92 Higher Drive Limited

Highfield House

Inspection report

Highfield House
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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

Overall summary

This inspection took place on 9 and 12 October 2015. We last inspected the service in October 2013. At that inspection we found the service was meeting all the regulations that we assessed.

Highfield House is a purpose-built care home providing accommodation, personal and nursing care for up to 27 people who are medically highly dependent due to their complex needs. The service specialises in the care and management of people with a wide range of neurological problems including those in a minimally awareness state, and people needing mechanical ventilation.

There was a registered manager in post at the time of our inspection. 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.

The manager and members of staff clearly understood their roles and responsibilities to protect people from harm. Risks were assessed, and appropriate provision was made for staff to manage these effectively. People

Summary of findings

consented to their care and treatment and staff had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS exist to protect the rights of people who lack the mental capacity to make certain decisions about their own wellbeing. Services should only deprive someone of their liberty when it is in the best interests of the person and there is no other way to look after them safely.

People were cared for by a multi-disciplinary staff team who were qualified, supported and trained to meet their needs. The provider had a proactive approach to the personal and clinical development of staff, who were well trained and skilled. They were provided with specific training and development, and supported to carry out their role competently and had opportunities to develop further.

Management were proactive in following safeguarding procedures, the manager had made a safeguarding alert to a local safeguarding authority when the care provided by another service was unsafe.

Medicines were managed safely. The provider had policies and procedures in place for the storage and administration of medicines which reflected the guidelines recommended by the National Institute of Clinical Excellence (NICE) for managing medicines in care homes.

People had enough to eat and drink throughout and there were suitable arrangements in place to identify and support people who were nutritionally at risk.

The home had systems in place to ensure there was an appropriate number of staff on duty at all times, and there was a good balance of knowledge, skills and experience

People were supported with access to healthcare services and staff were involved in the regular monitoring of their health. The service worked effectively with a range of healthcare professionals and was pro-active in referring people for treatment.

The service had policies and practices to support people and their relatives around end of life care.

The home was well managed, and had effective quality monitoring process in place to drive continuous improvement and high quality care. Action plans were developed and discussed with the staff team for learning and making improvements.

Summary of findings

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.

Safeguarding procedures were robust at the service. Staff were knowledgeable about how to recognise signs of potential abuse and followed reporting procedures.

Staffing levels were kept under review and appropriately deployed to keep people safe and meet their needs. People were protected against unsafe or inappropriate care because risks were identified, managed appropriately and acted upon promptly.

Appropriate systems were in place for the safe storage, administration and management of medicines.

Is the service effective?

Good

The service was effective.

Staff supported people to make decisions about their care in accordance with current legislation. Where restrictions were placed upon people, staff ensured people were enabled to continue living their life in accordance with their care needs and preferences.

People who used the service, their families found that staff were well trained. The multidisciplinary staff team were provided with a wide range of training in order to help them carry out their roles effectively. The staff team included a range of health professionals who ensured that people's health care needs were met.

Is the service caring?

Good

This service was caring.

People were treated with respect, kindness and compassion. Practices were observed by management to ensure staff promoted good practice guidance and supported people in a dignified and respectful manner.

Staff were familiar with the people they cared for and were committed to helping them achieve the best quality of life. People received care and support in line with their needs and wishes. People were involved in discussions about their care.

Is the service responsive?

Good

The service was responsive.

The care and support people received was responsive to their needs. People's individual needs were considered, and changes responded to quickly and appropriately.

Advice was sought from specialists when required and this guidance was used to appropriately deliver the care and treatment people required.The staff team were competent at following advice and guidance provided by external healthcare consultants.

There was a complaints process in place that helped ensure any complaints or concerns about the service were appropriately investigated.

Summary of findings

Is the service well-led?

Good

The service was well led.

The management structure was strong and gave clear direction to all. Staff felt well supported and motivated to do their jobs well.

The culture in the home was open. People using the service, relatives and staff could raise concerns with managers, and had confidence they would be listened to and issues addressed appropriately.

The home took action to reflect and learn from incidents to ensure that improvements were made. The home had links with, and followed guidance from, a range of organisations that promoted best practice.

Highfield House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 unannounced inspection took place on 9 and 12 October 2015.The inspection was conducted by one inspector, and a specialist advisor who is an experienced social worker.

