Pathways Care Group Limited

The Highlands

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 18 February 2016.

We last inspected The Highlands in January 2014. At that inspection we found the service was meeting all the legal requirements in force at the time.

The Highlands provides accommodation and personal care for up to 14 adults who have a learning disability or acquired brain injury. These numbers include people who may stay for a short break.

A registered manager was in place. 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.

People said they were happy and felt safe. There were sufficient staff to support people and ensure they received their medicines in a safe and timely way. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Risk assessments were carried out that identified risks to the person. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. People had access to health care professionals to make sure they received appropriate care and treatment.

Staff received regular training, supervision and appraisal and they were supported in their role.

People were supported to be part of the local community. They were provided with opportunities to follow their interests and hobbies. People received a varied menu.

People were overwhelmingly positive about staff. Staff knew the people they were supporting well. Care was provided with patience and kindness and people's privacy and dignity were respected.

The Highlands was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Records were in place as required by the Mental Capacity Act (MCA) 2005 to show best interest decision making when people were unable to make decisions themselves.

People we spoke with said they knew how to complain but they hadn't needed to. Staff said the registered manager was supportive and approachable. People were consulted and asked their views about aspects of service provision.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe and staffing levels were sufficient to ensure people were looked after in a safe and timely way. Staff were appropriately recruited.

Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected. Staff were appropriately vetted to make sure they were suitable to work with people who lived at the service.

Policies and procedures were in place to ensure people received their medicines in a safe manner. However, we have made a recommendation about the management of medicines.

Is the service effective?

Good

The service was effective.

Records were available to show if people had capacity to make decisions and to document people's level of comprehension.

Staff had received the training they needed to ensure people's needs were met effectively. Staff were given regular supervision and support.

People received appropriate support to meet their healthcare needs. Staff liaised with GPs and other professionals to make sure people's care and treatment needs were met.

People nutritional needs were met.

Is the service caring?

Good

The service was caring.

Relatives and people we spoke with said staff were kind and caring and were very complimentary about the care and support

staff provided.

People's rights to privacy and dignity were respected and staff were observed to be patient and interacting well with people.

Staff were aware of people's individual needs, backgrounds and personalities. This helped staff provide individualised care to the person.

People were helped to make choices and to be involved in daily decision making.

Is the service responsive?

Good

The service was responsive.

Support plans were in place to meet people's care and support requirements.

People were provided with a range of opportunities to access the local community.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff told us the registered manager was supportive and could be approached at any time for advice. The registered manager had promoted involvement and choice for people who used the service.

People who lived or stayed at the home told us they enjoyed being there and we saw the atmosphere was good.

The home had a quality assurance programme to check on the quality of care provided.

The Highlands

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.

Before the inspection we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care. We spoke with the local safeguarding teams. We received no information of concern from these agencies.

This inspection took place on 18 February 2016 and was an unannounced inspection. It was carried out by an adult social care inspector.

We undertook general observations in communal areas and during a mealtime.

As part of the inspection we spoke with six people who were supported by Highlands staff, five support workers, the registered manager, the chef and three relatives. We observed care and support in communal areas and checked the kitchen, bathrooms, lavatories and three bedrooms after obtaining people's permission. We reviewed a range of records about people's care and checked to see how the home was managed. We looked at care plans for four people, the recruitment, training and induction records for four staff, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and the quality assurance audits the manager completed.

Good

Is the service safe?

Our findings

People told us they felt safe living at The Highlands. People's comments included, "I definitely feel safe living here, staff are always around if I need them," "The staff are very approachable," and, "I can speak to the staff if I'm worried."

The registered manager told us staffing levels were determined by the number of people using the service and their needs. Staffing levels could be adjusted according to the needs of people using the service and we saw that the number of staff supporting people could be increased as required. We considered staffing levels were sufficient to meet the needs of the 14 people who were using the service at the time of inspection. Staff members' comments included, "There are definitely enough staff on duty," and, "There are always enough staff." The home was staffed by five support workers from 8:00am until 10:00pm, we were told this increased to seven support workers depending upon the needs of people who used the service and if 1:1 care was required for some people. Two members of staff were on duty overnight. These numbers did not include the registered manager who was also on duty during the day and was available 'on call' overnight to provide any support and guidance when required.

