Highfield Residential Homes Limited

Highfield Residential Home

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 inspection took place on 12 March 2018 and was unannounced.

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

The care home accommodates up to 15 people in one adapted building and provides care to older people some of whom are living with dementia, and or physical or sensory disabilities. At the time of our inspection there were 13 people living at the home.

There was a registered manager 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.

At our previous inspection of this home in August 2016 we found improvements were needed in three of the five key questions. At this inspection we found that the provider had made improvements so that people received care that met their needs.

People said they felt safe and staff knew how to recognise signs of abuse or harm and how to report this. Staff knew the risks people faced in relation to their health conditions and how to support people with these. People were complimentary about the availability of staff and the provider practiced safe recruitment with the required checks carried out before staff started work.
People received their medicines on time from staff who had been trained to administer these safely. There were processes in place to ensure the premises and equipment were regularly checked and to manage the prevention and control of infection. The manager reviewed accidents and falls to ensure people had the right support to keep them safe.

Staff had effective support, supervision and training to develop the skills needed to care for people effectively. People told us they enjoyed the meals and we saw staff offered people hot and cold drinks throughout the day. People were supported to access health professionals when they needed. Staff supported people to have maximum choice and control of their lives in the least restrictive way possible; the policies and systems in the service support this practice. The provider was improving the premises and facilities. To ensure these were suitable to meet the needs of the people who used the service further consideration of signage and colour schemes to help people orientate themselves was needed.

People were very complimentary about the caring approach of staff. They said they were kind and considerate. We observed caring and friendly relationships between people and staff. We saw people's dignity and privacy was respected and they were supported to express their views about the care they

received. There were examples of a compassionate response to people's emotional needs.

People told us they had choices and made decisions about their care needs and that staff respected these. People were particularly complementary about the social opportunities available to them. They had access to a range of community based activities of their choosing, with access enhanced by use of the provider's mini bus. Staffing was planned so that people had one to one support with their social events. People's care was centred on them and they had been involved in this process. There was clear system in place to manage complaints which were investigated and responded to.

The management of the home had improved with a full management team now in place. People spoke very positively about the management style being open and friendly. The registered manager had improved their oversight of the service and was carrying out regular checks to ensure people experienced good outcomes. Quality assurance audits needed some minor strengthening to ensure the provider was looking at all aspects of the service. There were links with other agencies to gain advice and share best practices to improve the quality of care to people. People's views on the service were sought and staff were confident the provider's improvement to the service would continue such as the extension currently being built.

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 felt safe living at the home and staff understood how to recognise and report abuse. Potential risks to people's safety were assessed and managed. People benefitted from support from enough staff to meet their
needs in a timely way. People had their medicines safely from trained staff. The premises and equipment were regularly checked so they remained safe and systems were in place to manage the prevention and control of infection.

Is the service effective?

Good

The service was effective.

People were involved in identifying their needs, preferences and choices. Staff had received training to make sure they had the skills to meet people's needs. People enjoyed their meals and had access to regular drinks. Health care professionals were accessed for support. Staff understood and protected people's human rights.

Is the service caring?

Good

The service was caring.

People told us that staff were kind and caring to them. Staff respected people's privacy and dignity and encouraged people to maintain their independence. People said staff sought their views and they were able to express their views about the care they received.

Is the service responsive?

Good

The service was responsive.

People were involved in the planning of their care and were central to this process. This resulted in them having access to a variety of community based activities of their choosing. People were encouraged to speak out and raise any concerns or complaints and could be confident these would be listened to.

There were processes in place to ensure people would receive appropriate care at the end of their lives.

Is the service well-led?

Good

The service was well-led.

People spoke highly of the provider and management and reported they had consistently good care. The provider's audits had improved but needed strengthening. The provider had established links with other agencies to gain advice and share best practices to improve outcomes for people. People's views on the service were sought.

Highfield Residential 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 visit took place on 12 March 2018 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert by experience is someone who has experience of caring for someone who uses this type of care service.

When planning our inspection, we looked at the information we already held about the provider. This included any notifications they had sent us. These contain details of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We reviewed the information provided to us by the home in their Provider Information Return (PIR). The PIR is a document that the home sends to us to inform us how they are currently meeting standards and future improvements they intend to make. These help us to plan our inspection.