Before the inspection we reviewed information we held about the service and the service provider. This included reviewing statutory notifications submitted by the service, information from staff, members of the public and other professionals who visited the home. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection visit we spoke with the family members of three people who used the service, six staff and the manager and deputy manager, and 12 of the people who used the service. We also received feedback from four healthcare professionals that regularly visited the home. We reviewed records that were part of the provider's quality assurance tool, tracked the care of six people who used the service. Following the inspection visit we made contact with and received feedback from eight relatives.

As staff records were not held in the home we visited the head office on the second day to look at personnel records for seven members of staff.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living in the home. One person we spoke with said, "Staff are good at their job and know how to look after me and use the equipment I need safely." The view of people who used the service and their relatives was that staffing levels were good and these helped keep them safe. Relatives told us they felt the premises were well equipped with suitable equipment that maintained people's safety.

The home had systems for ensuring concerns about people's health and welfare were managed appropriately. Clinical risk assessments were in place which were outcome led. The service used National Early Warning Score (NEWS) in order to standardise the assessment of acute-illness severity in the home. Records showed concerns about people's safety were reported promptly to other agencies such as the local authority and the CQC. For example, a person moved to the home with signs they had received poor skin care elsewhere. Staff dealt with this appropriately and reported to the relevant bodies to prevent a reoccurrence.

Staff demonstrated an understanding of what abuse or neglect was and how to report concerns. Staff were knowledgeable in recognising signs of abuse, and reported all concerns to the manager of the service. Staff told of their confidence in the management team, in that any concerns raised would be investigated fully to ensure people were kept safe. Staff liaised with people's relatives, their social workers and other healthcare professionals involved in their care when they had any concerns about a person's safety or welfare. Staff told us, and records confirmed they received regular training about how to keep people safe and to make sure they were up to date with reporting systems and national guidance. Monitoring of safeguarding concerns took place and were regularly reviewed and addressed at staff meetings.

Staffing levels were assessed to meet people's needs and keep them safe. For example on the first floor unit there were seven people using the service, five of these had one to one staffing over twenty four hours, and the other two people had one to one at night as they had to use a ventilator overnight. In addition to these staff there were four staff on duty on the floor including a qualified nurse. On the ground floor there were 11 people, staffing levels comprised of one nurse and four carers. Staffing Level assessment tools were in place and staffing levels were reviewed and monitored daily. Thorough staff handover reports were completed with specific paid time allocated for this task. Staff rotas were produced (monthly) and reviewed daily by deputy managers to check if they were suitable. The deputy manager told us if a person relied on a ventilator or had a tracheotomy a suitably trained and competent member of staff was assigned to assist them to appointments and during periods when they were hospitalised. Staff told us the staffing numbers were adequate and they were rarely short staffed. Our observations were that staff members were not rushed and gave people quality time. People told us they did not have to wait long for assistance when they needed it. Relatives also reported their confidence in the staffing levels and competencies based on their observations and discussions with staff. A visiting relative said, "It gives the family confidence knowing that there are always plenty of suitably skilled staff on hand to promote my spouse's safety and welfare."

Infection control policies and procedures were in place and adhered to. The premises were clean and well maintained. Staff had completed mandatory infection prevention and control training. We observed domestic staff taking pride in their work and cleansing thoroughly a bedroom area. The registered manager told us that care staff were responsible for ensuring the cleanliness of all equipment, and this was recorded in the staff handover documents, and this was periodically checked by management staff. We saw that staff followed the service's uniform policy and used protective clothing such as gloves, which decreased the risk of transmitting a healthcare associated infection. The service infection control measures in place were monitored. We observed good hand hygiene practice when we were present. Hand sanitizers were filled with sanitising gel and were available throughout the home, and in the individual rooms used by people with high dependency. A visitor told us, "The place is kept spotless; staff always wear clean uniforms and use protective clothing."

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. Care records developed with individuals included the plans to manage the risks identified and minimise the risk of harm. We saw management plans for risks associated with needs such as respiratory, malnutrition or dehydration, those at risk of falls, moving safely around the home and skin care. Risk assessments were specific and risks were

Good

Is the service safe?

kept under review and managed using risk indicators/ severity ratings leading to risk analysis. The home had a number of people accommodated in one unit who were highly dependent and required mechanical ventilation. One to one staff staffing levels were provided for those on mechanical ventilators to ensure continuous observation of vital signs, and so that responses to any alarms could be rapid. Daily observations were made so that early warning indicators could be identified in advance. To promote the safety of people who were ventilated there was emergency equipment and suction machines supplied in their bedrooms which staff were trained to use.

