Highcleeve Limited

Horton House Residential Care Home

Inspection report

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Gloucester
Gloucestershire
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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

Horton House 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. Horton House can accommodate up to 24 people. At the time of our inspection there were 22 older people living there of whom 17 were diagnosed as having dementia. Horton House provides family style accommodation in the middle of Gloucester. People each have their own bedroom which they have personalised and share bathrooms, a lounge, dining room and conservatory. The garden to the rear is accessible.

This inspection took place on 7 and 8 August 2018. At the last comprehensive inspection in February 2016 the service was rated as Good overall.

At this inspection we found the service remained Good.

People's care was individualised and person centred, reflecting their backgrounds, likes and dislikes and needs. Staff understood them really well. People's needs had been assessed and were monitored and reviewed each month or sooner if their needs had changed. Their relatives were involved in this process and kept informed about any changes. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were encouraged to be as independent as possible. Staff encouraged them to do as much as they could for themselves. Risks were assessed and strategies were in place to minimise any hazards. People felt safe living in the home. They had been asked about which activities they would like to take part in. These included music for health, drama and arts and crafts. People were supported individually to go out for walks, for lunch or on day trips. They were supported to attend a place of worship. Friends and family were able to visit whenever they wished. People used video links and the telephone to keep in touch with them.

People were supported to stay healthy and well. Their nutritional needs were closely monitored. Special diets were provided if needed. People were encouraged to drink hot and cold drinks. If they needed help to eat this was provided by staff. People had access to their GP, optician, dentist and chiropodist. Staff liaised closely with health care professionals. People's medicines were managed safely.

People were supported by enough staff to meet their needs who had been through a satisfactory recruitment process. Staff felt supported in their roles and had access to refresher training to keep their knowledge and skills up to date. Staff were knowledgeable about people, their backgrounds and individual needs. People were treated with respect and sensitivity. They had positive relationships with staff and enjoyed spending time in their company. Staff understood how to keep people safe and were confident any concerns they raised would be listened to and the appropriate action taken in response.

People's views and the opinions of their relatives and staff were sought to make improvements to the service provided. Annual surveys had been completed and improvements had been made to the service as a result. The provider and registered manager worked as part of the team enabling them to lead by example and to also ensure their values were embedded in people's experience of their care. People told us, "Staff are so helpful and friendly, nothing is too much trouble" and "It's beautiful here."

Quality assurance processes were carried out by the registered manager and provider to make sure the standard of care they wished to provide were maintained. The registered manager said, "We are always aiming for the best, for excellence. The delivery of high standards of care is embedded in the way we work."

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Horton House Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 7 and 8 August 2018 and was unannounced. This inspection was completed by one inspector.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make. We had received a report from the commissioners of the service and an independent advocacy organisation.

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 spoke with seven people and two visitors. We spoke with the registered manager, five members of staff, the chef and two domestic staff. We had feedback from two health care professionals. We looked at the care records for four people, including their medicines records. We looked at the recruitment records for three new members of staff, training records, health and safety records and quality assurance systems. We have used feedback given to the provider by people, relatives and professionals as part of their quality assurance process.

Good

Is the service safe?

Our findings

People's rights were upheld. They said they "had no worries" and were "treated well". Relatives commented, "I have complete peace of mind", "It's a weight off my mind when I leave here. I know that she is safe and well cared for" and "I know my Nan is safe, happy and healthy." Staff kept their knowledge and understanding of safeguarding up to date and talked about safeguarding procedures at staff meetings. They had access to updated policies and procedures guiding them what they should do if they suspected abuse. Staff said they were confident the appropriate action would be taken in response to any concerns they raised. Safeguarding alerts had been raised by the registered manager with the local safeguarding team and the Care Quality Commission (CQC). The appropriate action had been taken to keep people safe.