During our inspection visit we spoke with eight people who used the service and one relative. We spoke with the registered manager, two assistant managers and two members of care staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We sampled four people's care plans and looked at the arrangements for their medicines. We sampled records used by the provider to manage the service such as their audits, infection control practices, maintenance of equipment, handover information and daily records. We looked at accident records, falls logs, complaints, menus and surveys. Staff information was sampled to include; two staff files, induction processes and rotas.

Good

Is the service safe?

Our findings

People told us they felt safe living at the care home. One person told us, "Oh yes, [I feel safe] as care homes go this is one of the best". A relative told us, "I always feel mum is safe here she has a named carer who keeps me informed and lets me know if she needs anything".

Staff we spoke with were aware of signs which may indicate that someone was being harmed and how to report any concerns about people's safety. Staff had training in safeguarding and told us they were confident the registered manager would take action if they raised concerns. There had been no safeguarding concerns raised about this service at the time of the inspection.

People told us they were happy with the way staff helped them with their safety. One person said, "I'm not too good walking but the staff always come and walk with me so I don't fall". A relative told us how the staff supported their family member after their mobility deteriorated; "We had a meeting after that to discuss the way forward so she is staying in bed for a while and that's fine with us". Staff we spoke with understood the risks to people's safety and how these should be managed. We saw risk assessments were in place for a person at risk of falls and this specified the support they needed and the equipment they used. The person's records showed there had been a decrease in falls as a result of how they were being supported. Another person's risk assessment identified that their bed needed to be on the lowest setting as they had a history of falling or climbing out of bed. We saw their bed was on this setting to ensure the person could get out of bed without falling from a height.

Risk assessments had been undertaken for people in relation to pressure sores, weight loss and behaviour that might place them or others at risk of harm. These contained clear guidance to staff to keep people safe. We saw that the electronic records system in place alerted staff to all known risks to people's safety. Staff told us they accessed this information using IPads which allowed them to update information to show how the risk is managed. For example we saw for one person how staff updated the frequency of changing the person's position to reduce the risk of developing pressure sores. We saw for another person that staff consistently updated their fluid intake to reduce the risk of dehydration. The electronic system enabled managers to monitor that appropriate action was being taken at the right times to support people safely; for example if a person's fluid intake had met the target for that day.

People told us there was enough staff to meet their needs. One person said, "Oh yes you just press the buzzer and they come you don't wait long". Another person told us, "They are lovely and attentive, and there's enough of them to take us out and do nice things, I have no complaints". We saw there were staff available to support people promptly. For example on the morning of our inspection there was a medical emergency which staff were attending to. During this time a person told us they were due to go out on a shopping trip. We heard from the person that additional staff were called in and a taxi arranged so they could continue with their plans. The person told us, "They are lovely like that; nothings too much trouble". We saw that staff provided one to one support to a person with a high risk of falling, and provided support to people who preferred to remain in their bedrooms. We heard from people in their bedrooms that they had their personal care attended to and staff checked them regularly. Staff told us they had no concerns about

staffing levels.

People told us they had their medicines when they needed them. One person said, "They know what I have and I get them on time and they always remind me what they are; some [tablets] are my favourites and they know the ones I don't like!" We observed a member of staff administer medicines and informing people what they were for. They were patient and had a gentle approach towards people encouraging them to take their medicines. Medicines were administered by staff who had been trained in safe medicine management as well as training in using the electronic medicine system. We saw that the system covered all aspects of medicine management to include the ordering/receipt and administering of medicines. Staff were competent in using the electronic system to record when medicines had been administered. A red alert on the system showed managers where medicines had been missed and allowed them to check and follow up. The most recent external medicine audit identified good practice areas and some minor amendments to enhance the otherwise good practice. The registered manager advised us they would be implementing these.

Safe recruitment procedures were followed. The provider had recruited new staff and we saw from staff files that checks had been made staff were employed. This had included references and a check with the Disclosure and Barring Service (DBS). The DBS check would show if a prospective staff member had a criminal record or had been barred from working with adults. A staff member recently employed confirmed these checks had been undertaken.

