The Office *of the*
Committee *for*
Health & Social Care

REGISTRATION AND INSPECTION
OF
PRIVATE NURSING AND RESIDENTIAL HOMES

HIGHFIELD HOUSE

CARE HOME

INSPECTION REPORT

DATE: 31/07/18

REGISTRATION AND INSPECTION OF PRIVATE NURSING AND RESIDENTIAL HOMES

The Registration and Inspection unit for Health & Social Care has a statutory responsibility to inspect private nursing and residential homes within the Bailiwick of Guernsey at least twice per year. The Registration and Inspection Officer undertakes a minimum of one announced and one unannounced inspection per year.

The inspections are undertaken in order to establish whether the care home is meeting the legal requirements i.e. The Nursing and Residential Homes (Guernsey) Law 1976 and it's associated Ordinances, together with the agreed standards.

In reading the report the following factors should be borne in mind:

- The report is only accurate for the period when the home was inspected.
- Alterations to physical facilities or care practices may subsequently have occurred in the home.
- Feedback will have been given orally to the senior person on duty at the time of the visit.
- Both the Inspector and the Registered Home Owner/Care Manager of the home to which it refers will agree the report as an accurate report.
- The report will show the compliance with the regulations and standards and the required actions on behalf of the provider.

Name of establishment: **Highfield House Care Home**

Address: **Rue a L'Or, St Peter Port, GY1 1QG**

Name of registered provider: **GRH Holdings - Mr M Joyce**

Name of registered manager: **Mr Guy Mitchell**

CATEGORIES/NUMBER OF REGISTERED BEDS

CATEGORY	**NUMBER REGISTERED**
Nursing	**24**
Residential	**19 (currently 36 residents in total)**

Date of previous inspection visit: 22/06/17 - Announced 19/12/17 - Unannounced
Date of inspection upon which this report is based: 31/07/18
Category of inspection: Announced

Registration and Inspection Officer Vanessa Penney

The Inspection findings relate to the Projet de Loi and its associated Ordinances. These are supported by the agreed Guernsey Standards for Care Homes and the Guernsey Standards for inspection of homes specialising in caring for people with Dementia as examples of 'Best Practice' and it is against these that form the basis of the inspection and its findings. The report follows the format of the Guernsey Standards and the numbering shown in the report corresponds to that of the Standards.

INSPECTION REPORT

Identified below are areas addressed in the main body of the report, which are seen as health and safety, and/or good practice issues which the Registered Provider should consider for implementation.

RECOMMENDED PRACTICE DEVELOPMENTS	Refer to standard
It is acknowledged that systems of work have been re-organised in order to improve staff cover at certain times when the workload is heavier and this should continue to be monitored and the staffing level increased as needed	**27**
For further development of the home, consideration should be given to the employment of an Administrative Assistant to support the Care Manager. The provision of a larger office should be considered as there is no private dedicated area where meetings can be held with individual residents and relatives, or with visiting healthcare professionals without interruptions	**33**

STANDARD 1: INFORMATION

OUTCOME: The intended outcomes for the following set of standards are:

- **Service users have the information they need to make an informed choice about where to live.**
- **Each service user has a guide to the facilities.**
- **Each service user has a written contract/statement of purpose setting out the aims and objectives of the home.**
- **Each service user understands how to contact the Health Services Inspector and other local health and social services.**

Key findings/Evidence:

Highfield House has a pre-admission booklet, which is offered to all prospective residents (or their next of kin – NOK) when a person is considering taking up accommodation in the home. The information includes key terms and conditions regarding residency. There is also a very informative residents' handbook, which is in large print for a person with visual impairment and the information can be printed on yellow paper with black print for people who have dementia; a recommendation from the Alzheimer's Society for the provision of clear readable information for people who have dementia. The handbook includes the following information; statement of purpose, philosophy of care, aims and objectives of the team and the terms and conditions of the home. The information displays the name of the registered provider and the name of the registered manager; along with contact details. There is also a paragraph regarding the staff structure within the home.

There is a description of the accommodation available within the home and of the services provided. There is also information included that, whenever possible, residents will be offered a choice in the gender of the person who will be assisting him/her with personal care as there are both male and female carers within the team.

The residents' handbook includes the policy for smoking in the home in line with current legislation, alcohol and pets in the home, as well as information for making a complaint. If a complaint cannot be resolved by the Care Manager or by the provider of Highfield House, contact details for the Registration and Inspection Officer from within Health & Social Care (HSC) are displayed on a notice board outside of the Care Manager's office, where residents, relatives and visitors to the home are able to see it. This information is also in the residents' handbook along with how to access a copy of the home's most recent inspection report. The Care Manager said that the handbook is continually reviewed and updated with the most recent information as changes occur, which is generally several times each year.

