Miss Fiona Carter, Mrs Alicia Hackshall and Mrs Audrey Carter

High Hurlands Community Homes

Inspection report

Gentles Lane
Passfield
Liphook
Hampshire
GU30 7RY

Tel: 01428751202

Date of inspection visit:
31 May 2016
01 June 2016

Date of publication:
03 August 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

We carried out an unannounced inspection of High Hurlands Community Homes on 31 May and 1 June 2016. High Hurlands Community Homes is a collection of five individual cottages providing accommodation and support for 15 younger people with learning disabilities, some of whom also have physical disabilities, in a small village set in the countryside on the outskirts of Liphook in Hampshire. High Hurlands Community Homes are set in the grounds of High Hurlands Nursing Home which is a separate service operated by the same provider. The people living at the Community Homes had access to the facilities available at the nursing home, which included a sensory room, a hydropool and specialist activity rooms.

High Hurlands Community Homes had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a 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 is required by a condition of its registration to have a registered manager. The registered manager was unavailable on the days of our inspection; however the provider was available, along with other member of the management team.

There were sufficient staff to meet people's care needs. Where shortfalls were identified the provider managed these internally by deploying staff flexibly across the community homes and nursing home, in order to ensure staffing levels were maintained.

However, the provider had not in every case ensured that all the relevant recruitment checks were carried out for newly employed staff. This meant that people might not always be protected from the risk of employment of people who were not suitable for their role.

Staff had undertaken training in safeguarding adults and understood their role in relation to keeping people safe from the risk of abuse. Where safeguarding incidents had occurred these had been dealt with appropriately, including being correctly reported to the relevant authorities and action taken to minimise the risk of re-occurrence.

Risks to people had been assessed and measures were in place to manage them. Staff understood the risks to each person and ensured these were managed appropriately. The outcomes of incidents were reviewed in detail at monthly meetings in order to identify any potential risks to people and in order to take any required actions to keep people safe.

There were effective systems and processes in place to ensure people's medicines were ordered and stored safely and that their administration was documented. Staff had undertaken training to enable them to administer people's daily medicines safely.

Staff received an appropriate induction and continued to receive regular supervision and relevant training in

their role. People were cared for by well trained and well supported staff.

People's relatives told us they had been consulted about decisions that their loved ones lacked the capacity to make for themselves. Deprivation of Liberty Safeguards (DoLS) applications had been made for all people as required. Mental Capacity Assessments and Best Interest decisions had been carried out for people on some areas such as implementation of their care plan. We have made a recommendation that the provider ensures that appropriate mental capacity assessments and best interest decisions are clearly documented for some specific decisions taken on a person' behalf, for example around restraint, in order to demonstrate that the least restrictive outcomes for people were always in place.

People were supported to eat and drink enough to maintain a healthy balanced diet. People had access to freshly cooked food which looked and smelt appetising and which people could help prepare. People enjoyed their meals which were a social occasion in each of the cottages.

People's records demonstrated they were supported by staff to see a range of health care professionals. Staff were proactive in ensuring that people were able to access healthcare services when they needed to.

We saw that staff were kind, warm and thoughtful in delivering care to people and went out of their way to ensure that people had a positive and personalised experience of care. They ensured they communicated with people in a way which helped people feel included and that they mattered. They were knowledgeable about people and spoke of them as if they were their own relatives or friends. Staff had the skills, understanding and motivation to deliver good quality care.

People were supported by staff to be involved in decisions about what they ate, what they wore and what they wanted to do each day. Staff had access to guidance about how to communicate with people, which they followed. The provider had implemented the use of "storyboards" as a means for people to communicate decisions about their care, and that staff used to communicate back to people. Staff and relatives were able to describe to us how people's privacy was maintained when their care was provided. We saw that staff treated people with respect when they were delivering care and support to them.

People's relatives were involved in the planning and reviewing of their care on their behalf. Staff had a good knowledge of each person's care needs, interests and characteristics. People were encouraged to be independent where possible. Staff supported people to attend a well organised and extensive programme of activities which enabled them to lead stimulated and fulfilled lives.

Relatives told us they had little cause to complain, but felt they would be relaxed and confident in approaching the registered manager or provider if they had any concerns, as they knew that they would be dealt with promptly and effectively.

