possible abuse.

Is the service effective?

Good

Highbury House Nursing Home was effective.

Staff ensured people had access to healthcare professionals when they needed it.

People were provided with food and drink which supported them to maintain a healthy diet

Staff had an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Good

Highbury House Nursing Home was caring.

Staff communicated effectively with people and treated them with kindness and respect.

People were encouraged to make their own decisions and independence was promoted.

Relatives were able to visit at any time and were made to feel welcome.

Is the service responsive?

Good

Highbury House Nursing Home was responsive.

Care and treatment was personalised and tailored to people's individual health needs and preferences.

Care plans contained information about people's social and emotional needs.

There were meaningful activities for people to participate in.

Is the service well-led?

Good

Highbury House Nursing Home was well-led.

People and staff were positive about the management and culture of the home.

Quality assurance processes monitored practice to ensure the delivery of high quality care and drive improvement.

People's opinions and wishes were taken into consideration in relation to the running of the home.

Highbury House Nursing 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 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.

We visited the home on the 30 August 2016. This was an unannounced inspection. The inspection team consisted of two inspectors.

During the inspection, we spoke with five people who lived at the home and five relatives. We also talked with three care staff, a registered nurse, cook and maintenance person, the registered and deputy manager. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the morning in the lounge area. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority, looked at safeguarding concerns that had been raised and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. A Provider Information Return (PIR) was submitted prior to the inspection. A PIR asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

During the inspection we reviewed the records of the home. These included staff training records and procedures, audits and four staff files along with information about the upkeep of the premises. We looked at five care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation and

obtained people's views on living at the home. This allowed us to capture information about a selected group of people receiving care.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that the home was a safe place to live and there were enough staff to meet people's needs. They were confident the staff did everything possible to protect them from harm. One relative told us, "Staff are quick to respond to the call bell and we can always find staff around." However, despite positive comments, we found areas of practice that required improvement.

People's consent was gained and they were supported to take their medicine in their preferred way. We looked at the management of medicines. Medicines rounds were carried out by registered nurses. All nurses should be assessed as competent to administer medicines on an annual basis as a minimum in line with best practice guidance. The policy of the home was that all registered nurses should undertake medicines competencies. However, not all nurses had been assessed this year to date. We brought this to the attention of the registered manager who gave an undertaking this issue would be addressed. They later confirmed that they would arrange yearly competency checks from now on with all nurses, and their policy was changed to reflect this. We have therefore identified this as an area of practice that needs improvement.

Each person had a medicine administration record (MAR) which contained information on their medicines and included other information such as any known allergies. The MAR contained guidance for staff to follow for the administration of medicines. Regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines. This ensured the system for medicine administration worked safely and any issues could be identified and addressed.

Some people were prescribed medicines that they could take as and when they required them. The process for administering 'when required' medicines was included in the homes medicines policy. The process followed for this medicine included recording the reason for giving 'when required' medicine and in the example of pain relief, recording the outcome for the person experiencing discomfort. Some medicines were stored in a medicines fridge, the provider ensured good practice was followed by ensuring that the temperature of the fridge was regularly monitored and recorded. Medicines could be less effective or harmful if they were out of date. Some liquid medicines and creams have a limited shelf life once opened, observations showed that the date of opening was recorded on these medicines.

Risks associated with the fire safety of the environment were not always identified or managed appropriately. The registered manager had not ensured all appropriate fire safety measures were in place to minimise the risk in the event of a fire. There were risk assessments that included the individual needs of those who may be at risk. They considered how the risk could be reduced and managed to protect the person. Fire training sessions included sessions on how to evacuate from a bed, from a smoke filled room and out of the building. The staff had walk arounds of the home and were shown the updates in the fire fighting procedures. However, the registered manager had not ensured staff received appropriate fire drill training. This meant staff were not equipped with all the skills needed to observe procedures they needed to follow. We brought this issue to the attention of the registered manager who gave an undertaking this issue would be addressed and they told us subsequently that fire drill training dates had been immediately arranged. We have therefore identified this as an area of practice that needs improvement.

Systems in place monitored the safety of the premises and included health and safety checks. These were undertaken to ensure safe management of, for example, food hygiene, hazardous substances, the hot water system and equipment. The home annually updated its Contractors Health and Safety Certificate. To achieve the certificate the registered manager demonstrated compliance in both their health and safety policy and their organisation for health and safety.