There were processes in place to ensure the premises and equipment was checked to ensure it was safe. We saw regular checks were undertaken by external contractors for fire detection systems and equipment. Supplies such as gas appliances and water were checked and equipment such as the stair lift and hoist equipment was serviced regularly. The provider also conducted their own checks on water temperatures and fire detection systems to make sure the home was a safe environment for people to live in.

People told us they were happy about the standards of cleanliness in the home. One person said, "I was pleasantly surprised; you hear rumours about these places but its spotless, I am spotless. I have been happy here it's different here lovely and clean. I do like cleanliness". Another person told us. "They clean your room every day; strip all the bed, clean bed clothes". We saw the home was clean and tidy with no offensive odours. Staff used personal protection equipment (PPE) when delivering care and changed aprons and gloves between care tasks or when handling food. Staff had training in infection control and cleaning schedules were in place for domestic staff to follow. We saw the provider had appointed a member of staff as the infection control lead and checks were carried out monthly to ensure the premises remained clean and hygienic. The front of the property was limited due to contractors vehicles and building supplies and whilst this does create more difficulties in keeping the area safe, hazard free and clean, there was a need to address the smoking area as the appearance of cigarettes butts on the ground and old worn chairs to sit on did not enhance the appearance of the property.

The registered manager informed us that any safeguarding matters would be reviewed to establish if any lessons should be learned. We saw records reflected that action had been taken to review a previous safeguarding and the person's family had been involved in this process. We saw they had updated the person's care plan to reduce the risk of them falling in the future. This helped staff to support the person with their safety. The provider was able to demonstrate they had initiated contact with other professionals where they believed there was a safeguarding risk such as self-harm that needed strategies to be in place to support a person's safety. We saw that the provider had involved the person in decisions about risks to their safety, specifically where there were concerns about the person's ability to retain control of this aspect of their care. The provider had involved external key professionals to work with a person around risks. This was

to ensure that they explored the least restrictive way of supporting the person whilst balancing this against risks and the person's capacity.

Good

Is the service effective?

Our findings

At our last inspection in August 2016 we rated this key question as 'requires improvement'. We found that staff did not always receive an induction into their role to ensure they had the skills and training to do their job. At this inspection we found that this had improved.

Staff we spoke with told us they received an induction when they commenced work at the home. One staff member was in the process of completing the care certificate as part of their induction. The care certificate is set of minimum standards that can be covered as part of the induction training of new staff; primarily where they have had no previous training in care work. They told us their induction included opportunities to work alongside established colleagues. Another staff member told us their induction included a range of training relevant to their role and the needs of people they supported.

We found improvements in the way that staff were supported. Staff told us that they received support through regular one to one meetings with a member of the management team. One staff member said, "I can discuss any issues or problems and I get positive feedback as well on my performance". Another staff member said, "yes I've had supervision but we also get support on a daily basis; the managers work alongside us and they do set good standards".

We saw from staff training records that training was planned in advance and included additional specific training suited to the needs of the people being supported. For example staff told us they had completed training in dementia awareness and we observed they used this training to support their interactions with people. Another staff member told us how their training in nutrition and hydration had helped to keep them aware of best practice and the importance of monitoring people at risk of dehydration or not eating enough. Senior staff had additional training in the safe management of medicines as this was part of their role. They had also undertaken training in the management of the Proactive Care System [PCS] which is an electronic system for the management of medicines. All staff felt they had the training to support people's needs.

Staff had training in equality, diversity and human rights and we saw they had a good understanding. We saw examples of how they worked to these principles to provide support to meet the diverse needs of a person related to their disability. This had included sourcing external professionals to support the person with decisions around their care. We saw another example of how they had were exploring access for some people to a local community event. This showed they were taking into account people's individual social needs related to their disability. People using the service also commented on how well their individual needs were met in relation to gender and faith, one person told us, "We used to have a religious service come in but we didn't really want that; the owner has asked us and would take us to any church if we wanted". Another person told us, "We have male staff and I was asked if I was okay with having support from a man and I was fine; it's nice to be asked". These approaches helped to enable staff to taken into account the diverse needs of people when assessing and planning people's care and ensure there is no discrimination when making decisions about people's care.