Staff applied the provider's values in their work with people. The culture of the service was person centred, and it was clear that people's experience of care was a priority for the provider, the registered manager and staff.

The registered manager was visible, gave clear direction and was supportive to the staff team. They ensured that staff were supported by a well-managed supervision and appraisal system. The provider worked closely with the registered manager and the rest of the management team to ensure that the service was working as well as it could and that high quality care was being delivered to people.

Processes were in place to seek feedback on the quality of the service provided and the provider was

proactive in implementing systems to monitor and improve the quality of the service provided. The registered manager was quick to implement changes in response to concerns to improve experiences for people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The provider had not ensured that all staff had completed the relevant pre-employment checks to ensure their suitability to work with people at the home.

People were protected from abuse and avoidable harm by staff who knew how to recognise signs of abuse and how to report any concerns.

Risks were effectively identified, documented and managed, to enable people to lead fulfilled lives safely. Guidance was provided to staff to enable them to manage risks to people safely.

People were supported by sufficient numbers of staff to meet their needs.

People were protected from the risks associated with medicines by trained staff who administered their prescribed medicines safely.

Is the service effective?

Good

The service was effective.

People's needs were met by staff who had received an appropriate programme of induction, training, supervision. Staff were supported to ensure that they had the required skills and knowledge to fulfil their role.

Where people lacked capacity to consent to their care, their relatives or advocates had been consulted. Legal authorisation had been sought where people were deprived of their liberty. We have made a recommendation that the provider documents the best interest decision making process for explicit decisions taken on behalf of a person, for example, around the use of restraint.

People were supported to eat and drink enough to maintain their nutrition and hydration needs.

People were supported to maintain good health and staff ensured that people had access to healthcare professionals whenever needed.

Is the service caring?

Good

The service was caring.

People received care and support from staff who knew them well, were kind and encouraging and delivered a caring experience. Staff had developed companionable and warm relationships with people.

People were encouraged to express their views and were able to make choices about how they liked things done through innovative and creative ways. Staff promoted and respected people's choices.

People received care which was respectful of their right to right to privacy and which maintained their dignity.

Is the service responsive?

Good

The service was responsive.

People received care that was personalised to their needs and the service responded quickly if people's needs changed. Staff regularly reviewed people's support plans and risk assessments, with the involvement of relatives, health professionals or advocates, to ensure they continued to reflect people's needs and wishes.

People benefitted from taking part in rewarding day service activities and had opportunities to take part in activities in the local community.

Processes were in place to support staff, relatives and health professionals to regularly express their views and to raise any issues as required. Relatives and staff told us they would feel comfortable in raising any concerns.

Is the service well-led?

Good

The service was well-led.

Staff felt supported by the registered manager and empowered to speak up if they had any concerns or to make suggestions for improvements.

Staff understood the provider's values and practised them in the delivery of people's care.

The provider and registered manager effectively operated systems to monitor and assure the quality of care provided and to drive service improvements for people.

High Hurlands Community Homes

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 31 May and 1 June 2016 and was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection we reviewed the information we held about the home. This included previous inspection reports and any statutory notifications. A notification is information about important events which providers are required to notify to us by law. We did not request a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We gathered this information during our inspection.

We spoke with the provider, five members of care staff, the administration manager, the training manager, the management assistant, five relatives and two healthcare professionals. We reviewed care records for five people living in the homes and medicine administration records (MAR) for seven people for the previous six weeks. We also reviewed recruitment files for four staff, and personnel files for four other staff, staff rotas and other records relevant to the management of the service such as health and safety checks and quality assurance audits and systems. During the inspection we spent time observing staff interacting with people, including during lunchtimes. This helped us see how caring staff were when they were engaging with and supporting people.

The last inspection of this home was completed on 13 January 2014 where no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

Relatives told us that they felt that their loved ones were safe at High Hurlands Community Homes. One relative told us that her loved one was "very safe and very loved. I can tell that". Another relative said that High Hurlands Community Homes was "The best place" for their loved one and that they had "Total piece of mind".