Peoples care plans had a number of assessments that covered such areas as skin integrity, hydration and nutrition, falls and mobility. The risk assessments identified hazards to good health, the risks these posed and the measures taken to reduce the risk to the person. These were regularly reviewed. Accidents and incidents were recorded and monitored to ensure that actions were taken to minimise reoccurrence. For example, records showed that one person had experienced a number of falls within a period. The use of a falls mat was assessed and adopted for the person at risk.

Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they were to witness any concerning incident. There were policies to ensure staff had guidance on protecting people from abuse. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. Records confirmed staff had received safeguarding training as part of their essential training at induction and that this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. A staff member said, "By being a friendly home I think people have trust in you as staff and raising any concerns becomes so much easier. I have done the safeguarding training and we have talked it over in meetings and I can assure you that I would report anything straight away, but it's never come up."

There were sufficient staff to ensure that people were safe and cared for. People we spoke with told us staff were always available to provide care and support. Staff were available to respond to people's requests and needs promptly. Individual bedrooms were fitted with call buttons and staff responded in good time to people's call bells. This meant that people did not have to wait for staff to provide assistance. Staff had time to speak with people and to check that people across all areas of the home were safe. Staff told us they checked in with people who preferred to spend more time in their bedroom and we saw that no one was left alone for long periods of time. This included discreet observation of staff supporting people who were nursed in bed. The relative of one person commented, "Staff are around when they're needed. The staff ratio seems much higher here than in other homes I have seen." Staff told us that they were happy with the numbers on duty. One member of staff said, "I have worked in a lot of homes and I have stuck with this one. They have the resident's best interests at heart. Look at the good staffing levels. We are a good home because we have time for the residents."

Staffing levels were reassessed when the needs of people changed, to ensure people's safety. For example, the registered manager told us about an insulin dependent diabetic person whose additional needs meant their personal care took longer to support. They told us, "We consider people's needs before admission and in this case staff fed back to me the extra time this person needed. Staff shared with me their experience and we adapted the rota so that one carer started their shift an hour earlier. It remained in place as long as the person needed it and feedback was that it worked well."

The provider had effective systems in place for the safe recruitment of staff. Records showed that recruitment checks were in place to ensure staff were suitable to work at the home. Prior to their employment starting there were security checks completed and employment history was gained. Disclosure and Barring Service (DBS) checks were carried out for all the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people.

Good

Is the service effective?

Our findings

A person told us, "Staff are trained to look after us, I see can see my GP when I need to." A relative said, "Staff are all very kind and aware of what [my relative] needs to keep them well."

Staff understood people's dietary requirements and how to support people to stay healthy. Where it was required, input from dieticians and speech and language therapists were also sought. Guidance was available in people's care plans about any special dietary requirements such as a soft diet. The chef said, "We talk with the carers daily about people's requirements, and we have had the dietician and Speech and Language Therapists (SALT) in to advise us." People's weight was regularly monitored and documented in their care plan. Staff said people were always consulted about being weighed and their choice was respected. The scales used were calibrated annually to ensure accuracy.

People had an initial nutritional assessment completed on admission. Their dietary needs and preferences were recorded. People told us that their favourite foods were always available and that the food was good. Staff offered choices at mealtimes and with drinks and snacks in between. The relative of one person said, "The food is absolutely delicious. Mum enjoys a lovely tart made with goats cheese. She let me taste it and it was good. The staff then went and got me one." Another relative told us, "[My relative] wasn't eating very well when she first arrived. The cook made a point of coming over and introducing themselves and said, 'if there's anything you like I will make it.' They send out an extra jug of gravy or cream out with the meals and my relative doesn't like their food too dry." The chef said, "People have a assessment when they arrive which is shared with the kitchen. We cater for diabetic, vegetarian, soft, pureed or other special diets."

We observed the lunch time service. Food was well presented and it was clear that the promotion of the whole dining experience led people to look forward to and value the opportunities for a pleasant dining and social experience. The dining area was attractive with pleasant views over the garden. Tables were set with condiments and glasses, including adapted cutlery and crockery where it was required. People could choose where they sat, though most people had preferred positions that they selected. People chose either to eat in their room or in the dining area and we were also told by one person that they sometimes ate outside on the patio. One person who ate in their room said, "I am more comfortable eating here [indicating their room] it suits me." The staff recorded amounts that were eaten where there were concerns and encouraged people to eat a healthy diet. We saw that snacks were available for the evening and night if people were peckish. The chef said, "The kitchen is always open, so that if someone wanted a sandwich, for example carers can get bread and fillings."