The website for the care home remains under construction; it is envisaged that once the site is fully developed, the home's inspection reports will also be accessible on their website.

DEMENTIA STANDARD 1: PERSON CENTRED CARE
OUTCOME: A person with dementia receives individualised quality care and support from staff who actively support residents to make choices about their care and needs.
Key findings/Evidence:
Highfield House has its own written philosophy of care, which alludes to person-centred care. If a resident is not able to be active in their programme of care, their NOK meet with the Care Manager/deputy whenever they visit for an update on their relative's health and well being, or to discuss progress and care issues etc. Relatives can make a more formal appointment to meet with the Care Manager or to have a telephone conversation if they prefer this to an informal 'catch up' and this is organised with some relatives who live off-island. Choices are regularly offered to the residents in their day-to-day living; choice of meals or clothing each day and there is a comprehensive section for activities and interests, which have been completed with the resident's NOK/relatives. Additionally, within the admission documentation, there is a request for relatives to summarise any special needs; food likes and dislikes and there is a letter and a form identifying resuscitation wishes, which are confirmed by the resident's GP. This is excellent as it demonstrates that the home is proactively seeking to tailor the care delivered to each resident. The Care Manager is on the Dementia Friendly Guernsey Committee and undertakes dementia awareness training with relatives, staff and with groups of people within the wider community. He also has a link to Dr Gemma Jones (Dementia Care Consultant in the UK) to enable support to be provided for team training to enable ongoing good quality dementia care, based on the latest research and practice developments, which is a good initiative. He also involves the community psychiatric team for support with managing care for individual residents as needed.

STANDARD 2: CONTRACT
OUTCOME: Each service user has a written contract/statement of terms and conditions with the home.
Key findings/Evidence:

A contract which forms part of the residents' handbook, is provided prior to a person moving in to the home so that they have this information before the person/NOK make their final decision that Highfield is the care home for them. The contract is in large print and is clear to read and to understand. For a person with dementia, the contract is made available as recommended for people with dementia; black print on yellow paper (on request). The contract identifies the room to be occupied, care and services provided, trial period and weekly fee. Payment for incidentals such as the hairdresser, chiropody, incontinence products and GP visits etc are also included in the information (incidentals invoiced with accounts). It also highlights that if a resident is in hospital or is on leave from the home; for example a holiday, the fee remains the same for the period of absence.

The contract includes information for the safekeeping of valuables in the home and there is a policy for non-acceptance of gifts by staff. This also contains information to inform residents/relatives that a member of staff is not able to become involved with a resident's financial affairs, or to witness the signing of a will or other legal/financial documentation. This is to protect the resident, members of staff and the good reputation of the care home. Both the resident or their NOK and the Care Manager sign the contract and both parties retain a copy of the signed agreement. The handbook and contract have recently been reviewed and updated to ensure compliance with the Data Protection Law (Guernsey), which came in to place in May 2018.

STANDARD 3: NEEDS ASSESSMENT
OUTCOME: No service user moves into a home without having had his/her needs assessed and been assured that these will be met.
Key Findings/Evidence:

Highfield House Care Home is a dual registered home providing both residential (19) and nursing care (24) and it specialises in the provision of Dementia, Alzheimer's.

Prior to admission into Highfield House, the Needs Assessment Panel (NAP) assesses each residents' care needs and a certificate is issued to identify the level of care the person requires (unless private – self-funding). The Care Manager or his deputy would also assess the resident's needs to enable them to establish the level of care that the resident will require and to ensure that the home is able to meet the resident's care needs and expectations, and the expectations of their NOK. The community psychiatric nurses and the mental health consultant also provide relevant information, support and guidance. The Care Manager said that the resident's activities and interests are really important for this client group and therefore the activity co-ordinator continues to attend the pre-admission assessment meeting also. Activities and equipment can then be planned and put in place prior to the person moving in to the home, rather than having to delay activities due to needing to put things in place after the person has moved into the home, which is good practice.

On admission each resident has a more comprehensive assessment, which informs the care plan further. This is to ensure that the resident's care needs are identified and will be met by the appropriate plan of care. The assessment undertaken is based on the Roper et al model - the activities of daily living. A more detailed assessment of the resident's mental health needs is also completed using a dementia behavioural staging analysis tool. This enables the Registered Nurses (RNs) to be able to clearly identify the current stage of dementia the person has, the level of functioning and the outcomes are then documented in the care plan.