However, we found the provider had not completed all the required pre-employment checks to ensure that new staff employed were of a suitable character and experience before starting their role. None of the recruitment records we viewed documented the applicants' full employment history, with an appropriate explanation of any gaps, even though this was a requirement of the provider's own recruitment policy. Although we didn't see the impact of this on people's care, it meant that the provider did not have all the information they needed to judge whether an applicant's employment history might indicate concerns about their previous work conduct or character that might put people at risk. There was a risk that staff being employed by the provider may not be suitable for the care roles they held. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other recruitment checks, such as proof of identity, provision of suitable references and a Disclosure and Barring Service (DBS) check were in place. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Two members of staff worked in each of the five cottages during the day and one at night. At the time of our inspection there were two staff vacancies. Staff vacancies and sickness had sometimes put pressure on existing staff to ensure that people received the care and support they needed. Vacancies were covered by overtime arrangements and the flexible use of staff across both the community homes and sometimes the nursing home locations. The provider told us that this enabled people to have consistency of care from staff they were familiar with, rather than employing agency staff.

Staff we spoke to thought that there were enough staff, and, during our visit, we saw that there were enough staff on duty to meet people's needs safely. We saw that this was achieved by staff working flexibly across the cottages and sometimes bringing residents over to other cottages where appropriate. This not only helped ensure there were enough staff to look after people, but also provided an opportunity for residents to spend time with people from other cottages. Staff told us "I think there are enough staff. We all cope really well. If it is short staffed, the cottages join up and help each other." We reviewed the staff rotas for the current and previous month which confirmed that where staff had been sick, their shifts had been covered appropriately. There were appropriate on call arrangements, particularly for members of night staff who worked on their own. This involved calling the nursing home for support or calling the registered manager or provider directly. People were kept safe because the provider ensured that there were sufficient staff deployed to meet peoples' needs.

Detailed and personalised risk assessments were in place for people. Staff were required to read people's risk assessments and then sign people's records to demonstrate they had read them as required by the

provider. The risk assessments were reviewed every six months. Risk assessments were individual and personalised. For example, one person's risk assessment detailed how they were particularly susceptible to slips, trips and falls relating to their epilepsy and how staff should manage these risks. There was written guidance for staff about which situations could present a higher risk to people and how they should manage these, for example people who were at risk from pressure damage to their skin as a result of staying in the same position for too long.

Clear accident and incident reporting protocols and procedures were in place at the home. The registered manager had put in place a system whereby accidents and incidents were recorded in detail by staff when they happened. These were then reviewed at a monthly meeting which reviewed all health and safety, infection control and medication incidents. The outcomes of incidents were reviewed at these meetings in order to identify any potential risks to people and in order to take any required actions to keep people safe. We saw that when people had falls, a post falls risk assessment tool had been completed, including observations of people's health for following 48 hours. This ensured that staff could identify any possible post fall complications that would require an urgent referral to a medical team.

People living at the home had Personal Emergency Evacuation Plans in place to ensure that people could be kept safe during an emergency. The provider had put in place a business continuity plan which was reviewed annually or when there were any changes. The provider had procedures in place to ensure the service continued in the event of an emergency such as a flood, or a loss of utility services such as gas or electricity.

The provider had ensured that all environmental risks around the home were regularly checked. We viewed a maintenance book which showed that each bungalow was inspected weekly by a regular maintenance man to ensure their upkeep and safety were maintained. The boilers in each of the cottages was serviced annually, as were the smoke and carbon monoxide alarms, and we saw that moving and handling equipment, such as hoists and slings, were serviced regularly. We viewed Health and Safety risk assessments and fire risk assessments for each of the cottages. People were protected from environmental risks around the home because the provider ensured that checks were carried out regularly to keep the environment and equipment safe for people.

There were clear processes and procedures in place to ensure the safe storage, administration and disposal of medicines. Each cottage had its own secure drugs cabinet and the team leaders in the cottages showed us how each person had their own shelf and that the medication and documentation were colour coded. Processes such as these helped ensure that the correct medicines were administered to the right person at the right time. Each team leader in each cottage did a weekly audit of medication in addition to a four weekly check carried out by the registered manager. These checks included whether all medicines had been signed for on the Medicines Administration Record (MAR) and whether medicines stock tallied. We checked people's MAR's and found staff had correctly signed them following the administration of people's medicines. We saw that procedures were in place for when medicines were taken out of the home if people were going on a trip and checked back in safely.