When the one to one staff member changed shift there was a handover in the person's room of the person's condition and progress also shared. Each bedroom was fitted with a ceiling track hoist to ensure people could be moved safely. We saw members of staff were competent in using the equipment. Staff were able to demonstrate clearly how they managed risk and could provide examples of how the service learned from mistakes. Bed rails were used where it was identified people were at risk of falling out of bed. We saw staff provided the care as detailed in people's risk management plans. For example, people with low body weight or at risk of poor nutrition had fluid and food intake monitored and supplements were supplied. A number of people were unable to swallow and required food be administered by tube. The staff team included speech and language specialists, they also liaised with the hospital speech and language specialists if there were swallowing issues. We spoke with a speech and language specialist visiting, and they confirmed good working relationships with the staff team who followed their recommendations.

Staff were keen to ensure these people were safe when using other services. The registered manager had developed suitable formats called hospital passports for sharing information with other health services, especially for people with communication issues and to help ensure they were supported with adequate nutrition and hydration when using other services. These were used to help improve the outcomes for the individual attending hospital for care and treatment.

Staff told us, and records confirmed they received regular training about how to keep people safe and to make sure they were up to date with reporting systems and national guidance. The service provided a safe and secure environment to people who used the service and staff.

Cameras had been installed externally and the premises were made secure. Records were provided confirming equipment was serviced and well maintained. Changes to the care and support people received were implemented where needed. The incident and accident records showed the registered manager reviewed significant incidents and occurrences at the home. There was a record of the actions that had been taken after an incident or accident occurred. The care plans showed updated information reflected any changes necessary to people's care. The registered manager also shared this information with staff via handovers and staff meetings, and by using a daily communication book. This made sure they knew about any changes to peoples care needs after any event had taken place.

The provider met the standards recommended by the National Institute of Clinical Excellence (NICE) for managing medicines in care homes. The registered provider had policies and procedures in place for the storage and administration of medicines which reflected the guidelines. Each person using the service had a medicine profile which also indicated any known allergies. All registered nurses had received a copy of the medication management policies and the NMC/NICE guidelines for medicine administration. The qualified nurse competency assessment was completed yearly by senior management (providing supervision, support and training). All registered nurses had a supervised medication round and were assessed within Highfield House medicine administration policies. A selection of medicine administration records (MAR) showed medicine was administered appropriately and recorded on their MAR chart. We looked at the topical medicines and liquids and found staff had recorded the date items were opened. Medicines were reviewed by the GP to ensure the effectiveness. The GP visited the home twice weekly and more frequently if required. We saw that PRN (when required) medicine protocols were in place to ensure the person's fluctuating needs were accommodated. Nursing staff were aware of what medicines needed to be taken and when.

We noted that meals were not interrupted when medicines were administered in line with good practice. We saw systems in place helped ensure that all prescribed medicines were available on time and stored securely. Medicine audits were completed monthly, these identified any gaps or errors in procedures including ordering supplies, and when necessary action plans were

Good

Is the service safe?

implemented to address shortfalls. We saw that controlled drugs were administered to people. We saw from records the nurse responsible for administering the controlled drug and a trained witness signed the controlled drugs register in accordance with regulation.

Records confirmed checks were undertaken to ensure a safe environment was provided that met people's needs and maintained their safety. There were smoke detectors and fire extinguishers on each floor. Records received from the manager showed that fire alarms and evacuation procedures were checked to ensure they worked and people were aware of what to do in the event of a fire.

Although not all references were filed correctly in some staff files we found recruitment processes generally were safe. We looked at seven personnel files for the most recently recruited staff. We found appropriate checks were made before staff began work. These included a check conducted by the Disclosure and Barring Service (DBS) to show they were not barred from working in adult social care and proof of the person's identity, and right to work in the UK. The manager recorded the outcome of the interviewing process. The manager conducted exit interviews for staff on leaving employment.

Good

Is the service effective?