A risk assessment is undertaken for nutritional status; where a resident's weight is recorded each month or more frequently if there are concerns (MUST assessment tool in place). The Braden scoring system is the system that is now used to assess tissue viability; which also includes an alarm system for skin flaps and bruising, which has been developed by the Care Manager. A moving and handling assessment is also undertaken in order to identify the level of risk for falls etc. The Barthel Index is completed to provide an indication of an individual's level of independence so that ongoing monitoring can be undertaken to further inform each residents' care needs. Following the assessment, a person-centred care plan is developed.

The team continue to work to improve the transfer of information between the relevant team members. The introduction of a communication file in work areas for care staff continues to work well. Relevant information is then transferred by the RNs into resident's individual files each day; communication within the team continues to improve as a result. Two carers from each side (residential and nursing) sit in on an initial handover and they are then able to pass on information to the other members of their team.

Since the previous inspection the Care Manager and the nurses have further upgraded the documentation and this is on-going. The Care Manager said he and his deputy are constantly undertaking research to ensure record keeping is user-friendly for all of the team and provides the information required to enable them to provide good quality care to their residents.

STANDARD 4: MEETING NEEDS

OUTCOME: Service users and their representatives know that the home they enter will meet their needs.

Key findings/Evidence:

Highfield House Care Home is a dual registered home providing care for people with varying levels of physical dependency, psychological needs and for the management of a person who has dementia; including residents with challenging behaviour. The home has a good working relationship with Sarnia unit and the mental health assessment team; as occasionally a resident may be transferred to Sarnia unit for further assessment if this becomes necessary.

Carers are encouraged to build on their current level of knowledge and skills and to keep up to date through both formal and informal programmes of training organised by the home. Mini teaching sessions are held regularly during handover e.g. good practice refresher for moving and handling, reflecting on practice incidents, and for ensuring adequate hydration in hot weather. More recently care staff have undertaken training to further develop recordkeeping. Staff also have access to the internet for information and research.

The RNs are offered quality training; for example, at the Institute of Health and Social Care Studies (IHSCS) and they have also taken advantage of belonging to an established link nurse system (nurses forum) with other nurses from within the healthcare teams.

The Care Manager also organises for teaching sessions to be undertaken in the home from other allied health care professionals e.g. dementia care updates with a community psychiatric nurse. Information for dementia care has also been translated into Portuguese, Latvian and Romanian to make it more understandable for some of the carers where English is not their first language, which really is excellent.

The Care Manager encourages and provides support to the nurses for maintaining their portfolio of personal and professional development, which includes revalidation for nurses to ensure competence with their practice; a Nursing and Midwifery Council (NMC) requirement.

Supervision sessions are undertaken where a RN works alongside a carer to give best practice guidance. Developmental needs are identified, which the RN then discusses this with the Care Manager who organises relevant training sessions (individual or as a group). Documentation of the supervision sessions undertaken is in place.

The Care Manager has completed a course for adult protection and provides the training in-house. He also uses documentaries where there have been issues relating to safeguarding for discussion and training purposes for the care team.

DEMENTIA STANDARD 2: ASSESSMENT AND CARE PLANNING

OUTCOME: Care plans are based on an assessment of an individual's life history, social and family circumstance, preferences, as well as physical and mental health needs.

Key Findings/Evidence:

Prior to admission, the NAP assesses the needs of each person to establish whether the person requires nursing or residential care. The Care Manager or his deputy and the community psychiatric nurse also assess the needs of each person prior to admission. On admission the resident has a more comprehensive assessment, which informs the care plan based on the Roper model for assessing the activities of daily living, as previously discussed in this report. The assessment and care plan documentation includes dementia behavioural staging analysis. This assessment indicates the level of functioning for each stage of dementia. A description is then provided of the significance of the dementia stage, which enables the team to plan achievable outcomes for individual residents. A falls assessment is also completed for all residents, which is kept in each resident's care plan. The four RNs act as key workers and are responsible for the care, communication and recordkeeping for their group of residents.

The RNs include the relatives in the admission process, by encouraging them to complete admission documentation to summarise any specialist needs and food likes and dislikes etc (ongoing discussions with relatives as necessary). Some relatives have taken the time with encouragement and support from the staff, to develop collages using photographs and memorabilia of the resident's life. This is excellent and is a useful tool for the staff to initiate conversation with individual residents and to engage in reminiscence. This will really help the staff to get to know the person and the life they led before moving in to Highfield House.