People's risks were assessed and managed to keep them safe from harm. The provider information return stated, "Risk Assessments are completed for all service users with the least restrictive options in use." Strategies had been developed to prevent the risk of injury or harm whilst promoting people's independence. For example, staff supervised people when using walking aids. Sensor mats had also been provided in people's rooms, so they could move around, in the knowledge that if they had a fall staff would be alerted. Accident and incidents were recorded and people were observed afterwards to ensure no injuries had been sustained. The registered manager closely monitored accidents and incidents, so they could take the necessary action, if they thought trends were developing. There was evidence referrals had been made to GP's to check people's physical health and advice had been sought from an occupational therapist and a physiotherapist, when the risk of falls had increased.

People occasionally became upset or anxious. Staff knew people well and what might cause or increase their anxieties. They described how they helped people to manage these. There were two dementia leads and two dementia link workers on the staff team who shared their knowledge with the rest of the staff. Staff told us they used distraction and diversion effectively and physical intervention was not used. Staff said, "We positively support people whose behaviour can be challenging for others by knowing residents and talking to them" and "We take them out or to their rooms." Staff were observed supporting people by talking with them calmly and patiently; reassurance was given when needed.

People lived in a well maintained home. There were systems in place to deal with day to day maintenance. Health and safety checks were carried out to make sure a safe environment was maintained. This included fire systems, water checks, portable appliance checks and servicing of equipment at the appropriate intervals. A fire service inspection in 2017 had been carried out by the local fire brigade. They confirmed the fire risk assessment and fire systems were satisfactory. Each person had a personal evacuation plan in place describing how they would leave their home in an emergency. A comprehensive business continuity plan was in place in case of emergency such as flood, fire or utility failure.

People were supported by enough staff to meet their needs. A core group of staff, who had worked together for a considerable time, provided consistency and continuity of care. New staff had been appointed when needed and staff levels were maintained. Agency staff were not used. Recruitment processes made sure checks were completed prior to staff starting work. These included a Disclosure and Barring Service (DBS)

check. A DBS check lists spent and unspent convictions, cautions, reprimands, final warnings plus any additional information held locally by police forces that is reasonably considered relevant to the post applied for. New staff completed an induction which included health and safety training.

People's medicines were safely administered and managed. Safe practice was observed and medicines administration records were completed correctly. Medicines were stored and kept in line with manufacturer's guidance. People's medicines were regularly reviewed with health care professionals. This was particularly important for people living with dementia or diabetes, to ensure their medicines were appropriately prescribed. Protocols were in place for the administration of medicines to be given when needed including the maximum dose to be given.

People were protected against the risks of infection. Staff had completed infection control training and followed policies and procedures to maintain a clean environment. People said, "It's always clean and lovely" and "Clean and tidy." An annual report for 2017, in line with the requirements of the code of practice on the prevention and control of infections, had been produced.

People's care and support was reassessed in response to lessons learnt from incidents or near misses. Their care records were amended to reflect any changes in their care. For example, increased observation or individual support when walking around the home. The registered manager described the actions they had taken to raise concerns about people's safety, with other organisations involved in people's care. Reviews with family and social care professionals were arranged.

Good

Is the service effective?

Our findings

People's needs were assessed to make sure the care and support they required could be provided. Their physical, emotional and social needs were monitored and reviewed to ensure their care continued to be delivered in line with their requirements and in line with national guidance. When there were concerns that people's needs had changed or they could no longer be met effectively the registered manager said she contacted healthcare professionals and commissioners. Any decisions were based on people's assessed needs, so they would continue to receive the appropriate levels of care and support.

People's equality and diversity was recognised and built into their care and support. Their individual needs in relation to their religious beliefs, sexuality, disability and ethnicity had been discussed with them and their families and incorporated into their care plans. Information technology and electronic equipment was used to improve the quality of care delivered. For example, maintaining accident and incident forms electronically giving instant access to information and providing sensory mats to alert staff if people had fallen.

People were supported by staff who had access to training and support. Staff said they were able to maintain their skills and knowledge. Individual records confirmed they had access to refresher training when needed such as first aid, food hygiene, equality and diversity and fire safety. Staff had access to training specific to the needs of the people they supported such as dementia pathways, end of life care and diabetes awareness. Staff had individual support meetings every two months to discuss their training needs and the care being provided. The provider information return stated, "There is regular sharing of information to staff via care plans, staff handover, the communication book and team meetings." Staff commented, "We have fantastic support" and "We work well as a team."

