Samily Care Ltd

Highgrove Care 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

Highgrove Care Home is a residential care home for 21 older people some of whom are living with a dementia. The home has two floors with the first floor having access via stairs or a stair lift.

At the last inspection, the service was rated 'Good'. At this inspection we found the service remained 'Good'.

People were protected from avoidable harm as staff understood how to recognise signs of abuse and the actions needed if abuse was suspected. There were enough staff to provide safe care and recruitment checks had ensured they were suitable to work with vulnerable adults. When people were at risk of falling, skin damage, infection or malnutrition staff understood the actions needed to minimise avoidable harm. The service was responsive when things went wrong and reviewed practices in a timely manner. Records had not consistently reflected that catheter bags were being emptied or changed regularly. During our inspection the process was reviewed by the registered manager and sytems put in place to manage catheter care more safely.

People had been involved assessments of their care needs and had their choices and wishes respected including access to healthcare when required. Their care was provided by staff who had received an induction and on-going training that enabled them to carry out their role effectively. People had their eating and drinking needs understood and met. Opportunities to work in partnership with other organisations took place to ensure positive outcomes for people using the service. 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 support this practice.

People and their families described the staff as caring and friendly and the atmosphere of the home as fun. People were able to express their views about their care and felt in control of their day to day lives. People had their dignity, privacy and independence respected.

People had their care needs met by staff who were knowledgeable about how they were able to communicate their needs, their life histories and the people important to them. A complaints process was in place and people felt they would be listened to and actions taken if they raised concerns. People's end of life wishes were known including their individual spiritual and cultural wishes.

The service had an open and positive culture that encouraged involvement of people, their families, staff and other professional organisations. Leadership was visible and promoted teamwork. Staff spoke positively about the service and had a clear understanding of their roles and responsibilities. Audits and quality assurance processes were effective in driving service improvements. The service understood their legal responsibilities for reporting and sharing information with other services.

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**

Highgrove 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.

The inspection took place on the 11 January 2018 and was unannounced. It continued on the 12 and 15 January 2018 and was announced. The inspection was carried out by one inspector.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to gather their experiences of the service.

The provider had completed a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During our inspection we spoke with seven people who used the service. We spoke with the director, registered manager, home manager, chef, and three care workers. We also spoke with a visiting health care assistant and a community nursing sister from local district nursing teams to gather feedback on their experience of the service. We reviewed four peoples care files and discussed with them and care workers their accuracy. We checked three staff files including an agency employment profile, care records and medication records, management audits, staff and resident meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

Good

Is the service safe?

Our findings

Staff had completed training and understood what types of abuse people could be at risk from, what signs to look for and the actions they needed to take if they suspected abuse. A care worker was able to tell us the telephone number for reporting safeguarding concerns was on the noticeboard. People told us they felt safe. One person told us "I feel safe; the staff are gentle. If I say 'No' they would respect that". Staff were familiar with the services whistleblowing policy. People were protected from discrimination as staff had completed training in equality and diversity. We observed interactions between staff and people that respected people's individuality.

Assessments had been completed that identified risks people experienced. When a risk had been identified actions had been put in place to minimise the risk. Some people had catheters in place. One person told us "It mustn't get overfilled. I call the girls (care workers) and they come and empty it". People had charts that recorded their catheter care including fluid input and output and weekly catheter bag changes. To minimise the risk of catheter bags overfilling the charts stated they needed to be checked four hourly. Records were not consistently reflecting that this had happened. Records did not confirm that bags were being changed weekly. This meant people were at risk of avoidable discomfort and infection. We spoke with the registered manager who during our inspection reviewed the catheter care process. Catheter bag changes were added to a person's medicine administration record so that once a week the person in charge would sign to confirm the bag had been changed. Fluid input and output charts had additional information added to detail minimum fluid levels, actual sizes of cups for more accurate recording and for charts to be checked by a senior each day.

When people had a risk of skin damage pressure relieving equipment was in place and checked daily to ensure it was being used correctly. We spoke with a community nursing sister who was visiting the service. They told us "On the whole a good home. They have an understanding of people who are at risk of pressure ulcers". One person had lost weight and a referral had been sent to their GP. Another person had been losing weight due to deteriorating health. When their risk assessment had been reviewed new actions included staff staying with them and supporting them to eat their meal.