We checked the management of medicines. People received their medicines in a safe way. All medicines were appropriately stored and secured. Medicines records were accurate and supported the safe administration of medicines. Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed in the handling and administration of medicines. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

Records showed one person had their medicine administered on their breakfast cereal and in a 'teaspoon of lemon curd.' This was rather than the medicine being administered on its own. We were told this was because of the person's swallowing difficulties. A record was not in place that showed the decision making process as the person lacked mental capacity to be involved in their own decision making. There was a letter available from the General Practitioner but it did not show who had been involved in the decision making. The record showed the relative had requested it, but not why the medicine needed to be administered this way. We regarded the method of placing medicine on food should be treated the same way as the administration of covert medicine (covert medicine refers to medicine which is hidden in food or drink). The 'best interest' decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had not taken place with the relevant people. NICE guidelines state, "A best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests."

Medicines were given as prescribed and at the correct time. The senior support worker told us medicines would be given outside of the normal medicines round time if the medicine was required. For example, for pain relief. One person's care plan stated, "(Name) listens to music in their room from about 10:00pm until 2:00am and then has Paracetamol before going to bed." We saw there was written guidance for the use of

"when required" medicines, and when these should be administered to people who showed signs of agitation and distress.

Staff had received training with regard to administering a specialist medicine for severe seizures in order to provide the necessary care to a person in an emergency situation until the required medical assistance arrived at the service.

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They were aware of the provider's whistle blowing procedure. They told us they currently had no concerns and would have no problem raising these if they had any in the future. Staff told us, and records confirmed they had completed safeguarding training. Staff members' comments included, "I've had local authority safeguarding training," "I'd inform the manager if I had any concerns," and, "I'd tell the senior in charge if I had any concerns." The PIR showed level 2 safeguarding training was planned with the local authority so staff would be more familiar with the local authority multi-agency procedures and the role of the alerter.

The registered manager understood their role and responsibilities with regard to safeguarding and notifying CQC of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities where necessary. A safeguarding log was in place and four safeguarding incidents had taken place that needed to be raised with the local authority since the last inspection. These had been investigated and resolved.

Staff were aware of the reporting process for any accidents or incidents that occurred. These were reported directly to the registered manager so that appropriate action could be taken to prevent further incidents occurring.

Assessments were undertaken to assess any risks to people and to the staff supporting them. This included environmental risks and any risks due to the health and support needs of the person. These assessments were also part of the person's care plan. There was a clear link between care plans and risk assessments addressing for example, moving and assisting, mobility needs, epilepsy and going out independently. For example, one risk assessment for a person who went out on their own stated, "(Name) to have a fully charged mobile telephone on them so they can contact The Highlands or we can contact them."

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

Care plans were in place to show people's care and support requirements when they became distressed. Information was available that detailed what might trigger the distressed behaviour and what staff could do to support the person. Care records provided detailed and up-to-date information for staff to provide consistent support to people if they became distressed and challenging. For example, one care record stated, "My anti-social behaviour has to be addressed and staff must be consistent in the way this is managed. It should be handled by one member of staff when necessary and not lots of different staff members."

Staff had been recruited correctly as the necessary checks had been carried out before people began work in the home. We spoke with members of staff and looked at four personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered

their job. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people. Documents verifying people's identity were available on staff records. Copies of interview questions and notes were available to show how each staff member had been appointed.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building. Routine safety checks and repairs were carried out such as checking the fire alarms and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances.

We recommended the registered manager considered the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

Good

Is the service effective?

Our findings

Staff told us they were kept up to date with training. People's comments included, "There are opportunities for training," "We get loads of training," and, "We can say what training we are interested in."

Staff members told us when they began work they had completed an induction. They told us they had the opportunity to shadow a more experienced member of staff. This made sure they had the basic knowledge needed to begin work. The registered manager told us new starters studied for the Care Certificate as part of their induction to equip them with some of the required skills to work with people.

The staff training records showed staff were kept up-to-date with safe working practices. Staff told us and the staff training records demonstrated they had opportunities for training to understand people's care and support needs. They said training was appropriate. The PIR stated, "We link our training especially distance learning to needs at a moment in time e.g. one person developed dementia so we had the dementia nurse do an awareness session and then staff did distance learning course to give more understanding."

The registered manager told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training that helped them to understand people's needs and this included a range of courses such as, learning disability awareness, dignity in care, distressed behaviours, mental health, stroke awareness, dementia care, End of Life care, diet and nutrition, dementia awareness, Percutaneous Endoscopic Gastrostomy (PEG) training. PEG is a tube which is placed directly into the stomach and by which people receive nutrition, fluids and medicines. Some staff told us they had studied for National Vocational Qualifications (NVQ) at level 2 (now known as the diploma in health and social care) and some were studying for the diploma at level 3.