The Care Manager and his deputy continue to encourage relatives to develop life stories for residents; to provide a summary of the resident's past experiences, personal preferences and current capabilities and again will encourage staff to really get to know the true person from years back; rather than just know them as they see them now. This will further facilitate an understanding of the effects of dementia and provide a deeper understanding of the resident's care needs and the needs of their relatives. The 2 activity co-ordinators in the team are both dementia champions so they have knowledge and experience to support relatives to develop an understanding of their relatives care needs, activities and behaviour in relation to the person's environment and time of day etc.

Since the previous inspection the Care Manager has put the 'Herbert' protocol in place, which is a national scheme introduced to the Bailiwick of Guernsey and is a partnership between the police and dementia friendly Guernsey. This document provides useful information if a vulnerable person goes missing. The aim of the document is that the information is documented in advance so that it reduces the time for the gathering of information so that the person can be found promptly, which is a good initiative.

DEMENTIA STANDARD 3: MONITORING AND REVIEWING CARE
OUTCOME: A person with dementia has their care and support needs regularly reviewed. They and / or their carers participate in the process where possible, to ensure that the individual's strengths and abilities are maintained and changing needs are met.
Key Findings/Evidence:

As discussed above, the care team provide care for people with psychological needs, dementia and for people with challenging behaviour.

The RNs use a tool based on the activities of daily living, which incorporates a dependency level score (Barthel Index). Dependency levels are reviewed each time the care plan is reviewed; at a minimum of every 3 months; some had been undertaken more frequently. The Care Manager said a significant change in a resident's condition would direct this change to be documented sooner; rather than waiting for the review date. This demonstrates that collectively, the resident's needs are being assessed and their needs are being met and the dependency levels are also being used to guide staffing levels and training needs/opportunities within the home.

All care plan entries examined are signed and all reviews are signed and dated. All RNs receive training in relation to developing good record keeping skills to facilitate further developments with the care plan system. The Care Manager and his deputy audit the care plans every month; 4-5 care plans are audited each time and as a result of the findings, staff are supported with additional training in this area as necessary, which is excellent practice.

Each resident has a nutritional risk score, which is reviewed and is updated each month (MUST tool). Residents are weighed every month unless there are concerns for a particular resident, who is then weighed more frequently. This demonstrates that the home is committed to ensuring that the nutritional status of each resident is maintained. If a resident's dietary intake diminishes, a supplement such as Fortesip is offered (prescribed by GP) and further advice from the dietician or from the resident's GP is sought as necessary. A food diary is also commenced if necessary.

Care staff record the daily care each resident has been assisted with so a RN/carer can see at a glance the care each resident has received over the whole week. The resident's care requirements are listed on the sheet and the staff circle the care delivered and any observations; including a resident's dietary intake. Staff sign at the bottom of the column to demonstrate the care that has been delivered or observed (at least 2 entries are made in every 24hrs).

Medication is reviewed in-house with the RNs and the GP is contacted to review individual resident's medication as considered necessary. The psychiatrist and the community mental health nurses also review the resident's medication whenever they visit their client. Case conferences for individual residents are held with the relevant person's NOK and with person's within the health multi-disciplinary care team as required.

DEMENTIA STANDARD 4: MANAGING RISK

OUTCOME: **Residents are supported and enabled to make choices and live their lives as independently and freely as possible through the management of risk.**

Key Findings/Evidence:
Residents are able to wander freely throughout the home and around to the back garden and a falls risk assessment is undertaken for each resident. The Care Manager and the maintenance person undertake a general environmental risk assessment of the home by conducting a walk through the home each month. This assessment includes examining control of substances harmful to health (COSHH) and observing moving and handling, managing challenging behaviour, identifying trip hazards, lighting, windows, water and surface temperatures etc, which is excellent. However, the maintenance person undertakes a walkthrough the home whenever he is on duty to monitor safety and to address any areas that require maintenance work. Residents' assessments include a risk assessment, which facilitates residents to be supported and enables them to make choices and to live their lives as independently and freely as possible.