People's needs were assessed prior to their admission and included people's preferences relating to their

care and communication needs. Some people were able to confirm their involvement in this process. One person told us, "They came out to visit me first and asked me and my family about what help I wanted and what things I liked; we went through everything". A relative confirmed that the assessment process included seeking information about the person's history and preferences as well as any specific risks such as falling. Care plans were in place to reflect people's needs and how these should be met. For example we saw plans were in place to support a person at high risk of falling and we saw staff supported the person using assistive technology such as a sensor alarm to monitor the person's movements. Some people required support with mobility and had access to walking aids. Where people needed particular equipment such as beds that can be lowered to the floor, these were in place to support their needs and helped staff to deliver effective care.

People were positive about the meals provided. Their comments included; "I can't fault it the meals are pretty good I had a bacon sandwich for breakfast cornflakes and toast". "I am a vegetarian and the food is very, very good", and "You always get a choice and we also go out for lunch, I like going out especially for fish and chips". A relative told us how pleased they were when staff supported their family member with their eating. They said, "Mum stopped eating they called the doctor, gave her lots of choice about food to try and tempt her and the manageress reassured me". We saw the meals looked nice and portions were good, a person telling us, "Oh yes you can always have more". We saw one person was unwell and staff were regularly checking on what she might like to eat and offered her lots of alternatives. People had the assistance they needed to eat their meals; staff were mindful to explain what the meal was to a person with a sight impairment, who upon finishing their meal commented, "Oh its lovely." We saw that where people had specific dietary requirements related to health conditions such as diabetes these were met. People at risk of weight loss had their weight monitored and were supported to maintain their weight with meals fortified to add extra nutrition. We saw people had access to regular drinks of their choosing such as milk shakes, juice tea or coffee and where needed people's fluid intake was monitored if they were at risk of dehydration. Monitoring records for fluid intake were maintained and targets set for individual people. Where target intake fell staff were aware of the action to take to increase fluids such as offering smaller amounts more frequently or alerting the doctor.

People told us they had no concerns about accessing health professionals. We saw staff linked effectively with health professionals to ensure people received specialised healthcare when needed. For example staff ensured they referred people for treatment in a timely way to such as the continence team, doctor, diabetic nurse, and occupational therapist who had all provided support to people to maintain their health. People told us if they needed to visit a health professional, for example at hospital, then a member of staff would support them to arrange this or accompany them. When people were ill they told us staff were attentive to them, one person, pointing to a staff member said, "That lady is ever so kind, yesterday I had a sick turn and they really looked after me."

The premises were being extended and improved to meet the needs of the people who lived there. This included additional communal and bathing areas with bedrooms with patio doors leading onto the newly landscaped garden. One person told us, "I'm having one of the bedrooms it will be lovely for me and my cat can get out in the garden". The existing communal areas such as the lounge and corridors lacked colour changes and signage to help support people who had dementia to move around independently. We saw feedback from people using the service had included comments related to the décor needing to be improved. The provider recognised the decoration in some areas was also in need of an update and that this was part of their on-going improvement plan. The rear garden was out of use due to building works but we saw this was being levelled and landscaped to create a suitable outdoor space for people to enjoy. People told us that in the current weather they would not be using the garden areas. In addition we saw people were frequently taken out on trips via the homes mini bus, consequently no one complained about not being able to get out in the fresh air.

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. We saw staff understood the importance of obtaining consent before assisting people with aspects of their care. People told us and we saw that staff always asked people before carrying out care tasks. Staff we spoke with told us they had received training in MCA and could identify where people gave consent with gestures or body language. One staff member said, "People may not answer you but you can wait and see if they respond by walking with you; we would know when someone is consenting".

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. We saw capacity assessments were in place where decisions had been made in people's best interests. Four DoLS applications had been approved and we saw restrictions on people's liberty were reflected in people's care plans. Staff were able to describe restrictions in place and why this was important to the person's safety. We saw that equipment that could be construed as invasive, such as sensor alarms and consistent monitoring of people's movements, had been authorised in line with people's need for safety.

Good

Is the service caring?

Our findings

The registered manager and staff team continued to provide a caring service to people who told us that staff were kind, considerate and thoughtful. One person commented; "This is the only one [care home] I know with any warmth and I visited a few".