There were processes in place to ensure people's medicines were ordered and stored safely and that their administration was documented. We noted that the medicines cabinets in each of the cottages did not have a thermometer to regulate the temperature of the room to ensure that it did not exceed the recommended maximum for keeping medicines safe and effective to use. The provider took action to order thermometers for each of the cottages directly after the inspection.

Staff told us, and we saw, that they were confident in administering medicine to people because they

received training, supervision and were subject to regular competency checks. Three medicines competency checks were carried out in a person's first year of employment and annually thereafter as part of staff appraisals.

Any medication errors were recorded by staff on an appropriate incident form, which was a different colour to other incident forms. This helped the home monitor and keep track of medicines errors separately to other types of incidents. We viewed one incident where a paracetamol tablet was recorded as missing. Staff explained to us how this was reported and then investigated at a Health and Safety meeting. Staff told us that the provider operated a "two strikes" system with regard to medication errors. If a member of staff made a mistake more than twice, they were required to repeat their medicines training.

The home kept some controlled drugs. These are prescription medicines controlled under the Misuse of Drugs Act 1971 and have additional safety precautions and storage requirements. We saw that these drugs were stored correctly and recorded appropriately in the controlled drugs book, in accordance with procedures under this Act.

The home had clear safeguarding policies and procedures in place to keep people safe. People were protected from the risk of abuse because staff knew the signs of abuse and were able to describe how they would recognise changes in a person's behaviour or actions. They were confident in what action they would take to protect people if they identified these. We viewed a safeguarding record which confirmed that the manager had liaised appropriately with the relevant health and social care team and put appropriate actions in place following a safeguarding incident. Relatives we spoke with told us that they felt their family members were safe at the home and that if they did have any concerns they would know how to raise these.

Good

Is the service effective?

Our findings

The relatives we spoke with were positive about the staff and their ability to meet their loved one's care needs. Relatives said that they felt staff were well trained and had sufficient knowledge and skills to deliver care.

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.

At the time of our inspection, the registered manager had received DoLS authorisations for 11 people living in the community homes and was awaiting the outcome of a further four applications. Records showed that the service had carried out some mental capacity assessments and that accompanying decision-specific best interest decisions had been made for people when they lacked the capacity to agree to decisions involving their care. These included decisions relating to choice of GP, implementation of care plans, and the use of specialist chairs and protective headwear. We saw that these best interest assessments were carried out in consultation with relatives, friends, advocates and health and social care professionals and were subject to regular review.

We did not see, however that mental capacity assessments and best interest decisions had been carried out specifically in respect of the use of restraint for people, which included the use of bed rails, lap belts and shoulder straps for wheelchairs. The use of these restraints were reflected in care plans, which had been shared with relatives and might have been appropriate in order to keep people safe and enable them to have a better quality of life. However, we could not see how the provider had gone through the process of considering how the use of restraint was necessary and proportionate and that less restrictive alternatives had been explored.
We recommend that the provider ensures that they are able to demonstrate that an appropriate best interest decision making process has been followed in relation to the use of restraint.

New staff undertook a comprehensive induction programme delivered by the training manager which was mapped to the Care Certificate standards. The Care Certificate is the industry standard which staff working in adult social care need to meet before they can safely work unsupervised. While High Hurlands were not using the Care Certificate for their induction training, their induction training programme was designed to ensure that staff received appropriate training to meet the requirements of the industry standards. Staff's

competence was assessed by the training manager which formed part of a regular ongoing assessment for staff called the Care Competency Assessment.

The induction process also included a mentorship scheme which new staff undertook before they were able to work alone with people. New staff shadowed their mentor for two days and were then supported to undertake the role with the help of their mentor for one to three days, according to their previous experience. They were then observed for two days working alone.

We viewed documentation which confirmed the various elements of induction completed by staff.

People were cared for by staff who had undergone a suitable induction to their role to ensure they could provide people with effective care.

Staff were trained to understand the perspective of the people living at High Hurlands Community Homes and what it was like to have a physical and learning disability. There was a training process in place called 'Subject Therapy', where, for example, staff were taken blindfolded on a trip on the minibus, or were moved in a wheelchair or a hoist. The purpose of the training was to help staff understand what life was like for the people they were caring for, who might be blind, unable to move for themselves, or unable to communicate. Staff spoke enthusiastically about the training and how it helped them to understand the care they were delivering from the person's perspective and to feel empathy with the person. It also helped them to understand the importance of communicating with people as they were delivering their care, for example by explaining what they were going to do before doing it. We observed this during the inspection as staff were helping people to move or administering their medicines.