People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency. Equipment was regularly serviced including the stair lift, hoists and gas and electrical appliances. The provider told us "We have had fire professionals come in and carry out risk assessments in the home and we listened to them and carried out their recommendations such as new evacuation slide sheets".

People were supported by enough staff to keep them safe. One person told us "I just ring the bell and one of the carers comes but normally they are coming (into bedroom) all the time, popping in and out to help everyone". Staff had been recruited safely. Relevant checks were undertaken before people started work. For example references were obtained and checks were made with the Disclosure and Baring Service to ensure that staff were safe to work with vulnerable adults. We checked records of agency staff which included details of their employment checks, experience and training ensuring they were suitable to support

people living at the service.

We spoke with two people who had a medicine prescribed for pain for as and when required. They told us that they had requested it during the night and been told by night care workers they needed to wait until the morning as they were not trained to administer medicines. We spoke with the registered manager who told us the process was for the night team to contact the senior on out of hour's duty who would come into the home and administer medicine if needed. A senior told us "The night staff are in the process of being medicine trained. I was called back a couple of weeks ago as a person was upset and agitated". At the time of our inspection the night team were undertaking medicine training which meant a member of staff would then always be in the home to administer medicine when needed. Protocols were in place for PRN medicines explaining what the medicine had been prescribed for and how often it could be take. Some people were prescribed PRN paracetamol. The protocol stated minimum gap four hourly. The administration record showed a pre populated am, pm, evening, night time rather than the exact times administered which meant there was a risk of the four hour gap not being met. We discussed this with the registered manager who told us they would ask staff to record exact times. When people had a prescribed topical cream a chart in their room indicated where the cream needed to be applied and how often. Records showed us people received their topical creams as prescribed. Medicines were ordered and stored safely. Some people had been prescribed controlled drugs which are medicines that require additional storage and administration safeguards than other medicines. We checked and these were being followed. When a person had refused their medicines records included reviews of the risk with the persons GP.

People were protected from avoidable risks from infection as staff had completed infection control and food hygiene training. We observed staff wearing gloves and aprons appropriately. All areas of the home were clean and odour free. The registered manager understood their responsibilities for reporting incidents to public health when required.

Accidents and incidents were recorded and shared with staff at shift handovers including any changes to how risks to people needed to be managed. Where concerns had been bought to the registered manager's and provider's attention they had co-operated fully with relevant authorities to ensure people were protected. Lessons were also learnt from external events. An example had been following national coverage of a tower block fire they had organised a fire risk assessment by a professional organisation in order to get a fresh pair of eyes to review fire safety standards in the home.

Good

Is the service effective?

Our findings

Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. The plans contained clear information about people's assessed needs and the actions staff needed to take to support people. People and their families were involved in discussions about their care needs and had their life choices respected. Care was delivered in line with current legislation and good practice guidance. Technology and equipment was available that increased people's independence and safety. Examples included sensory alarm mats for people at risk of falls, hoists for assisting with transferring people and a call bell system that enabled people to call for assistance when needed.

Staff had received an induction and on going training specific to their roles which enabled them to carry out their roles effectively. Induction included the Care Certificate. The Care Certificate is a national induction for people working in health and social care who did not already have relevant training. Staff told us they felt supported in their roles and this included supervision with a senior member of staff and an annual appraisal. Staff had taken opportunities for professional development. A team leader had completed a level 3 diploma in health and social care. They told us "I chose the dementia pathway. I like to be able to understand what's going on with people. I've learnt that as peoples understanding fluctuates I need to change my style of approach accordingly".

People had their eating and drinking needs understood by both the care and catering teams. The chef explained "We have information about people's likes and dislikes and also any special equipment they may need such as plate guards. We always leave food in the kitchen should people want something to eat through the night". We observed well balanced nutritional meals being served to people in the dining area, lounge and people's rooms. One person told us "The food is very good and there's always lots of choice". We saw snacks of crisps, sweets and fruit in public areas and people helped themselves.