STANDARD 5: TRIAL VISITS
OUTCOME: Prospective service users and their relatives and friends have an opportunity to visit and assess the quality, facilities and suitability of the home.
Key findings/evidence:

A 1 month trial period is offered to each new resident (flexibility through discussion with Care Manager). The Care Manager said that some residents may take longer to settle in to a new environment than others and this is taken in to consideration as needed. Within the trial period an assessment of the resident is undertaken with input from the resident's NOK, the prospective resident (if able), NAP and the community psychiatric nurse. Trial periods may therefore be either through a respite stay, periodic day care or through a provisional period of long term care with a view to continuing to remain in the home if the person settles in well.

A day care service is also offered at Highfield House. However, there are currently no service users using this service. The Care Manager said this service continues to be an element of care offered at the home, to enable carers to have a few hours break if caring for a relative at home and it is also encouraged as a stepping stone for the care the person may require in the future. By visiting Highfield House for day care and getting to know the staff; when the person requires long term care, the move in to Highfield House will hopefully minimise relocation stress for both the resident and their relatives. The Care Manager said the staffing levels are increased accordingly in order to accommodate this service on the relevant days (when additional day care in place).

The Care Manager has accepted emergency admissions, which usually happen as a result of a referral through the CPN. This service may be required only for a few hours of day care to enable the CPN to organise a package of care in the person's home; it can be longer if the home has a vacant bed/room. The Care Manager said a protocol for accepting an emergency admission has been introduced to ensure the admission is appropriate e.g. care needs can be managed at the home, time of admission to ensure medication can be acquired and health care input from outside providers is available if needed.

STANDARD 6: INTERMEDIATE CARE
OUTCOME: Service users who are assessed and referred solely for intermediate care are helped to maximise their independence and return home.
Key findings/Evidence:

Highfield House does not have dedicated accommodation for intermediate/respite care but would accommodate a person if there was a vacant bed/room at the time of need. The services of other health care professionals are sought for support as necessary, such as physiotherapy, occupational therapy, speech and language therapy and stroke nurse specialist etc. The home does not have specialised programmes, or staff, who have qualifications for specialist rehabilitation programmes.

Specialist personnel then provide rehabilitation training for staff as and when it is required. There have been several people who have moved into Highfield House who have been wheelchair dependent; due to multi-disciplinary support the person has been able to gain mobility so as not to be dependent on the wheelchair and has been able to help the person to achieve and be able to maintain their goal.

There is some specialised equipment in the home such as hoists, walking aids, assisted baths, walk in showers, raised toilet seats and an activities programme etc. The care team aim to continue to maintain or build upon the person's current level of independence so that they are able to return home following their period of respite.

STANDARD 7: SERVICE USER PLAN
OUTCOME: The service user's health and social care needs are set out in an individual plan of care.
Key findings/Evidence:

On admission each resident has a comprehensive assessment which informs the content of the care required and a person-centred care plan is developed. This provides guidance for the staff in order to meet the identified care needs and also includes the resident's comprehensive mental health needs. Residents who require nursing care have a more detailed assessment due to a higher dependency level.

Each resident's care plan includes admission information and contacts for NOK etc. The plan of care is in a written format and is developed as a result of the information obtained from the resident (if able), their NOK, resident's GP, social worker and other allied healthcare professionals where relevant e.g. community nurse or CPN etc. Risk assessments for mobility and falls and for tissue viability have been updated and the core care plan for hygiene is updated weekly. There is also a nutritional risk score for each resident (MUST). Core care plans are also in place for chest infection, urinary tract infection and catheter care etc. The RN key worker has responsibility for keeping their group of resident's records up to date.

The staff have 4 handovers each day on the change over of each shift and the RNs receive training for completing the care plan documentation when they commence employment in the home (within induction programme).

Consent for restrictions for some of the residents who are not able to leave the home alone is given by the resident's NOK and this is documented in the resident's care plan.

The Care Manager and his deputy undertake a monthly care plan audit (4-5 care plans each month). This is followed by an action plan and additional training or supervision with the RNs as necessary.

STANDARD 8: HEALTH AND PERSONAL CARE
OUTCOME: Service user's health care needs are fully met.
Key findings/Evidence:

Residents receive visits from their GP either in their own room or provision is made for them to use a room within closer proximity if for example the person is sitting in the lounge, e.g. shower room.

When a resident is admitted a body chart is completed within the assessment process to identify whether a person is admitted into the home with tissue damage. A quick reference chart for wounds and change of dressings and treatment is also kept in the staff communication file. Highfield House has several preventative strategies in place; airwave cushions and mattresses and the Braden scoring for tissue viability. A skin bundle protocol is in place (provided by HSC's tissue viability nurse) and 2 nurses have undertaken recent refresher training with the tissue viability nurse. The Care Manager also maintains a written data base for skin tears, bruising and episodes of aggression, which he uses to inform training needs and staffing levels. Advice and additional equipment can also be sought from the appropriate services; community nurse, CPN, or St John Ambulance.