The training manager ran a comprehensive training programme for staff and kept an electronic schedule to manage when training was last undertaken and when it was next due. This ensured that people were supported by staff who were up to date with their training and therefore able to provide safe and effective care. Staff told us that "The training is really good here" and "I can't fault their training". Staff told us they could ask for refresher training in any areas whenever they felt that they needed it. One relative told us that she placed her loved one at High Hurlands because they were the only home they had visited that knew about, and had experience of, their loved one's medical condition. They described how staff had just been on training for it. They told us "there is a lot of depth to their [staff's] knowledge."

Staff told us, and records confirmed, that supervisions took place approximately every 8 weeks for new staff and then every 12 weeks thereafter. This process was in place so that staff received the most relevant and current knowledge and to enable them to conduct their role effectively.

People were assisted by staff who received guidance and support in their role through a thorough induction, training, and programme of supervision and appraisals.

We saw that people were supported to eat and drink enough to maintain a balanced diet. People's support plans contained an eating and drinking section to highlight the care needs for each person in terms of their nutrition and hydration and their food likes and dislikes.

The provider told us that food provided was either "Apetito" meals (a form of nutritionally balanced ready meals cooked from frozen) or was freshly prepared by staff in the kitchens of each of the cottages. During our inspection we saw staff freshly preparing food in the cottages and that meals looked and smelt appetising. Relatives told us they were very happy with the food provided.

We saw people eating their meals happily and enjoying them. Those able to do so ate independently, while others were supported to eat. People were supported appropriately, for example, we saw one person being encouraged not to rush their food. Staff told us that people had good appetites and would eat most meals however staff knew people's likes and dislikes and would offer alternatives accordingly. Food diaries were kept in each of the cottages including what foods had been served for each meal on each day to ensure that a variety of foods were offered to people.

People had regular visits to healthcare professionals, both on a routine basis, and also when there were issues or concerns about their health. Care plans included Health Action Plans for each person which evidenced regular visits to the dentist, hygienist, opticians and vaccination records. We saw that people had annual health checks with their GP. We also saw that people had been seen by a speech and language therapist (SALT) and attended hospital appointments where appropriate. Staff we spoke to were able to discuss recent changes in people's needs and how to respond to them. This demonstrated that they understood people's medical conditions well. One relative told us how the provider had responded so quickly in getting her loved one to a doctor when they noticed something was wrong, that it had prevented a hospital visit. A health professional told us that "staff were responsive to changing clinical picture and would seek help appropriately" and were "excellent at communicating with wider multidisciplinary team".

Care plans included 'Hospital Passports' which contained up to date facts about people if they needed to attend hospital. This ensured that information about people's needs and support was available to other healthcare professionals to ensure continuity of care.

Good

Is the service caring?

Our findings

Relatives we spoke with were enthusiastic about the care that their loved ones received at High Hurlands Community Homes. One relative told us "I am fantastically happy with the care". Another said "I don't know anywhere else they [their relative] would get this care" while another said "I can't speak highly enough of them". Relatives valued their relationships with the staff and management team and appreciated that staff went the extra mile for their loved ones. For example, one relative explained to us how the registered manager spent a lot of time with her loved one during a hospital stay; another told us how staff visited her loved one every day while she was in hospital.

We observed kind, caring and compassionate interactions between people and staff throughout our visit. Staff talked to people all the time and involved them in conversations, explaining what they were doing and asking for people's opinions. People were praised for their achievements, such as clearing away their dishes.

The service had a strong person-centred culture, where staff knew each person well, and were interested in each of them, talking to us about their personalities and interests. Staff were warm and jovial, engaging people in friendly conversation as they went about their daily tasks. In turn we saw that residents were relaxed and happy in their company. People were also smiling and communicating with us and seemed to enjoy having visitors.

All staff showed that they treated people with respect and showed genuine concern for people's wellbeing. A member of staff told us "They are not just service users, they live here, this is their life" and "This is a lovely job to have, they are such characters". We saw that a member of staff bring a resident over to another cottage during the inspection as the grass had just been cut and they were worried that it might cause the person's hay-fever to flare up. Staff cared about people's welfare. They spoke and interacted with people with warmth and kindness as if they were members of their own family.