People's nutrition and dietary needs had been assessed. When people were at risk of dehydration or malnutrition they were closely monitored. Records were kept evidencing their food and fluid intake and people were weighed either every two weeks or monthly depending on their individual risk. People at risk of weight loss had fortified food and drinks using cream, butter and milk powder. The cook described how they ensured people living with diabetes had access to sugar substitutes so they could continue to enjoy puddings and cakes. A softened diet was provided for one person because this was what they preferred. Staff were observed encouraging people to drink. Cold drinks were available in communal areas and in people's rooms. People who needed support with their meals were given individual attention by staff. Staff were observed taking time with people, not rushing them and helping them to eat at their own pace.

People's health and wellbeing was promoted. Their health care needs were clearly identified in their care records and any health care appointments were recorded. People living with diabetes had access to regular blood tests and chiropody services. Staff raised concerns about changes in people's health and wellbeing and the necessary action was taken to access their GP, optician and dentist. Staff worked closely with social and health care professionals to share information to ensure they received co-ordinated and timely services when needed. For example, there was close co-operation with community mental health teams. Staff liaised with health care professionals when people needed to attend hospital for outpatient or inpatient services.

People benefited from renovations to their home. Considerable improvements had taken place since our last inspection in 2016. Carpets on the ground floor had been replaced with laminated flooring and new furniture had been provided in the lounge and dining room. A conservatory had been added to extend the communal space available to people. Two new bedrooms had been created. This increased the number of people able to live in the home by one. This additional room had been registered with CQC. Signage around the home helped people living with dementia to find their way around. For example, toilets and bathrooms had visual displays illustrating the room's use. Subtle lighting in corridors prevented shadows which might confuse people. The registered manager had sought advice from a national organisation promoting environments for people living with dementia. They were considering the suggestions made to make positive changes to corridors and communal areas.

People made choices about their day to day lives. They were observed choosing how to spend time, what to eat and drink and who to sit with. People's capacity to consent had been assessed in line with the Mental Capacity Act (MCA) 2005. 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. Decisions had been made in people's best interests, for example for finances and medicines. Records confirmed those involved in making these decisions such as their relatives and health care professionals. People's care records indicated what day to day decisions they could make for themselves and prompted staff to respect this. For example, encouraging people to participate in activities by offering choices. Where people had a lasting power of attorney there was evidence to confirm these arrangements were in place. A lasting power of attorney is appointed to oversee a person's health or finances when they no longer have the capacity to make decisions for themselves.

People deprived of their liberty had been granted the appropriate authorisations in line with the Mental Capacity Act (MCA) 2005. 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). Further applications had been made to restrict people of their liberty as needed. The registered manager confirmed they monitored any conditions associated with the authorisations such as making sure people were supported to go out and about. Staff had a good understanding of the MCA and DoLS. They had discussed these topics at staff meetings and attended refresher training with an external provider.

Good

Is the service caring?

Our findings

People had positive relationships with staff. They were observed enjoying the company of staff. They chatted with them, shared jokes and were relaxed in their company. People said, "Staff are good as gold", "They're really nice, we have a lot of fun" and "The staff are cheerful and chatty. If I need help, I get it." Relatives said, "Staff are so helpful and friendly, nothing is too much trouble" and "Staff are caring and kind." Staff understood people well. They were aware of their backgrounds and personal histories. Staff reacted quickly to ensure people's wellbeing; they offered reassurance when needed. Staff were observed anticipating people's anxieties and worries, enabling them to cope with and manage their emotions. A health care professional said, "Staff really know their residents which helps us to deliver the care required." Feedback from an external advocacy organisation included, "Interaction between staff and residents is gentle. Carers were observed listening to residents effectively and reassuring them."