The tissue viability nurse is contacted for advice on wound care and dressings, dietician for dietary advice and the diabetes specialist nurse for the management of a person's care who has diabetes (1 resident reviewed recently). There are 2 residents in the home with a pressure wound. Following further discussion with the Care Manager the 2 residents who have a pressure wound have medical conditions where there are complications. This is documented in the care plans. The 2 residents have relevant pressure relief aids in place and there is a re-positioning chart in place when these residents are in bed. A nutritional management plan is also in place, which includes a food diary and/or a fluid chart if needed. Supplements required are prescribed on the person's Medication Administration Record (MAR) by the person's GP.

Residents are weighed each month; weekly where there are concerns and the person's GP and the dietician are notified. The Care Manager or his deputy undertakes a monthly audit of each person's weight to ensure referrals are not overlooked.

All results from appointments and visits are recorded in the resident's care plan and there is a separate document for the resident's GP to record information for each of his/her visits (medical services sheet in place).

Carers' support all residents who require assistance at mealtimes and there are special utensils provided where appropriate, to enable a resident to maintain that little bit of independence. If there is a concern with a resident's nutritional intake, the RN informs the carer who then assists the resident with their meal. The carer then reports back to the RN at the end of meal time and the information is recorded by the RGN in the resident's care plan and is then forwarded to other staff at handover, and the chef if necessary. Residents who require protection of their clothing during meal times are provided with a waterproof apron, which is removed as soon as the resident has finished their meal to ensure their dignity is maintained.

The chef is also very involved with the resident's nutritional intake and he takes note of whose plates are returned to the kitchen and how much of their meal the resident has eaten. He then discusses any concerns with the Care Manager or the RN on duty, which is

STANDARD 9: MEDICATION
OUTCOME: Service users where appropriate, are responsible for their own medication, and are protected by the home's policies and procedures for dealing with medicines.
Key findings/Evidence:

The medication system, which is provided through Stonelakes Pharmacy is the system used at Highfield for administering medication. The RNs dispense the medication from the individual blister packs (photo identification on packs), which are transported in a locked trolley, directly to each resident. Due to the volume of medication supplied to the home a RN is supernumerary for the purpose of checking the medication in to the home so that he/ she is able to complete this without being disturbed (monthly delivery for next month's cycle).

On examination of the resident's MAR; all records have been completed correctly and are in good order. Each MAR displays the resident's name, date of birth, name of the resident's GP and known allergies. At the front of the medication file is a signature list of the names of all of the RNs who administer medication.

There is one resident who self-medicates with supervision from the nurse (administration of insulin). Where a resident is self-medicating a locked drawer is made available in each resident's room if required and a risk assessment for self- medication is undertaken with regular monitoring and frequent reviews. Medication reviews are undertaken by the medical team e.g. resident's GP, psychiatric consultant, or CPN at least 6 monthly; although in practice this is often undertaken more frequently with individual residents if needed.

Two residents are receiving covert medication (lack capacity). There is a form in place to indicate this and the relevant people involved in the decision have signed the form; NOK, GP, pharmacist and Deputy Care Manager.

Medications are stored in compliance with current regulations and codes of practice and the nurse in charge of the shift carries the keys.

All residents are offered an annual flu vaccination and the Care Manager retains a list of the residents who have had or who have refused the vaccine (consent obtained from NOK if resident unable to make decision).

Highfield House received their last annual inspection by the deputy chief pharmacist from within HSC in August 2018 where everything was found to be in order. There is an up to date British National Formulary (BNF) available in the home for the nurses and visiting healthcare professionals to refer to if needed.

There are policies and procedures for the receipt, recording, storage, handling, administration, disposal, and self-medication and for reporting errors (Croner + in-house policies and procedures and NMC guidelines).

STANDARD 10: PRIVACY AND DIGNITY

OUTCOME: Service users are treated with respect and their right to privacy is upheld.

Key findings/Evidence:

The majority of the rooms at Highfield House are single occupancy. Recent building work has changed 2 shared rooms in to 3 single occupancy en-suite rooms on the 2nd floor. Residents who occupy these rooms are required to have a risk assessment in place to demonstrate that they have a good level of mobility and minimal level of supervision required. There is however a stair chair lift that services these rooms. There are now 2 shared rooms in the home. Residents who share these rooms have access to screening for additional privacy.