People were supported to express their views and be involved in decision making. Some residents used 'Storyboards' as a way of communicating. This was a board on which symbols and signs were removed and re-attached to a board to 'Tell a story" of what was happening each day and enable people to be involved in making choices. One resident spoke enthusiastically of how her loved one had "Come on in leaps and bounds" while living at the home and who rarely used to speak or express decisions, but now did. She spoke of how her loved one and staff used the storyboard to communicate with each other and how her loved one could select pictures to attach to the board to express what she wanted to do. The provider used creative ways to ensure that people had accessible, tailored and inclusive methods of communication.

We saw that people were offered choice. We viewed the minutes from one service user group meeting where it had been noted that one person didn't enjoy arts and crafts, and so was offered alternative activities instead. Staff understood how people communicated and were able to interpret their movements, behaviours, how they vocalised and their expressions. This information was also included in people's care plans. We saw support plan guidance on communication for one person which provided guidance to staff on what sounds the person made and what they meant, and how staff should respond. This included all the

words the person could say and how these should be used to understand the person's choices and wishes. Another person's care plan detailed how choice should be offered by touch or smell, and how another person would point at their preference. A relative told us that their loved one was "Enabled choice to the best of their ability".

People were treated with dignity and respect at High Hurlands Community Homes. Staff were able to explain to us how they maintained people's privacy and dignity by knocking before entering bedrooms, closing doors when delivering personal care, and covering up people appropriately during their personal care routines. Staff spoke about ensuring that personal care was delivered in peoples' bedrooms or bathrooms and not in communal areas. One told us how they would discreetly take someone to their bedroom if they needed to change, and not make a fuss. A relative told also told us how their loved one's dignity was maintained as staff would always close the door behind them if they went into the bathroom, even if they had left it open themselves, and would deal with any accidents quickly and discreetly.

We saw that one person received their food via a PEG tube. Percutaneous endoscopic gastrostomy (PEG) is a procedure by which people receive their food via a tube directly into their stomach, through their abdominal wall, when they are unable to eat normally. This person was asked if they would like to have this in their room or with his housemates while they were having lunch. This both demonstrated this person being offered choice, and being respectful of their privacy. It was also sensitive and caring as it acknowledged that the person might have found it difficult not being able to take part in the same food routines as their housemates. Staff appreciated and respected people's individual needs around privacy and dignity.

Good

Is the service responsive?

Our findings

People's care needs were documented clearly in their care plans, which were reviewed every six months, or more often if there were changes to people's needs. We saw that care plan reviews included the person, their family and staff. There was a more formal review annually which included social services. We saw that the registered manager wrote regularly to relatives to keep them involved in their loved one's care, inviting them to reviews, giving updates and providing notes of meetings they hadn't been able to attend. Relatives told us that staff always kept them up to date on the care being provided to their loved ones. One relative told us "They let me know the slightest thing" and "They tell me everything that's happened during the day, not all homes do that. They are very professional and on top of it all". Relevant people were kept involved and updated in the assessment and planning of care. We observed care being delivered in accordance with care plans. A staff member told us "The care plans are our bible".

People's care and support plans were personalised to each individual. We saw from one person's care plan that they liked to lie in the sun and we saw that their care plan reflected the risk of sunburn and sunstroke and what staff should do to minimise this. Care plans included a disability distress assessment tool and distress passport. These included appearances, vocal signs, habits or posture for when a person was in a content state, or a distressed state, to help staff understand people's moods and help ensure their needs were met. Care plans also included triggers of distress so that staff knew to avoid these where possible.

In addition to the care plans, staff were provided with a separate folder to provide an overview of each person and their care needs as a quick reference document. This summarised information about the person's history, the important people in their lives, things that matter to people, things that make them sad or worried, things that they would like to try, the person's behaviours and detailed information around how the person communicated. This information was very person specific, explaining if, for example a person might fake a seizure to gain attention and how staff should tell the difference. The documents helped new staff to get to know the person to enable them to provide personalised, safe and effective care for them.