Staff told us and their records showed they received regular supervision from the registered manager to discuss their work performance and training needs. They also received an annual appraisal to review their work performance. Staff members comments' included, "The manager does our supervisions," "At supervision I can say what I want to do in the future and what my plans are," and, "We have supervisions every three months." Staff said they could approach the management team at any time to discuss any issues. They said they felt well supported by colleagues and worked as a team.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The Highlands' records showed three people were legally authorised to be deprived of their liberty by the local authority. Staff confirmed they had received training

about mental capacity and DoLS.

Records were available to show assessments had been carried out, where necessary of people's capacity to make particular decisions. Records were available that contained information about the best interest decision making process, as required by the Mental Capacity Act. Best interest decision making is required to make sure people's human rights are protected when they do not have mental capacity to make their own decisions or indicate their wishes. Information was available to show if people had capacity to make decisions and to document people's level of comprehension. Staff, because they knew people well, could tell us about people's levels of understanding.

Staff told us communication was effective and a written handover was available from each shift to keep staff up to date with the current state of people's health and well-being. Staff members' comments included, "Communication is very good," "We have a handover at the beginning and end of each shift," "We discuss what's going on and what's been happening with people," "The registered manager is in at 7:30am for the handover," and, "We have a verbal and written handover and the communication book is also used for staff."

We checked how the service met people's nutritional needs and found that systems were in place to ensure people had food and drink to meet their needs. If people were identified as being at risk of poor nutrition they were supported to maintain their nutritional needs. They were assessed against the risk of poor nutrition using a recognised tool, the Malnutrition Universal Screening Tool (MUST). This included monitoring people's weight and recording any incidence of weight loss.

Care plans for people's nutrition were in place where required. For example, one person's care plan stated, "(Name) to be assisted from their right hand side," "Try not to make eye contact with (Name) as they will often sit giggling and won't concentrate on eating." Risk assessments were in place to identify if the individual was at risk when they were eating or had specialist dietary requirements. For example, one person's care plan stated, "If (Name) won't eat their food, offer them custard, rice pudding or something similar instead." We saw there were a number of choices available for the evening meal. The food looked appetising and well-presented. Results from the provider survey for 2015 included several positive comments about the food. Comments included, "I've enjoyed all my meals especially the spaghetti bolognaise," "Two words to describe the food very enjoyable," "All of my meals have been top notch," and, "The catering cannot be faulted it was like staying in a hotel." Menus on display showed the four choices of meal available and also the allergens in each particular meal in case of allergies.

Records showed the health needs of people were well recorded. Information was available in their records to show the contact details of any people who may also be involved in their care. Care records showed that people had access to a General Practitioner (GP), dietician, district nurses, speech and language therapist, physiotherapist and other health professionals. One person told us, "I make my own GP appointments." The relevant people were involved to provide specialist support and guidance to help ensure the care and treatment needs of people were met. For example, one person's care plan stated, "Support (Name) to physiotherapy appointments when required."

Good

Is the service caring?

Our findings

People who lived in the home, respite guests who stayed for short breaks and relatives were all positive about the care provided by staff. Peoples' comments included, "It is better than living at home," "The staff are lovely," "The staff are brilliant," and, "I love living here." Comments from the provider survey of 2015, sent out to people who used the service included, "A home from home," It's a great laugh, the staff are exceptional," "Really kind and helpful," "I'm very happy here, keep it going," "Staff were excellent and always go that extra mile to help," "If at all possible ten times better than the first time I stayed. I love the place," "My stay was lovely, friendly and welcoming," "and, "Couldn't do enough to make you feel comfortable."

During the inspection there was a happy, relaxed and pleasant atmosphere in the service. People moved around the home as they wanted. We observed people came into the dining room and made drinks for themselves throughout the day or were supported by staff. Staff interacted well with people, sitting with them and spending time with them when they had the opportunity. Camaraderie was observed amongst the people who used the service and they were supportive and caring of each other. A visitor to a coffee morning had commented, "It was lovely to sit and see everyone laughing and enjoying the day." People were supported by staff who were kind, caring and respectful. Staff were patient in their interactions with people and took time to listen and observe people's verbal and non-verbal communication. Staff asked people's permission for example, one staff member asked a person, "Is it okay to sit with you (Name)." They also asked permission before carrying out any tasks and explained what they were doing as they supported them. For example, one care plan stated, "Always explain your interventions to (Name) before carrying out any tasks."