Working relationships with other professional agencies supported positive outcomes for people when receiving care. Examples included working with district nurse teams in supporting people with the management of catheters and wound care. The home had also worked with the local NHS and implemented the 'Red Bag Scheme'. The scheme involves using a red bag containing information about the person that stays with them and ensures an effective transition between services.

People were supported to maintain their health and had timely access to healthcare when needed. A community nursing sister who had experience of the service told us "If there are any changes with people they are quite appropriate at contacting us in a timely way". Records showed us that people had access to a range of health practitioners including opticians, dentists, chiropodists and audiologists. Care files contained health fact sheets pertinent to a person providing care staff with an understanding of any health conditions. Examples included information about strokes, dementia and urinary tract infections.

The environment provided opportunities for people to access communal areas, private areas to meet with family and friends and accessible outside space. Access to rooms on the first floor was via stairs or a stair lift.

This meant that people some people with mobility restrictions would be unable to live on the first floor.

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.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People who were able to consent to their care had done so and told us they directed the care they received. We observed staff supporting people in choices about their day to day care such as were to spend their time or joining in an activity. . Staff provided care in people's best interests when they could not consent. This had been recorded as having been decided within the framework of the Mental Capacity Act 2005 and had been reviewed monthly. Examples included decisions in relation to personal care and medicines. Files contained copies of power of attorney legal arrangements for people and staff understood the scope of decisions they could make on a persons' behalf. A Health and Welfare Lasting Power of Attorney (LPA) gives one or more trusted persons the legal power to make decisions about people's health and welfare if they lose capacity.

Deprivation of Liberty Safeguards had been applied for where a person who needed to live in the home to be cared for safely did not have the mental capacity to consent to this. This meant people were having their rights upheld and their needs met.

Good

Is the service caring?

Our findings

People and their families described the staff as caring. One person told us "The staff are very patient when they help me and always friendly". Another told us "It's very, very good living here. Everybody is so kind". One person had poor hearing and explained; "The girls have put sub titles on my TV for me which is great". Another person said "It's the crème de la crème; I'm in my comfort zone". A team leader told us about one person who can become anxious. They explained; "She likes lots of cuddles". We read their care plan which explained when the person was anxious they approached staff for a hug.

We observed friendly, warm interactions between people, their families and the staff. Staff shared banter and good humour with people which created a relaxed and happy atmosphere. Staff had a good understanding of people's interests, past life experiences and people important to them. This meant that staff could have conversations with people about things that were important and of interest to them. Bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. Families told us they could visit at any time and were always made to feel welcome. A team leader told us how families often came and shared a meal with people.

Throughout the inspection we observed staff explaining their actions to people, giving people time and listening to what they had to say. Staff used appropriate non-verbal communication to demonstrate listening and to check people understood them. For example talking with people at eye level and using hand gestures and facial expressions. Staff understood people's communication needs. One person had fluctuating communication abilities. A team leader explained "We have a communication folder with pictures and sometimes we write things down which can help".

People were encouraged to share their views and be involved in decisions about their care and support. We observed one person discussing having their mattress changed for a type they felt would be more comfortable. Another person told us "They (staff) help me when I want them to. If I wanted to go to bed I just ring the bell and they come and help me". We read a care plan where the person had requested female carers only.

People had their dignity and privacy respected. We observed staff knocking on doors before entering people's rooms and addressing people in a respectful manner. Staff were able to tell us ways they supported people's dignity such as ensuring bedroom curtains were closed when providing personal care and discreetly offering support. People's clothes and personal space reflected a person's individuality.

Facilities were available for people's mobility scooters which meant they had the means of accessing the community independently. Dementia friendly signage was available in parts of the building for toilets and bathrooms which enabled people more opportunity to be independent when in public areas of the home. Confidential information was stored in a locked cupboard or stored on password protected computers.

Good

Is the service responsive?

Our findings

People had care plans which reflected their personal care needs and choices and were reviewed at least monthly. Life stories had been completed and included information about pets, schools, hobbies, careers, holidays and other important events. A formal process for involving people and families in planning and reviewing care and support was not in place but due to be implemented. The provider told us "We have created a 'consultation and review form' to put into place. We're about to share with senior staff and then it's being implemented as part of our February reviews".