We saw that care plans contained specific guidance to staff about people's medical conditions so that staff knew and understood how to care for each person individually. For example, care plans provided details guidance to staff on what an epileptic seizure would look like and how they should respond for each person. They included an epilepsy profile and screening list, information sheet and seizure charts for each person, so that staff could monitor the frequency and severity of seizures, and watch for any trends or patterns. We saw guidance in one care plan which instructed staff how to reduce one person's seizure activity in the morning by providing a drink or snack close to bedtime. Support plans provided detailed guidance to staff to help them protect people from the risk of seizures, and to ensure that they got help when they needed it, including referrals to hospital if trends suggested a rise in frequency or severity.

People were facilitated to remain independent. For example, one person's support plan described that they were able to undertake small tasks such as emptying rubbish into the bin. The home facilitated this by ensuring that they had a flip top bin in that's person's cottage rather than a pedal bin. This enabled the person to be able to take part in doing the things they were able to do.

Each cottage was individual to the people living there and there was a real sense that each was their home. Bedrooms were personalised and as you might expect to see if the person was living at home with their family. Communal areas contained things which were important to people and reflected their interests, containing bird and animal decorations, or musical instruments.

People took part in programmed day activities run by a dedicated day services manager and their staff. Relatives described the day services manager as "Really good – always looking for new things". Daily activities included use of High Hurland's facilities including the sensory room, pottery room, art room and hydropool. Other offsite activities included walks, feeding the ducks, lunch and coffees out, visits to the local lake and pub, picnics and shopping as well as visits to garden centres, the seaside, theatre and local attractions. People living at the home regularly went on holidays. One person regularly had a trip abroad that reflected and was in keeping with her religious beliefs. The home facilitated these trips and we heard the person talking excitedly about their next visit and counting down the days. People were supported to live full, interesting and active lives.

Relatives told us about how they could tell their loved ones enjoyed living at High Hurlands Community Homes. One said "You can tell she is happy. She will chat to you about things she wants to tell you about – she never used to do that so much." They told us that after they had been home for a visit, their loved one "always want to go back" and "laughs all the way back".

One relative spoke about how they had noticed how much their loved one's communication had improved through being at the home and taking part in activities, they were now much more vocal than they used to be and able to express themselves through using their voice. They described how their loved one liked their care worker, saying that "He thinks he's hilarious" and described how he had a friend at the home whose characteristics and behaviours he now often mimicked. We saw a note from a staff meeting that the registered manager was keen to explore other opportunities for people to mix with other residents and we saw that people were often supported to visit other cottages. People were supported to maintain relationships with staff and other people.

The home had a complaints policy and procedures in place to act on feedback. We viewed the complaints file and saw that there had not been a formal written complaint since 2010. However, relatives we spoke to confirmed that they would know how to make a complaint if they ever had cause to, by going straight to the registered manager or provider, and would be confident that any problems would be resolved quickly. One person told us they would "Have no qualms whatsoever" in making a complaint, but noted that they have never needed to. One relative told us about when she has had any concerns, she had raised them with the registered manager and that they had been "Dealt with within 48 hours". Another told us that they have "Only got to say something and they act on it. They are quick to reorganise things."

High Hurlands Community Homes sought feedback by means of an annual questionnaire for relatives and health professionals and an annual staff satisfaction survey across both the community homes and nursing home locations. The feedback we viewed across all of these formats was positive.

Service user group meetings were also held for each of the cottages. We viewed the notes of one of these meetings for one of the cottages which was held in February 2016. The registered manager, staff working at the cottage and the people were all present. We saw that the meeting covered how things were going in the cottage, whether anything needed to change or be improved, whether people were enjoying their activities and whether there were any ideas for new activities. Staff engaged with people and asked for their opinions during the meeting and the notes of the meeting detailed people's responses, for example "[person] agreed by nodding and laughing".

Good

Is the service well-led?

Our findings

The provider had a range of values they required staff to exhibit in their work with people and these were contained within their statement of purpose and their 'Philosophy of care'. These included the commitment to providing a loving and secure home for service users and positively meeting each service user's individual needs. They also included enabling service users to enjoy the companionship from those employed to care for them and fostering satisfying community involvements.

Staff were observed to uphold the provider's values in their work with people. They spoke of taking people bowling and to the pub as "An easy way to integrate people into the community" and moving people between different cottages for visits as "A safe way for people to have other friends". We could see during our inspection that the provider promoted opportunities for social interactions both within the groups living in each cottage and with people living in neighbouring cottages. People living in each cottage went out as a group for their activities, but also spent time with people in other cottages, including joining up to work on the vegetable and herb patches in the communal gardens.