People told us that they were treated with kindness, respect and compassion. We heard examples of how the staffing arrangements were often in response to people's needs. People said they enjoyed positive relationships with the staff who they described as 'going out of their way' to support them. For example one person told us "The staff are very kind, they will take my shopping list and do all my shopping because I don't like to go out". A relative described their initial meeting with the registered manager; "They were very pleasant when they came and fetched mum in the minibus. It took two or three months for her to settle down but the lady manageress was very good and I have a very good relationship with them".

Whilst no one currently used an independent advocate, contact details for accessing this service was available. In addition the registered manager and management team demonstrated a strong commitment to providing compassionate care. It was clear that they knew people well and had a good understanding of how best to support them. An example of where they had acted as an advocate for a person was shared with us which demonstrated how they had supported a person who had been estranged from their family. They had initiated contact and undertaken practical arrangements to escort and transport the person to family re-unions. This had resulted in the person feeling less isolated.

People received emotional support. For example one person was extremely distressed at the thought of being separated from their dog but the registered manager had made provision for the dog to live in the home with the person. They told us, "I could not go to any place without her, the dog walker comes to take her out but I do take her into the garden as well and staff will walk her". Another person told us how they could not be separated from their cat and how the staff had accommodated these needs and shown kindness and understanding towards them, "I could not go anywhere without my cat and she can be here with me in my room". Domestic staff demonstrated a positive approach to the wellbeing of the people in a caring and meaningful way. For example they told us they were happy to undertake any additional cleaning which enabled people to keep their pets and said it did not present any more challenges; "No, I have to do the floor every day but I would anyway it's no problem."

Staff encouraged people to maintain relationships with their friends and families and to make new friends with people living in the home. Two people told us how they liked sitting together to eat their meals and 'have a good chat', one said, "We have made friends with each other, we do get on don't we?" Visitors were welcome and could stay as long as they wished. Visitors told us they were welcomed and always offered a drink. One relative told us how they were regularly included in events and celebrations such as a lovely meal at Christmas and how much this meant to them to share that time with their family member.

We heard examples of staff responding in a compassionate way when people experienced pain or distress. A relative described a situation where their mother had fallen, they said, "Mum had a fall and the manager lay

on the floor holding her hand because she was so upset she would have to go to hospital."

We saw that staff were respectful when talking with people; calling them by their preferred names and making sure they greeted people and enquired how they were. Staff referred to people with affection and in positive terms. People's dignity was protected by staff knocking on people's doors and waiting before entering. People told us they had privacy, one person told us, "I prefer my bedroom and staff always respect that."

Staff had training in equality and diversity and told us that they respected people's individuality. One staff member told us, "People's sexual orientation would be personal to them and I'm confident that staff would not have any prejudices". Another staff member said, "We'd look to support people with their partner and accessing community events if that's what people wanted".

Good

Is the service responsive?

Our findings

People told us they were involved in planning their care. One person said, "They asked me about my health, what I could do for myself, my family, I think they got a good picture of me".

People told us that staff knew their daily routines and preferences and supported them in ways they wanted and needed. People told us that they discussed changes to their needs on a regular basis. One person said, "They will ask you if there have been any changes or if you need more help; they are good like that". A relative told us there have been some recent changes to their family members care and they had been involved in reviewing the care plan. Records we looked at showed that people's care needs were regularly reviewed as their needs changed.

Staff told us they had handovers at each shift so that changes to people's needs was communicated. We saw the electronic records included 'alerts' to update staff on changes such as if a person needed their position changed or was not eating enough. This helped staff to respond to people's needs and provide consistent care and support. A staff member told us, "The IPAD system allows us to have an accurate update on what is happening for that person, you have to read the updates before the system allows you to move on. Another staff member told us, "We know people well but also the care plans on the system shows any immediate risks such as risk of choking or falling. The actions we have to take are also clear so we know how to respond to people's needs".