We observed the lunch time meal. The meal time was relaxed and unhurried. Staff interacted with people as they served them. People sat at tables set with condiments and napkins. Specialist equipment such as cutlery and plate guards were available to help some people. Tables were set for three or four and staff remained in the dining area to provide help and support to people. Staff provided assistance or prompts if required to people to encourage them to eat, and they did this in a quiet, gentle way.

Not all of the people were able to fully express their views verbally. Guidance was available in people's support plans which documented how people communicated. For example, "(Name) likes face to face and eye contact, they often smile and chuckle in reply," and, "(Name) enjoys being included in meal times, their usual facial expressions are smiling, laughing and cooing." Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. This meant staff had information to inform them what the person was doing and communicating to them.

People were encouraged to make choices about their day to day lives and staff used pictures and signs to help people make choices and express their views. Information was available in this format to help the person make choices with regard to activities, outings and food. Care plans included details about peoples' choices. For example, one care plan stated, "(Name) chooses their own clothing and toiletries …." Staff gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing and two plates of food. This encouraged the person to maintain some

involvement and control in their care. We saw information such as the complaints procedure and information pack given to people when they first came to the service was in an accessible format for people who did not read. This helped people to remain engaged and be involved in decision making.

Care plans contained details with regard to how people liked and needed their support from staff if they were unable to express their views verbally. Examples from care plans included, "(Name) prefers to get up after 10:30am as they like to listen to '10 at 10' on the radio first," and, "(Name) will 'buzz' when they are ready to get up (Name) doesn't like staff knocking or entering the room before they have buzzed."

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. Some more independent people told us they went out when they wanted. They told us they could choose to spend time in their bedroom and could get up and go to bed when they wanted.

People's privacy and dignity was respected. Staff knocked on the door as they entered people's bedrooms. They could give us examples of how they respected people's dignity. A relative's comment from a provider survey sent out by the service for a respite person stated, "I am pleased to report (Name) has been treated with dignity and respect at all times and they rang me to tell me they enjoyed having a shower, something they were very worried about having." Staff told us they respected people's dignity as people were able to choose their clothing and staff assisted people, where necessary, to make sure that clothing promoted people's dignity. Care records also showed people's privacy was respected. For example, a care plan for personal hygiene stated, "Staff to give (Name) their towels and facecloths. (Name) uses a towel to maintain their dignity."

Staff informally advocated on behalf of people they supported where necessary, bringing to the attention of the registered manager or senior staff any issues or concerns. The registered manager told us of a staff member who had advocated on behalf of a person who required a particular course of health care and treatment. There had been a positive outcome for the person who used the service as they had received the necessary treatment to improve their quality of life. We were told two people had a more formal advocacy arrangement in place to assist them with some decisions and promote their views. Advocates can represent the views of people who are not able to express their wishes.

Good

Is the service responsive?

Our findings

People said they were supported to follow their interests and hobbies. They were positive about the opportunities for activities and outings. They all said they went out and spent time in the community. Comments from people to us at inspection and from the survey after their stay included, "It's brilliant here, there's loads to do," "I had a great stay, especially the trip to the pictures," "I enjoyed the ten pin bowling," and, "I enjoyed my stay at The Highlands and my shopping trip. The steak pie was lovely." Records and photographs showed there were a wide range of activities and entertainment available for people. For example, themed menu nights, bingo, visiting art galleries, dog racing, museums, meals out, cinema trips, concerts and arts and crafts. People were also supported to go on holiday and we heard people had enjoyed trips to Haggerston Castle and Blackpool. People told us they had enjoyed Christmas and other seasonal parties that were arranged. A relative had commented, "Due to circumstances (Name) had to spend Christmas at The Highlands. I was made very welcome and witnessed first-hand how Christmas Day was spent and was warmed by the spirit of Christmas shown by staff."

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort. Records showed pre-admission information had been provided by relatives and people who were to use the service. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans provided instructions to staff to help support people to learn new skills and become more independent in aspects of daily living whatever their needs were. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, mobility and communication needs. A care plan for personal hygiene stated, "Sponge to be used on (Name)'s lower body and white flannel on their face. No soap to be used on (Name)'s face."