People's health and well-being was monitored on a day to day basis. Staff understood the importance of observing people's health and well-being for any indication that they required additional medical attention. People had visits from and to health and social care professionals such as dieticians, SALT and tissue viability nurse. They documented the guidance and input provided. People and their relatives expressed confidence their healthcare needs were effectively managed and monitored. One person told us, "I am fortunate to be here. The nurses and staff are lovely and straight onto it if I am not feeling myself."

The management team organised and monitored the training provided to staff. Staff received a range of training that included; safeguarding, food hygiene, fire evacuation, health and safety and infection control. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were assessed as competent to work unsupervised. Staff also received additional training specific to peoples' needs, for example in dementia care and end of life care. Additionally, there were positive opportunities for staff to complete further accredited training such as the Diploma in Health and Social Care. One member of staff said, "All of us [staff] are encouraged to get the training we need. I have completed a National Vocational Qualification in Care." One member of the care staff was being supported to work towards an NVQ level 5 with the aim of eventually taking a management role.

Staff applied their training while delivering care and support. We saw that people received assistance with eating and drinking, all undertaken in a respectful and professional manner. Staff also showed that they understood how to assist people who were living with the earlier stages of dementia. For example, people were reminded of key events that day in order to re-orientate them and reduce any possible anxiety arising from their condition.

Staff received supervision regularly. Feedback from staff and the registered manager confirmed that formal systems of staff development, including an annual appraisal was undertaken. Staff told us that they felt supported and valued the supervision they received. One member of staff said, "My supervision has been really good. I find it helps and the nurses work with us on the floor to make sure we are all working together correctly.' Staff supervisions gave opportunities to staff and their supervisor to share and reflect on their practice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met.

People commented they felt able to make their own decisions and those decisions were respected by staff. Staff understood the principles of the MCA and gave us examples of how they would follow appropriate procedures in practice. There were procedures in place to access health and social care professionals to conduct or advise on an assessment of capacity. People's mental capacity was assessed as part of the process before they were admitted to the home and this was then reviewed. Staff were aware any decisions made for people who lacked capacity had to be in their best interests. There was evidence in individual files that best interest meetings had been held and enduring power of attorney, where appointed, was consulted. During the inspection we heard staff ask people for their consent and agreement to care. For example, care staff were heard to ask people quietly and sensitively if they wanted support to take their medicine or eat their meal.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). The registered manager knew how to make an application for consideration to deprive a person of their liberty and records showed that this system was being used appropriately, with new applications made and updated as required.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. People and their relatives stated they were satisfied with the care, treatment and support they received. One person said, "Staff here have love, care and compassion in abundance." The relative of a person said, "The overwhelming feeling is that it is like a family. Staff treat our mum like it's their own mum and we are part of their family."

People's needs were respected and staff were aware of what was important to people. For example, some women liked to wear make-up, jewellery and particular clothing to reflect their lifestyle and staff supported them to do this. We saw rooms held small items of furniture and possessions that the person had before they entered the home and there were personal mementoes and photographs on display. Communal areas had displays on the wall that reflected people's interests, some of which they had created. People were supported to live their life in the way they wanted. We spoke to people who preferred to stay in their room. One person told us, "My choice to stay here is respected."

Staff provided care, treatment and support in a happy and friendly environment. We heard staff patiently explaining options to people and taking time to answer their questions. We also heard laughter and good natured exchanges between staff and people throughout our inspection. For example, we saw one person who declined an aspect of care at the time it was offered. The member of staff acknowledged their choice and sensitively said, "There's no rush [named person] I can wait," and then chatted with them about other matters until they were ready to accept the support.

People were consulted with and encouraged to make decisions about their care. They told us they felt listened to. One person told us, "Sometimes, I just want to sit or lie down on my bed. On these days I don't like to be badgered and staff respect that." Another person said, "We are always consulted and involved, nothing is changed without talking it through." Staff asked and involved people in their everyday choices, this included participation in activities on offer that day, seating arrangements at meal times and choice over the meal itself.

Staff told us how they assisted people to remain independent. We saw staff encourage people to mobilise and to eat and drink at their own pace. A member of staff said, "We work around the resident, for example with dressing in the morning, when a resident needs a bit more support we give them time and encourage them to do as much as they comfortably can."