We saw that care plans were centred on the person and contained information about the person's health, religion, preferences and included details of people's daily routines. We saw staff responded to people's needs in line with their plan. For example staff respected people's choices of when they got up and went to bed and when and where they ate their meals or how they spent their time; whether in their bedrooms or communal lounges. We saw examples of how staff had provided support to meet the diverse needs of people using the service including those related to disability. People's care was responsive to their emotional needs and took into account what was important to them, ensuring they had as much choice and control as possible. This approach had enabled some people to keep their pets and they told us how important this was to them.

People's communication needs had been explored as part of their initial assessment in terms of the support needed to access information. This ensured that care planning took into account people's needs such as sensory disability or dementia so that people receive appropriate care centred on them. For example where a person with a sensory loss refused to use their hearing aid their plan reminded staff to provide clear instructions when speaking with them so that they could access information more easily. We saw the provider had referred another person to independent support and advice so that they could get information and advice to understand the best support options for them to manage their medicines independently and safely. We saw staff describe a person's meal to them to ensure they were aware of what they were eating, as well as regularly approaching the person throughout the day and explaining what was happening around them. Whilst the communication needs of people had been met information in other formats was not evident such as large print or braille, picture menus or signage around the home to help people to find their

bedroom. We discussed this with the provider who told us these would be developed as part of the on-going improvements they were making.

People were very complimentary about the social aspect of the service. They told us of the many opportunities to go out for; lunch, pub visits, shopping trips and visits to places of interest. One person said, "The owner is great; he takes us out anywhere we want to go". Another person said, "They regularly ask me what I want to do and always take me shopping, I like having lunch out as well". Staff told us they enjoyed seeing people do the things that made them happy, one staff said, "No one is left out, we involve people in all sorts, they love it". The provider told us in their Provider Information Return, [PIR] how they had improved the social opportunities for people. They had introduced an activities coordinator and one to one social opportunities. They had planned activities and staffing levels so that people had one to one opportunities as; "This gives staff and the service user a more caring and personal approach and builds a better relationship". We saw that the provider had their own mini bus to support people to access community amenities. People said this had made a big difference to them 'getting out and about'. One person said, "Most homes for older people wouldn't consider getting us out so frequently". Another person told us, "I'm not one for games like bingo or puzzles; there's life in me yet!" We found that the provider had structured and organised a range of activities and ensured staffing levels enabled them to provide this aspect of person-centred care.

People's religious needs had been considered and a religious service had taken place at the home. However people decided they would prefer to attend services in the community. The staff team was made up with people from different faiths and cultures and staff told us that people's religious or cultural requirements would be respected and catered for. Staff informed us part of the on-going development of the home was to explore the amenities within the local community. We saw they had identified a community based social resource for people with dementia and were planning to take people to this so that people could stay in contact with communities organised around their needs.

People told us that they knew how to make a complaint and they felt confident it would be listened to. One person told us, "There would be nothing to complain about here; they are just such good management and staff". Everyone had a copy of the complaints procedure with details of how to make a complaint. A relative told us they had no concerns about approaching management with complaints. We saw complaints were recorded and investigated and that people had a written response and apology to any concerns or complaints.

The provider had considered the needs of people who required end of life care. Although they had not provided support to anyone who was at the end of life we saw they had a policy in place which covered the key areas of this care. We also saw that they had made links with their local hospice to source additional training for staff in providing this care. This meant that should people require end of life support in the future, there were plans in place to provide this.

Good

Is the service well-led?

Our findings

At our last inspection in August 2016 we rated this key question as 'requires improvement'. This was because at that time the governance arrangements and quality assurance systems in place to monitor care and plan on-going improvements was not effective. At this inspection, we found the governance system operated by the provider had improved but there were still areas where this needed to improve further.

During this inspection we found the registered manager had an improved management team and was supported by two assistant managers and a managing director. Each manager had specific management roles and tasks as well as supporting the care practice and developing staff. The team had clearly worked together well and were motivated to ensure people were well cared for. Staff told us the management team worked well together and were supportive to them.

There was a relaxed feel to the home and we saw all the management members spent time in their day speaking to people and there was an open door policy. People and relatives spoken with described the management of the home in very positive terms feeling they, 'Couldn't do enough' and, 'They are lovely people'. We saw arrangements were in place which demonstrated management had time to listen to people. For example a person told us that one of the management team was abroad but that he, "Skype's me because he knows I miss him and want to talk to him". We were present when the manager phoned in advance to tell the person he was about to Skype. Another person told us the registered manager was, "Very good; he comes to say goodnight to me every night, he will do anything for you." We saw people, staff, health professionals and relatives were confident to engage with management. For example a relative was able to speak directly with management and obtain a copy of the care delivered to their family member which helped them to answer any questions they had.