Our findings

People told us they felt well looked after by staff who were qualified and competent. People using the service and their relatives spoke positively about staff. One person said, “Staff really know their job.” Another person told us, "It is my home now, I need equipment to keep me going and staff are well trained and experienced.” We observed qualified staff attend promptly to a person in respiratory distress, using specilised equipment confidently to help the person with their breathing. Relatives told us, “I have great confidence in staff; they are so professional and capable.” A consultant physician said, “I have only ever received positive feedback from patients and relatives regarding their experiences at Highfield.”

People were looked after by staff who were familiar with their needs. Staff we spoke with were knowledgeable about the people they were looking after and were able to talk about their individual needs, their medical conditions and reliance on essential equipment, and daily routines. Staff turnover was low, of those who left in the past twelve months a number went on to complete further professional qualifications or to work in the NHS.

We saw that staff sought people’s consent before they provided care and support. For example, one nurse asked a person “Is it okay for me to check on your wound care now or do you want this done later.” Staff told us how they involved people in making decisions about their care. One staff member said, “Some people don’t have the capacity to make big decisions about their care, but we always offer them choices and respect their decisions for what clothes to wear and what to drink”. Each person had their mental capacity assessed as part of the admission process. We were told that where people lacked capacity these assessments were used to inform best interest meetings with local authority staff. Staff understood about the Mental Capacity Act 2005. This provides a legal framework for acting on behalf of people who lack capacity to make certain decisions. Staff attended relevant training and read the provider’s policies. People were supported to make decisions when they were able, for example, using communication means such as blinking to help them understand what care staff wanted to offer them. Some people had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place. This was a decision made by the individual or their representative in conjunction with the GP, to let people know that they did not wish to be revived if they stopped breathing. Where a DNACPR was completed we saw documentation was maintained on the person’s file. The consent processes were understood by staff and theyhad received training in following best practice.

The rights of people who used the service were protected because the registered manager and staff understood how to meet the legal requirements of the Deprivation of Liberty Safeguards (DoLS). These are a safeguard to protect peoples’ rights to ensure if there are restrictions on

people’s freedoms they are done lawfully and with the least restriction to keep them safe). When we visited, there were seven people at the service for whom a DoLS authorisation was in place, applications were completed for the remainder of people there and were waiting to be assessed by social services. One person had a DOLS for a specific reason; they had to wear mittens to prevent them from pulling the tracheostomy tube out. Staff told us the person liked to take the mittens off for some of the day to “let their hands breathe” but they had to be monitored very closely. We saw that another person who had a DoLS authorisation in place to prevent them from leaving the service unsupervised but was supported to go and see a show of their choice.

The staff worked hard as a team to ensure that they provided a service that met the complex needs of the people in their care. People were cared for by a multi-disciplinary in-house staff team who were qualified, supported and trained to meet their needs. Twenty four hour nursing support was provided within the home. A deputy manager told us, “If there are any issues the GP surgery can be phoned at any time and the response is good.” The main GP attended best interest meetings or MCA or IMCA meetings when required. There was also a neurosurgeon who linked with the GP about best care for people with complicated needs. The service had direct computerised access to the surgery for the GP on visits to the home which helped give a seamless approach to the medical care of people.

The holistic multi-disciplinary approach of the service meant people had access to in-house specialist, such as physiotherapists, occupational and speech and language therapists. Also involved in the care of people were a consultant neurologist, and a consultant respiratory physician. One of the healthcare professional we spoke

Good

Is the service effective?

with said, “Staff at Highfield House care for a group of complex multi-morbid patients with high nursing and medical needs. They enable this highly dependent patient population to live in a community setting rather than remain in hospital.” Staff worked well together as a team. Shift handovers were carried out at twice daily and as well as verbal handovers staff maintained a daily log book for the floor they were working on. The records showed shift handover included general information regarding people and individual areas of concern.

Staff told us they felt well trained to do their jobs. The service had a part time in house trainer in post. All new staff received an induction and worked under senior experienced staff until they were assessed as competent to undertake tasks on their own. As part of the induction programme staff completed all mandatory training and an induction schedule. The service had a training and development programme for staff that equipped them with the necessary skills and qualifications. The training was appropriate to their designated role, such as clinical development for qualified nursing staff, therapy training as appropriate for physiotherapists and occupational therapists. Staff told of participating in training delivered and of advance care planning from the specialist palliative care team. We saw from staff actions that staff had the skills they needed to meet people’s needs. We saw how a physiotherapist promoted a person's wellbeing with passive movements. A healthcare professional told us staff at the home were motivated and enthusiastic about their role, in particular about good end of life care. The manager and staff had worked hard to introduce effective care planning, but the provider told of changes they had planned and showed us examples of new formats proposed for a more person centred approach in care planning.