People told us staff respected their privacy and treated them with dignity and respect. Staff understood how to respect people's privacy and dignity. They told us how they were respectful of people's privacy and dignity when supporting them with personal care. For example, they described how they used a towel to assist with covering the person while providing personal care and ensured that their modesty was protected. One staff member said, "We have a dignity champion and they make us think about looking after the privacy and dignity of the resident. So I will always close the bedroom curtains, cover the person with a sheet or towel and I don't rush them. I will wait if they want to wash their personal areas themselves." Staff also ensured that people's modesty was protected when supporting them to move using a hoist. Staff

explained what they were doing before they started the procedure and continued to speak with them throughout. The use of the lifting equipment with people was followed in a professional and respectful manner that considered the needs of the individual throughout.

People received nursing care in a kind and caring manner. Staff spent time with people who were on continuous bed rest and ensured they were comfortable, clean and pain free. For example, we observed that pain relief was provided on request. The nurse then checked 30 minutes later that the medicine had been successful. In another example, staff ensured those who needed additional support with nutrition and hydration received it. People told us that they thought staff understood their health restrictions and frailty. A person said, "My impression is of a good place. Staff are friendly and hospitable. They remember who you are as a person."

People's care plans contained personal information, which recorded details about them and their life. This information had been drawn together, whenever possible by the person, their family together with staff. Staff told us they knew people well and had a good understanding of their preferences and personal histories. People confirmed that they had been involved with developing their or their relative's care plans.

Care records were stored securely. Confidential Information was kept secure and there were policies and procedures to protect people's confidentiality. Staff had a good understanding of privacy and confidentiality and had received training pertaining to this.

Visitors were coming and going during our visit. Relatives told us they could visit at any time and they were always made to feel welcome. A person said, "They are as flexible in this as they are in everything else. My family all sat and watched x-factor with me last weekend." A relative said, "I am always offered a cup of tea and a friendly word."

Good

Is the service responsive?

Our findings

People told us that the service responded to their needs and concerns. One person told us, "When I had an issue with my health, staff took care of it straight away." Another person said, "I only have to mention something and it's dealt with." In a care plan a person's preference was recorded, 'I like lazy mornings and like to have quiet, so when I say go away I mean it.'

People and their relatives told us that they were involved in decisions and were able to talk to staff if they ever had any concerns about health or care needs. People's physical and health needs were assessed and met. People's needs had been assessed when they first moved into the home and care plans had been devised that were person-centred, comprehensive and documented the person's preferences, needs and abilities in relation to their care needs. They considered the person and put them at the centre of the planning of their care. For example, information about people's lives before they moved into the home, their interests, hobbies or social and emotional needs provided staff with an insight into former lives and current needs. This helped to inform and develop relationships and provide more of an understanding of people's holistic needs. Plans provided detailed information for staff on how to deliver people's care. For example, information was found in care plans about the personal care that people required, their physical well-being, communication, mobility and dexterity.

Care plans were reviewed monthly or when people's needs changed. This ensured they remained up-to-date. Staff received training and guidance in care recording to ensure accurateness and consistency. The daily handover between staff was thorough and gave all staff the opportunity to discuss people's care and treatment. The handover meeting provided information on each person, so that staff had the latest update on each. For example, handover contained information on how people were feeling that day, their participation in activities of daily living and what they had drunk and eaten. Some people received continuous bed rest, staff documented their interactions and their care and treatment provided against the assessed plan of care.

Care plans promoted and provided guidance to staff on how to meet peoples' social needs. Staff considered peoples additional needs if, for example, they spent their time in bed or chose to remain in their room. Photographs and certificates were displayed in the communal areas about events. For example, on the prompting of one person, the home had entered and won an award in the village in bloom competition. On another wall, care and dignity awards were proudly displayed, including awards to both people and staff. The Social Care Institute for Excellence (SCIE) recommends that older people should be encouraged to construct daily routines to help improve or maintain their mental well-being and reduce the risk of social isolation. This recommendation was embraced by the appointment of an activities coordinator to take a lead in providing meaningful activities. Additionally, staff also took an active role in activities according to their strengths and interests. For example, it was noted how an afternoon cheese and wine group was scheduled to be facilitated by the registered manager on the day of our inspection. People used the lounge, dining and garden areas and staff kept up a constant friendly dialogue with people on their way through the communal areas. Others who chose to remain in their rooms received one to one time that included social engagement, personal care and assistance at meal times if it was required. A staff member said, "We all have

a role in the activities. So for example, I know that people like to get out and about so we go to Rudyard Kipling garden in the village or down to the seafront, anywhere they want to go."