Residents have the opportunity for their own telephone in their room for which they pay for the line and calls; however should a person choose not to have their own telephone, provision is made for the person to access a telephone to make a call if required. The Care Manager/deputy can organise for adaptations to be made to the telephones where necessary, for example large numbers or an amplifier if this is required to make it easier for a resident. A couple of residents have their own mobile telephone and laptop or computer.

All residents wear and choose their own clothing, which is labelled; this assists staff if searching for mislaid items. The residents and relatives that were spoken to were satisfied with the laundry service at the home.

All residents asked, said that the staff address them by their chosen name which is generally their Christian name and this is acknowledged in their care plan. Staff were observed to always knock on the resident's door and wait for a reply before entering, which demonstrates that staff understand the need to preserve a resident's privacy and dignity. Two relatives who were spoken to said that they were satisfied with the quality of care in the home. One relative said that she visited often and sat in the lounge with her mother. She said the carers have always been very kind and caring from what she has seen and said that they did an excellent job managing some quite difficult behaviours.

The Care Manager said due to the care needs of resident's, it is not always appropriate to have a lock on each resident's door as some residents would lock themselves in and become frightened if they could not get out. Therefore, for these residents, the locks have been isolated and are able to be returned to a normal locking device if another resident were to take up accommodation in that room.

Staff do not open a resident's mail. If a request is made by a relative to open a resident's mail this is carried out by the Care Manager e.g. for regular letters and cards from friends, appointments etc. Mail would otherwise be forwarded to the resident's NOK/ representative.

Highfield House has policies and procedures for adult protection and for privacy and dignity and the staff induction training pack incorporates; safeguarding, confidentiality, privacy and dignity, accountability, staff non-receipt of money and gifts, staff use of mobile telephones whilst on duty and customer relations (Croner policies and procedures).

STANDARD 11: DEATH AND DYING

OUTCOME: Service users are assured that at the time of their death, staff will treat them and their family with care, sensitivity and respect.

Key findings/Evidence:

If a resident requires end of life care he/she is cared for in the home by the RNs with additional support from the appropriate services; for example the palliative care team and the community nurses for as long as is possible. The Care Manager said an individual end of life care pathway is introduced and the staff are provided with training from the palliative care team, in addition to their general training for caring for a resident who is at the end of their life (1 currently in place). The Care Manager has an audit tool for monitoring quality for end of life care, which is good practice.

If a resident required a syringe driver for the administration of pain relief, the community nurses do the initial set up of the equipment. Two RNs always check the prescription and changeover of medication for additional safety and there is documentation in place for regular checks during administration.

Relatives who wish to sit with their relative are made welcome and the staff provide relatives with refreshments and comfort. If a resident had a particular cultural or religious need, the RNs would organise for these needs to be met wherever possible.

A resuscitation status is documented in each resident's care plan and it is regularly reviewed and updated. There is also a resuscitation 'grab' basket available in the home if needed in an emergency.

There are policies and procedures in place for end of life care and for resuscitation (Croner).

STANDARD 12: SOCIAL CONTACTS AND ACTIVITIES + STANDARD 5: ACTIVITY AND SOCIAL ENGAGEMENT FOR DEMENTIA CARE

OUTCOME: Service users find the lifestyle experienced in the home matches their expectations and preferences, and satisfies their social, cultural, religious and recreational interests and needs.

Key findings/Evidence:

There are 2 activity assistants who between them provide 40hrs of activity time per week; flexible depending on activities being undertaken. One of the activity assistants has attended an underpinning knowledge session for dementia care at the IHSCS, which is good practice. Both of the activity assistants are 'dementia friends'.

An activity profile is developed for each resident. 'This is me' is a document that is completed by the activity assistants with a person's NOK soon after admission. This enables the team to develop an understanding of the care needs of the individual person and to understand how they can enhance the care and support the person requires to enable the person to have a good quality of life and social stimulation. It has been acknowledged that completing such profiles really helps to engage the individual as a person; knowing what their interests are, particularly for those residents who have some cognitive impairment. Having individualised activities organised for residents on a one-to-one basis ensures that each person is encouraged to pursue individual hobbies as well as group activities. It is particularly important for those residents who choose not to, or are unable to socialise much during the day, that they are encouraged to pursue some leisure activity.