Staff told us they received individual supervision every three to four months, which gave them the opportunity to discuss the support they provided to people that used the service. These helped identify any areas for improvement and any training requirements, and development opportunities. We saw records of supervisions were monitored to ensure staff got the support they required. The registered manager confirmed that qualified nurses received clinical supervision and an annual appraisal process took place. The physiotherapy team was supported and managed by a senior physiotherapist. Staff told us they felt supported and gave examples of things that helped staff in their role.

There was evidence that people’s general health and wellbeing was managed well and monitored regularly by staff. Examples of this included monitoring of feeding regimes, peg feed, pressure area care, fluid and food input and output, vital signs. A community health professional told of providing training to staff on meeting specialist nutritional needs. They told us they found that staff took on board their recommendations such as correctly positioning the person, and adhering to feeding regimes for those artificially fed by PEG. Percutaneous endoscopic gastrostomy (PEG) is a procedure in which a tube is passed into a person's abdomen to provide a means of feeding when oral intake is not adequate. Some people required additional specialist care and monitoring arrangements ensured this was carried out appropriately such as daily checks by managers of postural management, tracheostomies and ventilators. We saw daily progress notes were kept for each person using the service which documented the care and support provided to them by staff. There was also current information about people’s medical visits and appointments with the outcomes of these documented on their individual record.

People using the service and their families and friends were listened to. One person told us, “What makes me happy here is that they listen to and consider my point of view and do not do things over my head, they are good at caring for people .” A visitor told us, “They add touches such as handholding, these make all the difference when you are anxious.” At lunch time we noted that a small number of people had meals in the dining areas due to the volume of people requiring artificial feeding. People were able to access their chosen dining area. One person told us they usually came from the upstairs unit to the ground floor for lunch as they enjoyed the company. Relatives told us that people enjoyed the food and could eat foods that met their individual preferences. Menus planners showed that meals served were those chosen by individuals or advised by relatives. One visitor said, “My relative gets plenty of what they like to eat and drink.” Another family member said, “There appears to be lots of choices at mealtimes.”

Good

Is the service caring?

Our findings

People were receiving care that was kind and compassionate. Relatives described the passion of staff working in the home and their commitment to providing good quality care. People spoke of the kindness and understanding shown by staff. One person told us of the efforts made to help him feel at home. They said, "I have been very happy here, look at my room and photos of my family and pets, all my family come in regularly and staff have got to know them." We saw the room was made very homely and was decorated with a number of the person's personal items. Another person said, "Great place to be when you are not too well, the people working here excellent." A relative told us, "Staff show they really care and get to know our family, they will always let us know what's happening which is reassuring, we are so much part of the home."

The home had a key worker system and a staff member was able to tell us who they were particularly responsible for. We saw this information was reflected in the person's file. We saw care staff displayed caring compassionate qualities, and they demonstrated they understood how to respond to needs and often frustrations of a person, and especially those with cognitive impairment.

People told us they were pleased with their accommodation, it offered privacy and comfort. People we spoke with told of entertaining their relatives and friends in the comfort of their rooms or using the lounge areas. A person spoke passionately about staff, they said, "The staff are caring and display integrity, they do not intrude and enter our rooms uninvited." Throughout the inspection the environment was generally calm, people felt reassured, their requests for assistance were responded to promptly by compassionate staff.

One person said, "I am called by my preferred name, because I said I would like staff to call me by that name." Another person said, "Staff remember to help me to do the little but important things that I find difficult, such as washing my hair."

We observed the relationships between people who lived there and staff were positive and caring. Staff used respectful ways to support and reassure people and demonstrate that they cared about them. For example, we saw a member of staff reassure a person who was upset, and giving them their time and attention. A visitor told us, "Staff are very respectful to my relative and staff chatter to him while doing personal care."