Staff knew about reporting safeguarding concerns and were confident that the management would support them to do this. Staff were aware of how to whistle blow if they were unhappy about people's care. This approach and these systems helped to support an open and transparent culture within the home.

We saw areas of the governance system were now improving the quality of the care people received. For example, we saw people got their medicines as prescribed. We found medication administration records had been consistently completed as a result of the new electronic systems in place. We looked at the records for medication administration procedures and found these had been consistently maintained and that any errors would be identified quickly for action. A staff member told us, "We complete any actions or updates straight into the IPAD which updates the care plan or any monitoring records. We do the same for people's medicines; you can see at a glance what has been done or what is outstanding". We saw examples of where people's care records were updated to reflect their needs. The registered manager showed us how they access the system to ensure care tasks are carried out at the required time, for example if a person needs their position changed, is due their medicine or has not drank enough fluid. The system enabled the registered manager to have an accurate picture of the care needs of the people living in the home and any potential risks to their health or safety.

The provider and registered manager shared a passion in wanting to provide the best level of care to people in a way that encouraged people's choices. There was a positive understanding of equality, diversity and human rights principles in the leadership of the service. This was demonstrated by the many examples of where people had opportunities to do the things they wanted to do such as going out regularly to access community amenities such as lunch clubs, pubs, parks and places of attraction. The provider's mini bus helped people access community amenities more easily. We saw there was a real focus on talking with people and finding out what mattered to them, to this end people had been supported in very personal ways to for example; to re-engage with their families, keep their pets or access services to support them with their choices. There was an individualised approach by management and staff in the way they cared for people.

The registered manager had ensured that new staff received an induction and regular support via supervision. Staff we spoke with confirmed they had regular support and time to reflect on their practice. The provider had updated their staff training records since our last inspection. We found staff had completed mandatory training courses and in addition the provider had sourced training to meet the specific needs of people living at the home in order for them to experience better outcomes in terms of their health.

People were encouraged to share their views about the home. A recent survey had been completed by people and their relatives and we saw comments were all very positive regarding the care people experienced. Where people had raised concerns about the quality of the decoration in the existing building, we saw the provider had taken temporary action to repair peeling paper. However redecoration of the communal lounge and hallway whilst identified by the provider as part of their action plan to improve the service had no date for action.

The manager conducted audits to ensure people had received effective care and that the environment was safe. For example where people had fallen individual risk assessments were reviewed and preventative measures taken. We saw falls were analysed for any patterns and for one person by changing their routine they had decreased the number of falls the person had. The registered manager had introduced more formal audits in relation to other aspects of the service such as infection control, medicine management and environmental checks. The environmental checks included visual checks on window restrictors but this was not recorded. The provider told us these were in working order and following our inspection sent us an audit document to show they had added this to their audit tool. We also saw that some of the visual checks carried out by staff did not pick up worn and torn table clothes. The assistant manager removed these and said they would be replaced. A free standing TV had not been risk assessed but when raised with the provider they removed this. Likewise a conservatory settee had been placed in the lounge but was not suitable for people to sit on, this had not been risk assessed. Whilst well intended the provider must ensure changes to the environment are assessed to make sure they are appropriate to the needs of people.

The provider had established links with other agencies to gain support or share best practice to ensure the quality of care and support was continually improved. They worked with the local authority to provide respite beds to people who were discharged from hospital but who were too poorly to return to their own homes. There was the beginnings of joint working with the local hospice to provide training that would enable staff to promote and raise the level of end of life care to people when this was needed.

The provider had notified us about certain events such as accidents and incidents, but notifications regarding restrictions on people's liberty had been overlooked. However this was rectified immediately after the inspection and the provider told us they would ensure these are sent on time.

Registered providers are legally required to display the ratings awarded by the Care Quality Commission (CQC). The provider does not have a website but we saw the most recent rating was displayed within the home.