People's equality and diversity were recognised in line with their protected characteristics under the Equality Act. People's rights with respect to their spirituality, disability, age, sexuality and ethnicity were respected. People were supported to maintain relationships with those important to them and were able to meet them in privacy if they wished. People had been asked if they had any preference about the gender of staff providing their personal care and this was respected. People's cultural and spiritual needs had been discussed with them and their relatives and the impact this was likely to have on their care and support. Staff had learnt key words so they could talk with a person in their own language. International holidays and celebrations had been observed promoting people's different cultures. For example, St Patrick's Day and Chinese New Year. People liked to attend a place of worship and religious services were also provided in their home.

People talked to staff about their care needs. People's care was reviewed each month. Their families were invited to formal reviews at least twice a year or sooner if needed. Relatives confirmed they were kept informed of any changes in people's wellbeing and were involved in making decisions about people's care and support. The provider information return (PIR) confirmed, "Meetings with family and next of kin take place throughout the year or frequently if required to discuss care needs of individual service users and gives family the opportunity to raise questions or concerns on behalf of their loved ones." People had access to information about advocates should they need their services. Staff were given the time to attend and complete training which did not impact on the quality of care they could provide to people.

People were supported to keep in touch with those important to them. Relatives and friends were able to visit whenever they wished. They said they were made to feel welcome. The PIR stated if people were unwell and unable to receive visitors, family were able "to telephone or Skype/ Face Time (video link) anytime to speak to their loved one".

People's privacy and dignity was respected. A person said, "They try very hard to understand and respect me." Staff told us, "Residents are all treated equally" and "We respect them." The PIR stated, "Carers demonstrate kindness, compassion, dignity and empathy in each of their daily roles whilst working with residents." People decided when they wanted to spend time alone and staff respected this. People were

encouraged to be as independent as possible. We observed people using walking frames around their home with staff discreetly providing support and encouragement. The registered manager said, "We take pride in the way people look", "We do our work with pride, showing people we care for them." A visitor told us, "People are loved. You can see this in the way staff treat them."

Good

Is the service responsive?

Our findings

People's care was individualised. Their personal needs, routines, wishes, likes and dislikes were explored. An external advocacy organisation said, "The care plan is in an excellent condition. It provides a good level of detail about X's health and care needs, and reflects the individual as a whole person, not just a set of needs." The provider information return (PIR) stated, "Person centred care plans are individually tailored to the service user." People's care records provided comprehensive information about their needs. When their health or wellbeing changed their records were amended to reflect these changes.

People were encouraged to be independent and their care records stated what they could do for themselves and what they needed help with. For example, getting dressed and walking around the garden without staff support. Staff understood people's diversity and individual preferences. Staff said, "People are treated as individuals" and "Care is person centred, it is all about them."

People had access to a wide range of activities. People's views had been sought about what activities they would like to be provided within the home and outside. The registered manager said they provided individual outings for people whenever possible. This made sure people could visit places of their own choice such as the museum, the docks or to go window shopping. People said they enjoyed the activities, particularly music for health. Other activities offered included memory drama, ball games, board games and art and craft. Links had been made with local schools and children visited spending time with people. People living with dementia had access to twiddle muffs (to keep active hands busy) and memory boxes providing prompts about their backgrounds and life. People were observed going out for walks and for lunch at a local pub.

People's communication needs had been considered. Their care records guided staff about how to interpret their behaviour and body language as an expression of how they were feeling. They also guided staff about how to interact with them, for example, using short sentences, speaking slowly and being jovial. The registered manager was aware of the need to make information accessible to people. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. Documents and information had been produced in easy to read formats using pictures and photographs to illustrate the text. The registered manager was aware of the benefits of information technology for example, promoting the use of video links for people to contact family and friends.