Some of the people who used the service had an acquired brain injury as the result of stroke or accident. Relatives and people we spoke with were very positive about the service and how through staff support, people had become and were continuing to become more independent in aspects of daily living. People were also supported to progress to live more independently if they chose to and were capable. A relative had commented in a recent provider survey, "I remember what (Name) was like when they first came to The Highlands (Name) couldn't do a thing for themselves. You just have to look at (Name) now to see what they have achieved." Positive risk taking was encouraged and was also part of the rehabilitation process. Details included in a care plan for a person who went out in their wheelchair independently recorded, "…. (Name) is to cross the road at a safe, designated place such as a zebra crossing. If (Name) is feeling unwell, tired, frustrated or upset they should be encouraged to postpone and review the outing." A person who was at high risk of falls was supported and encouraged to walk. Their mobility care plan stated, "Staff to encourage (Name) to stand up straight hold their head upwards and face forward and not to rush."

People's care records were up to date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. For example, (Name) loves the radio, going shopping and line-dancing," and, "I go to watch the football every other Saturday." Staff were knowledgeable about the people

they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service.

A daily record was also available for each person. It was individual and in sufficient detail to record their daily routine and progress in order to monitor their health and well-being. This was necessary to make sure staff had information that was accurate so people could be supported in line with their current needs and preferences.

Written information was available that showed people of importance in a person's life. Staff told us people were supported to keep in touch and spend time with family members and friends. For example, "(Name) has visits from their family and visits them at home." Several people had visitors every week.

Records showed that meetings took place for people and their relatives to discuss their care and to ensure their care and support needs were still being met. Relatives we spoke with said they were kept informed if there was any change in the health needs of their relative whilst staying at the service. The registered manager had also developed a communication sheet for the person to share with their relative at the end of each stay. This included details of how the person had been during their stay and activities and outings they had taken part in.

We were told monthly meetings took place with people to consult with them about activities and menus and to keep people up to date with the running of the home. The registered manager told us two resident and relative meetings took place each year. This was an opportunity for the registered manager to give the meeting any updates about the service and to receive feedback from people about the running of the home. A relative had commented, "We are looking forward to the next social get together, we may make more friends and feel quite at home."

We saw there were several compliments from relatives, people who used the service and visitors. These included, "You made me think differently, now I have a new outlook on life," and, "Staff go the extra mile." People had a copy of the complaints procedure that was written in a way to help them understand if they did not read. A record of complaints was maintained. Two complaints had been received since the last inspection and they had been investigated and resolved. A person commented, "I'd speak to my key worker if I was worried."

Good

Is the service well-led?

Our findings

A registered manager was in place who had been registered with the Care Quality Commission.

Regular analysis of incidents and accidents took place. The registered manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re-occurrence. The registered manager told us if an incident occurred it was discussed at a staff meeting. Reflective practice took place with staff to look at 'lessons learned' to reduce the likelihood of the same incident being repeated.

Staff said they felt well-supported. Comments included, "The manager is very approachable," and, "I can always speak to the manager."

The registered manager promoted involvement to keep people who used the service involved in their daily lives and daily decision making. Information was available to help staff provide care the way the person may have wanted, if they could not verbally tell staff themselves. Information was available in alternative forms other than the written word if people who used the service did not read. There was evidence from observation and talking to staff that people were encouraged to retain control in their life and be involved in daily decision making.

The atmosphere in the service was friendly and very relaxed. People who used the service moved about freely and pockets of people sat in small groups and stopped to talk to each other as they moved from the lounge or dining room. Staff were encouraged to spend time with people which meant that care was individual as the emphasis was not upon tasks but rather people. People were supported individually and care was delivered at the times the person wanted. Staff engaged in activities and meaningful conversations with people and they had the chance to sit and spend time together.

Staff told us staff meetings took place regularly. Meetings for health and safety took place monthly. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Meeting minutes were available for staff and for staff who were unable to attend meetings. They were signed by staff to show they had been read.

Records showed audits were carried out regularly and updated as required. A range of audits took place on a regular basis that ranged from daily to monthly. They included checks on finances, medicines management and the environment. Other audits included for health and safety, record keeping, catering and infection control. The operational manager visited monthly to provide an independent view of the service. Their monthly visit was to speak to people and the staff regarding the standards in the service. They also audited a sample of records, such as care plans and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.

The registered manager told us the provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually

to people who used the service. A survey was also completed by people who used the service after each stay to help capture peoples' views and the quality of care provided. We saw very positive survey results and many comments of appreciation about the running of the service and the opportunities available for people when they came to stay. For example, "(Name) has been coming for some years and standards keep increasing. It's reassuring to know (Name) is treated at The Highlands as they are at home and that's down to the manager and staff," Results from the family friends and advocates survey and other survey results showed there was an overwhelmingly positive response from all the people surveyed.