Meetings were held every three months for people to share feedback. The meetings were recorded and an action plan was drawn up after each meeting. A questionnaire was circulated at the conclusion of the meeting and the results fed into a quality assurance system. The latest questionnaire was completed in July 2016 and was available to view. It gained feedback from 16 people and four relatives and we saw that time had been devoted to obtaining the views of people who may otherwise struggle to have a voice, for example, those living with dementia. The responses showed a high degree of confidence and satisfaction with the home. There were also suggestions for improvement and changes were made to the service in response. For example, a theme in one response concerned the person's ability to take a bath when they wanted. We saw that, in response, staff listened to their wish in this area and arranged for baths in addition to continuing to support them to use their en-suite shower when they preferred.

Records showed comments, compliments and complaints were monitored and acted upon. The procedure for raising a complaint was available for people and their relatives. Complaints had been handled and responded to appropriately and any changes and learning were recorded. One complaint was recorded. In response to it extra monitoring of call bells was recorded so that the management could respond with confidence to the complainant about their concerns and demonstrate that they took seriously their concerns. One person told us, "The staff listen to me. If I was unhappy about anything I could talk to the manager or any of the staff." A relative said, "If I had a complaint, I would speak to the manager. I know I can talk to them if I need to but it really hasn't been necessary."

The home encouraged people to maintain relationships with their friends and families. Visitors were welcomed and interactions between staff and visitors were warm and friendly. Visitors were complimentary about the home, one relative said, "We visit at all times of the day and are greeted by all of the staff. We have total confidence in the home."

Good

Is the service well-led?

Our findings

The management of the home was strong and effective. People, their relatives and staff were complimentary about the leadership and management of the home. They told us that the management team were approachable, friendly and caring. One member of staff told us, "The home is well led, there is an open door policy to the office and we can always go to [the registered manager] confident that we will be listened to and supported."

A range of quality assurance audits took place within the home to ensure that the systems and processes used were effective. They helped to identify areas of practice to improve or change. The registered manager undertook quality assurance measures to monitor the standard of the service provided. For example, quality assurance processes included regular care plan and medicine audits. The use of quality assurance systems were embedded in practice and ensured that the home was effective and well run. They enabled the registered manager to have confidence that people were receiving the quality of service they had a right to expect.

The registered manager described their philosophy of care that was founded on privacy, dignity and respect. This was embedded in the culture of the home and implemented in the practice of staff. There was a friendly, warm and homely atmosphere and people told us that they felt happy and content. One person told us, "It's nice and homely here. It suits me very well." Relatives said the management of the home was very good. They told us they could talk to the registered manager when they needed to. A relative said, "[The registered manager] has been very helpful. Take finances. It has always been a concern but [the registered manager] has kept the accountants at bay. They have been wonderful." We noted the following feedback from staff, 'I wouldn't want to work anywhere else. I think we are a good team. We work together and as well as caring for the residents we care about each other.' The registered manager took an active role within the running of the home and had good knowledge of the people who lived there and staff. We observed throughout the inspection the registered manager spent time with people and talked with them and their visitors.

There were links with external organisations to ensure the most effective and appropriate care was provided for people. The registered manager kept up to date with new practice ideas, as demonstrated by their attendance on a 'Compassionate Leadership in Dementia Care' course that included taking a critical look at their own leadership model to look for areas of improvement. The registered manager had cultivated links with the local authority to participate in opportunities for learning and share experiences with other providers. They were outward looking, both in terms of opportunities to be involved in and contribute to, life in the village and further beyond. For example, the home welcomed students from a local college to receive experience of health and social care and had held a party to celebrate their success when their placement at the home came to an end. The registered manager positively involved people from the village to the home as part of dementia awareness week to consider becoming dementia friends and learn more about what it is like to live with dementia.

The registered manager worked closely with external health care professionals such as the GP and the Care

Home In Reach Team to ensure that people's needs were met and that the staff team were informed about the latest best practice guidance. A healthcare professional told us, "I am impressed with the care offered at Highbury House. The home has a loyal and committed staff team. The manager has embraced the support we can offer and works proactively with us."

There were clear lines of responsibility and accountability within the management structure. The registered manager was aware of their legal responsibility to tell us of all significant events, including injuries sustained and notifiable events that occurred.

The registered manager confirmed their personal commitment to an open and transparent service. They sought feedback from people, their relatives and staff to enhance their service. Staff meetings were regularly held to provide a forum for open communication. Staff told us they were encouraged and supported to question practice. Daily handovers, supervisions and meetings, for example department meetings, were also used to reflect on practice and examine procedures as they were currently followed in the home. For example, accidents and incidents, when they occurred, were reviewed by the registered manager to aid learning and drive quality across the home.