Various activities including therapeutic and social take place to provide stimulation and enjoyment to people in the home. An activities coordinator was employed; they recognised the difficulties presented by persons with communication needs. They found the person responded well when they engaged them in musical activity. In the afternoon of our visit the activities coordinator had arranged with staff to support four people attend a show at the Albert Hall. A relative told us a sibling was involved in working with staff to respond to the needs of their family member. They fixed a box that ideas in it about individual likes; carers used this information to allow the person to choose what they would like, for example football or rugby on the TV.

People's diverse needs were planned for. We saw information in care files to help staff understand how to support people to meet their individual religious and cultural needs. For example, a care plan gave details of how to support a person who was had a particular religious need and how to observe their beliefs regarding their healthcare needs.

Staff demonstrated good practice for end of life care with pain relief being high on the agenda. Relatives told of being kept informed regularly of their family member's welfare by phone/email or when they visited. Records showed people, and their relatives had been involved in advanced care planning so the person would be cared for in accordance with their wishes as they approached the end of their life. People's wishes for issues such as their funeral arrangements were also recorded. Special forms were in place to show if people did or did not wish to be resuscitated in the event of a cardiac arrest, or if it was in their best interests. These agreements were recorded following meetings held between the person, relatives and their GP, and were dated. Healthcare professionals told us of their involvement in introducing staff in the home to best practice guidance in end of life care.

Good

Is the service responsive?

Our findings

The care and support people received was responsive to people's needs. One person visiting said

"It is the best home one could get, my relative is very unwell I'm always made welcome and come here anytime." Another person said, "Staff can always be approached and will act straightaway. There is nothing I can fault here." We saw from care records and care arrangements evidence of care that was responsive to individual's changing needs. One person was moved to the lower floor for easy access to the garden so that their relative could take them out when they visited.

The manager told us they aimed to provide a service that responded to people's needs. They ensured that following an assessment and before people came to the service they made arrangements to have the correct equipment and support that people required. For example staff were trained and offered in house intravenous therapy and tracheostomy changes thus negating the need for people to have hospital admissions. Staff were trained to take bloods and use syringe drivers for pain relief. A range of equipment was available such mechanical ventilators, and staff were trained on using these correctly. The service held licences to use the ventilators. We observed staff were vigilant and saw them using suctioning equipment when it became apparent the person required this assistance. We saw too staff using a cough assist machine for persons who needed respiratory support. Care records showed that ongoing assessments took place of individual needs to identify and respond to any changes that arose.

People were consulted and had care plans developed that reflected the care arrangements necessary to meet people's needs. Relatives where agreed were involved in the development of care plans. Family members told us that staff explored the areas with them where changes took place such as the development of certain behaviours or areas of cognitive impairment due to brain injury or condition developed. This helped staff understand and support the person and work more effectively with family to be more understanding of the impact of the changes.

Care records showed that care and treatment was delivered appropriately, and that arrangements were altered to reflect when people's individual needs changed. We saw specialist advisors were contacted on a regular basis to review individual needs, and when there was a change recommendations were recorded and acted upon. There was an excellent working relationship between staff at the service and other healthcare professionals who spent time with

people in the service. We spoke with four professionals who told us of the progress made by a number of people using this service, and in particular two people who had made such unexpected progress they managed to be discharged back to their own homes.

A visitor told us their family member showed some signs of progress in response to the care and treatment at the home. They said, "When my relative first arrived at Highfield House they could not display any emotion, but now they show some reaction and carers are always talking with them." They told of examples of how responsive staff were, and said, "The eyes are used when the plays bingo, the carer helps by placing the button onto the number he selects with their eyes." A person told us the care staff listened to what they said and acted upon requests. They said, "Care staff can always be approached and will always act straightaway."

There was an activities coordinator employed. Activities included looking at newspapers and having a discussion; a memory group; pet therapy; relaxation group; orientation group with boards; computer help with iPad; sensory stories; board games; bingo and arts and crafts. On the day of inspection the coordinator was accompanying four people out to a show in London taking carers as well. A music therapist visited regularly to play, sing and include people with music therapy and playing easy instruments. There was a memory group for people with higher cognitive function to engage with. Bingo was popular and there were discussions with managers about having a second bingo group. Activity participation was recorded. The occupational therapist was involved in development and helped design activities for cognition and sensory group.