Although the registered manager was the key person in the leadership of the community homes, it was evident that members of the management team, including the provider, worked closely together in ensuring the delivery of effective care. We found during our inspection, even though the registered manager was away, the provider and the rest of the management team were aware of what was happening at the community homes and were able to answer all of our questions.

A relative told us "There is good management and leadership from the top down. I have access to all of them. There are genuine friendships there". They discussed having lots of open communication with the registered manager who they described as "Very capable".

Staff told us that the home promoted an open and honest culture. They told us that they felt that they could speak up if they had any concerns, and there would be an open and honest discussion and so things rarely got to the stage of whistleblowing.

Many of the staff had been at High Hurlands Community Homes for a long time, with one describing it as "A lovely place to work". They spoke well of the managers at the home, in particular the registered manager, who was well-liked by staff. Staff described her as approachable, open and supportive. The registered manager instilled confidence in staff that their concerns would be responded to and any problems resolved quickly. One member of staff talked about a new member of staff who was concerning her because the person was quite slow in their work. The registered manager responded by observing the person's work and giving tips, and the person's work rate improved. One staff member told us "I like the way it works here", and "The registered manager comes down to see us and thanks us. The owner come down to do quality checks and all know who we are". Another member of staff told us "The registered manager is really supportive, everyone likes her, she pops down to see us every other day, and we can go up to see her". There was clear, visible leadership within the service to ensure people received good quality care.

The provider set high expectations of staff in order to provide the best care for people. A relative told us "They don't want second best". Staff were motivated and understood what was expected of them. They were supported through clear supervision and appraisal processes. Clear standards of behaviour was set by the provider. Poor staff performance was not tolerated and was managed accordingly though appropriate disciplinary procedures. The provider operated a system of exit interviews to understand and learn from staffs' experiences of working at High Hurlands. Staff told us that managers did their best to ensure that staff worked well together, as well as being an appropriate match for the people living in the homes and their needs, and were "quick to act if things weren't working out". They told us that manager and provider put "a lot of thought into how to make teams work best" and "listens to us if we feel it's not working".

The registered manager had effective governance processes and procedures in place to ensure that people received high quality care. They did a weekly handover in each cottage at the beginning of each week, covering what had happened the previous week, what was happening for that week, and provided the opportunity for discussion of any issues or concerns. The registered manager produced a calendar for each cottage every week with people's weekly activities and appointments. The registered manager observed people's competency annually across a range of areas including medicines administration and using the hoist. Staff meetings were held every other month in each of the cottages. Meetings discussed updates for each resident, their health, behaviour, what people needed on shopping trips and any maintenance issues. People's wants and needs were identified and fed through to the registered manager for review.

Copies of policies and procedures were in place in each of the cottages and were reviewed annually by the registered manager and were signed by staff to say they had read them, including any updates. This helped ensure that staff working at the home were delivering high quality care in accordance with current guidance and practice.

The registered manager was well organised and proactive in ensuring the delivery of high quality care through a robust programme of quality assurance audits. These included monthly support plan, medicines and infection control audits. We saw that the registered manager had an overview of when all these audits were due and who was responsible for completing them. The registered manager also recorded when supervisions and appraisals were due, as well as dates for service user meetings and staff meetings in each cottage. One relative described the registered manager as "So much on the ball".

The provider had recently introduced a new procedure called "Resident Quality of Service Assessments" in March 2016. The aim of these was to audit people's quality of life living at High Hurlands Community Homes and involved the registered manager spending time with each person and observing their experiences, based around the Care Quality Commission key questions of Safe, Effective, Caring, Responsive and Well-Led. We viewed records for April and May 2016 and saw that action plans had been drawn up where any follow up action or a training need had been identified.

The provider had processes in place to monitor the quality of the service people received. These processes were implemented effectively by the registered manager to drive service improvements for people.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate effective recruitment procedures to ensure that persons employed were of good character. The provider had not protected people by ensuring that the information specified in Schedule 3 in relation to each person employed was available. This was a breach of Regulation 19(1)(a)(2)(a)(3)(a).