People knew how to raise a complaint. They said, "I have no worries" and "I would talk to the senior staff as they would cater with any problems or complaints." People were observed stopping by the office to talk with the registered manager who reassured them or offered advice. The complaints procedure was displayed in communal areas and people were encouraged to talk about any issues they had on a day to day basis or more formally at residents' meetings. The PIR stated, "Staff develop a trusting and positive relationship with service users so they feel able to talk freely and discuss any concerns." Feedback from an external advocacy organisation included, "Residents are provided with regular opportunities to give the provider feedback or raise any concerns; through resident meetings as well as monthly care plan reviews." No complaints had

been received by the provider. The registered manager described how they had been informed about comments made by a family member which they had treated as a complaint. They had spoken with the person and also responded by letter to the issues they raised. A full record had been kept.

People and their families had discussed their preferences for end of life care. End of life care plans described how they would like to be supported, their choice of service and memorial as well as what they would to happen to their possessions. Staff worked closely with relatives and health care professionals to ensure people's treatment and medicines at end of life were well managed. Relatives who had been supported to make decisions about the end of life care of a family member said, "They have gone above and beyond what was expected." The registered manager said she or staff would sit with people who did not have relatives with them. The PIR stated, "We have an open door policy with round the clock access to the home especially for family of service users nearing end of life." Relatives were offered overnight accommodation so they could be with their family member at the end of their life.

Good

Is the service well-led?

Our findings

People benefited from a provider whose website stated they prided themselves in providing "a consistently high standard of professional person centred care. A person told us, "It's beautiful here." Relatives said, "It's a home from home" and "People are very well looked after." Health care professionals c commented, "It is a very well run home" and "I only hear positive things about the home." By working alongside staff, the registered manager and provider were able to observe the quality of care provided first hand. This also made them accessible to people, their relatives and staff. They were able to lead by example and to impress on staff the culture and values of the service they wished to be provided. Staff said, "We provide really good person centred care" and "Everyone is brilliant." The registered manager told us, "We are always aiming for the best, for excellence. The delivery of high standards of care is embedded in the way we work."

There was a registered manager who had been in post since 2010. 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. Staff said, "The manager is open and accessible" and "I have every confidence in the manager. She listens and takes action." A relative said, "The home is well managed, with dedicated staff." The provider ensured they met CQC's registration requirements by continuing to meet all necessary regulations, by displaying the home's current inspection rating and completing and forwarding all required notifications to support our on going monitoring of the service.

The registered manager understood their responsibilities to meet the Care Quality Commission's (CQC) requirements and to adhere to health and safety legislation and keep up to date with changes in legislation and best practice. They maintained their professional development through membership of local and national organisations and networking with other providers. People's personal information was kept confidentially and securely in line with the General Data Protection Regulation. Staff felt supported in their roles and were confident raising concerns under the whistle blowing procedures. The registered manager had a range of quality assurance checks which they completed. These showed areas such as health and safety, fire systems, food hygiene and medicines were managed effectively. The provider monitored people's experience of their care and support through regular visits to the service.

People, their relatives and staff were asked for their opinions of the service which led to improvements. They had completed an annual survey in 2017 to give their views about people's experience of their care and support. These were incorporated into an annual quality assurance report produced in December 2017 with an action plan for the following year to replace carpets on the first floor and improve the garden. This report also commented about improvements carried out in response to the previous year's report such as seeking feedback from people about the activities being provided and replacing carpets on the ground floor.

People benefited from staff who had learnt from accidents and incidents and feedback from people. The provider information return stated, "A record is kept of all complaints, concerns, compliments and safeguarding referrals so that lessons can be learned and improvements made." For example, reviewing the

level of care provided to people and liaising with social and health care professionals to make sure people's needs were met. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.)

There were strong links with local agencies and organisations. Records confirmed information was shared with other agencies and organisations when needed to ensure people's health and wellbeing was promoted.

The registered manager had effective systems in place to monitor the quality of services and care provided to people. Policies, procedures and guidance was up to date and available to staff. Audits were completed on a regular basis by the registered manager and the provider in accordance with the provider's quality monitoring arrangements. These checked that safe practice and processes were followed and ensured the home remained compliant with necessary regulations. There was evidence when any actions had been completed. For example, updating staff training, improving activities and providing a dementia friendly environment. External audits had been completed by fire services, the food standards agency and the supplying pharmacy confirming these systems were well managed.