A number of people could not speak or make these decisions so staff had to 'choose' on their behalf and aid them in any groups so that they had some meaning and feeling of participation. The activities coordinator told of seeing people improving in the cognitive group, and some activities such as bingo were a successful learning experience with matching numbers which helped with cognition. Other examples of the responsiveness of the

Good

Is the service responsive?

service were seen. A person highly dependent was unable to breathe unaided. He was of Polish origin, the relative told us that due to the presence of several polish speaking staff at the home staff were able to communicate clearly with them in their native tongue. For people who were unable to participate in events we saw that the physiotherapy team were actively involved in engaging the person in passive movement.

The provider had a formal complaints procedure in place and information on how people were able to raise a complaint was in the information brochures which were provided to people who used the service and on notice boards. When we spoke with the relatives of people who used the service they told us that any initial teething issues were dealt with positively and that the provider was responsive to suggestions. They knew how to make a complaint, one person told us, “Staff are good at sorting out little niggles.” We examined the complaints register for the service and we found all complaints were recorded and investigated in line with the complaints procedure. Where possible written responses were provided to anyone that made a complaint. Complaints were audited and investigated as part of the Clinical Governance role.

Good

Is the service well-led?

Our findings

External health professionals involved in providing care and support to people using the service and family members told of the strong leadership in the service which put people first. The provider arranged for a management presence over seven days a week and until eight o clock three evenings a week, and there was also a sister in charge at night. The service had a registered manager in post and two deputy managers who worked over these days. Staff were clear about the direction given and found the leadership to be good. External health professionals and commissioning groups were positive about this service. The manager of one clinical commissioning group responded to our request for feedback, they said, “We use Highfield House and I can confirm that we have never had any concerns regarding quality and would happily recommend the home to other commissioners.” People who used the service and their visitors told us the management team spent time talking with them and were regularly seen walking around the service.

The service promoted an open culture, and had clear vision on future plans, with an extension in progress to the premises to increase bed numbers. The provider had set standards and values that were respected and followed by management and staff. Staff told us they felt empowered to improve the quality of care people received. Staff told us they felt listened to by the provider, and were able to communicate ways they felt the service could raise its standards. They felt confident to challenge practice if they felt more appropriate methods could be used to drive quality. Staff were aware of whistleblowing procedures.

Teamwork and staff morale was good. Staff told of being happy to work in the home, senior managers were seen to be respected and supportive of their staff. Staff told us it was a proactive place to work, where change was accepted and made as necessary for the benefit of those using the service. Staff told of ways that showed they were appreciated and rewarded, for example transport was available to take staff to and from the nearest railway station at the beginning and end of shift.

The service had continuity plans in place in the event of any emergency or disruption. The manager told of an incident recently when there was a power cut experienced in the area. The home was well prepared and had a generator available to manage this. This was put into good use and people using the service were not affected by the incident. Contracts were in place for the maintenance and repair of lifts and medical equipment. The service had a policy on reporting and management of serious untoward incidents and relevant groups including the CQC were kept informed in accordance with regulation. The service adopted the quality assurance process used by the Registered Nursing Home Association 'Towards Excellence in Care quality assurance', they felt this was an effective process to adopt to develop the service. People's opinions were sought and there were systems that monitored people's satisfaction with the service. Timely audits were undertaken in medicine management, care records and risk assessments. Relatives were invited to attend meetings about their family members, and the manager told us of plans to increase the frequency of these meetings. We saw that all audit meetings were recorded. The quality assurance process included the monitoring of staff training and development. Staff received on-going clinical supervision and appraisal.

Management were responsible for making sure dignity principles were promoted among staff in their day to day relationships with people using the service as part of their direct observations of practice. Senior staff attended professionals meetings and seminars to help their development. We saw from records that regular meetings were held between staff and the management team to ensure any issues raised were addressed promptly. Responsibility for floors allocated to particular manager with additional responsibilities allocated and documented. Seniority in the management structure was clear in the home; these included the nursing director, managing director, and finance director.

We found the provider continued to strive for excellence in working with others. The provider told us they kept up to date with legislation and best practice by using various sources including the National Institute of Clinical Excellence, Registered Nursing Homes Association and the Care Quality Commission. Changes and updates were shared with staff through training and supervisions. Changes to the Mental Capacity Act and the Health and Social Care Act were communicated to staff before changes were fully implemented. This showed the service was always endeavoured to work to best practice guidance and legislation.