Staff told us they were kept informed of changes to peoples care needs. A team leader told us "We have a handover with the night staff and this morning they told us (name) has a cough and (name) an on going sore shoulder". This meant that people were supported by staff who understood and could meet their changing needs.

Staff had a good knowledge and were respectful of people's individual lifestyle choices. A team leader described how they had discussed with one person how they would like to spend Christmas day as they were aware their faith didn't celebrate the event. Arrangements were made in line with the person's wishes.

People had opportunities to take part in activities. One person told us "There's lots going on to keep you busy. Singers, pantomime and do's". We observed people playing board games, reading the daily papers and sitting chatting with staff. Some people chose to spend most of their time in their room. One person told us "I keep busy with the TV and daily newspaper". A care worker told us "When people are in their own rooms we go and play board games. When entertainment comes we always encourage people to join in. We go to rooms and do nails. Every spare bit of time we get we go and see people". Links with the community included visiting a local pub, visits from a local schools and churches and including the local community in events such as an annual garden party. Technology was used to help people keep in touch with friends and family and included using social media sites such as Facebook. Staff completed an activity record which captured how people had spent their day.

A complaints procedure was in place and people and their families were aware of it and felt able to use it if needed. The procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government ombudsman. One person told us "If I wasn't happy I would tell them and they would so something about it". One complaint had been recorded and we saw it had been dealt with in line with the complaints procedure. Actions had been discussed with the complainant and steps taken to resolve the complaint satisfactorily.

The service met the requirements of the Accessible information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. People's communication needs were clearly assessed and detailed in their care plans. This captured the persons preferred methods of communication and how best to communicate with them.

People had an opportunity to develop care and support plans detailing their end of life wishes which included any cultural requirements and decisions on whether they would or would not want resuscitation to be attempted. We saw a compliment that said "Thank you for the fun times and wonderful support to the end".

Good

Is the service well-led?

Our findings

The service had a registered manager who shared their time across two services. 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 service had a home manager who oversaw the day to day running of the service.

People, their families and staff described the culture of the home as open and positive with visible leadership and strong teamwork. One person told us "It's all quite organised and we see a lot of (home manager)". A team leader told us "I love the managers; they try their best with us all". They explained "We spoke with (provider) because we needed a new belt for the stand aid and it was ordered instantly. They visit two or three times a week". Another team leader told us "The owners (provider) are lovely; it's really well managed. I can see how the home has progressed. The management has improved; the care has always been good". We observed staff interacting with management in a relaxed but professional manner.

Staff had a clear understanding of their roles and responsibilities and spoke positively about the service. A care worker told us "We get a 'block' allocation each shift. Then we know who were helping with personal care, breakfasts, whether were doing the tea round". They went on to explain that anything new they needed to know was put into a memo sheet which all staff had to sign to say they had read. Staff told us they felt appreciated. A team leader said "I really feel valued; it's nice how you get a thank you. The service had a staff award scheme which recognised staff who had gone the extra mile.

The registered manager had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner. The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

People and their families felt involved in the service. One example had been people getting involved in the lounge being redecorated. One person had helped chose the curtains. They said "I felt that they were bright and will look very nice in the lounge". A quarterly newsletter provided updates about staff awards, activities and events planned both in the service and the community. Staff felt involved in developing the service. A team leader told us "We were all involved in the 'block' folders (provides information about people's day to day care support), and it's been really helpful".

The service had a strong focus on learning which supported good practice. The home manager had completed a diploma in health and social care management. They told us "I carried out a study on the relationship between dementia and music to see how music could affect people with a dementia. I've been sampling new types of music and getting feedback". They went on to explain "When you talk with (name) you get very basic answers; yes or no. We've found if you put any music on he comes animated and talks more". Audits were carried out monthly in areas such as accidents and incidents, pressure care, health and safety. Findings were shared with staff at handovers and led to positive changes for people. An example

had been a person who had fallen and their care plan had been changed to reflect they needed additional support moving and transferring first thing in the morning. Policies had been updated annually or when changes to legislation or best practice had occurred.

The staff team also worked with other organisations and professionals to ensure people received good care. Records and feedback from professionals indicated that the staff followed guidance and shared information appropriately. A community nursing sister told us "The (registered manager and home manager) have been very receptive".