Residents have a flexible daily living routine, although residents are encouraged to have their meals down in the dining areas unless this is not possible or if they are unwell. There is one dining room for the nursing side of the home and one dining room for the residential side of the home. However, if a resident wanted to eat in either of the dining rooms as a preference, this is supported.

Several residents like to help out with the day-to-day activities in the home and therefore there are residents who potter around the garden to attend to the plants, fold the serviettes, dry some of the dishes, fold up the laundry and help with some of the minor kitchen chores etc. This is important as it helps to give some of these residents a feeling of purpose and can help maintain self-esteem and well-being.

There is a planned activities programme in place to include outside providers for entertainment sessions. Interestingly the programme displays time for more one-to-one activities. One of the activity assistants said there continues to be more residents in the home who benefit from this type of activity time and gave good examples of sensory activities she does involving the senses of touch (hand massage, feeling of textured articles, stroking a rabbit, dog), smell (flowers from the garden, familiar smells of perfume and foods), hearing (listening to music, reading poetry, news articles), sight (looking through books and magazines, photographs, time in the garden) and taste (different foods and drinks). She said one-to-one puzzles, games and colouring are also popular and a very beneficial interaction. The activity assistant said that the activity programme needs to be very flexible as what individual residents want to do each day depends on a number of daily factors; resident's mood, time of day, ability, choice and the weather; if planning an outside activity. The activity assistants are experienced in making relevant changes on a day-to-day or shift-to-shift basis as necessary and work really well as a team as they both have different skills.

There is a wide range of activities for the resident's and this includes art therapy where residents are able to make gifts for special occasions e.g. Christmas. The home is also

STANDARD 13: COMMUNITY CONTACT
OUTCOME: Service users maintain contact with family/friends/ representatives and the local community as they wish.
Key findings/Evidence:
There is an open visiting policy; however for the security of the residents the main door to the home is locked at 10.00 pm so residents returning late with their relative would need to be let in by a member of staff. The staff encourage residents to maintain current social networks and there is opportunity for residents to receive visitors in their own room. Relatives may make a cup of tea in the kitchenette if they wish which is excellent and contributes to normal practice of inviting someone into your home and offering them a cup of tea. Relatives are also informed that they are welcome to have a meal in the home with their relative if they wish; inform the staff in advance for catering purposes. Several relatives take up the offer of Christmas lunch each year, which adds to the festive atmosphere for the residents. The Care Manager has formed a good relationship with Acorn House school to support a 'Getting to know your neighbors' activity. This involves the children from the school coming to the home periodically to sing and to get to meet some of the residents in the home. He also talks to them about caring and supporting older people. The Kennel Club also visits the home periodically for the residents to be able to pet the dogs. The Care Manager also takes his dog to work each day, which the residents enjoy and is a real topic of discussion. The Care Manager said if a resident is upset or demonstrating frustrating behavior, a visit by the dog where the person is able to talk and stroke the dog will generally calm the person down and settle them again within a few minutes. An outside person also visits the home for pet therapy (Rabbits), which residents really enjoy as they can stroke the rabbit sat on their lap. The Care Manager said that he is currently looking at a pet partnership scheme from Spain. A resident will be sent pictures and will choose a pet to befriend. Following this, the person will be sent regular photos of 'their' pet with communication about how they are doing and a possibility that the pet could come to the island to visit the resident.

STANDARD 14: AUTONOMY AND CHOICE
OUTCOME: Service users are helped to exercise choice and control over their lives.
Key findings/Evidence:

The management have encouraged residents to bring in personal items to personalise their room if they wish; including pieces of furniture, ornaments, pictures and photographs etc. Residents and/or their relative are able to rearrange a resident's room to suit their needs and staff will advise of any health and safety or mobility concerns. Each resident has access to a secure lockable drawer for personal items/medication if they require it. Residents are offered choices at mealtimes, the days they would like to have their bath/shower and the time they would like to get up in the morning or go to bed during the day and at night (confirmed by 2 regular visitors – NOK and 4 residents).

Residents are not encouraged to keep valuables in their room and this is explained in detail in the resident's contract on admission. The Care Manager/deputy encourages the resident's NOK to take valuables and money home for safekeeping.

If a resident required access to an advocate or requests access to their care record, the Care Manager or his deputy would organise for this to be done. Two relatives said they are provided with regular updates on their visits to see their relative.

There are policies and procedures in place for adult protection, the safekeeping of valuables and for guardianship orders (Croner). The Care Manager also holds a safeguarding adult trainer certificate.

STANDARD 15: MEALS AND MEALTIMES
OUTCOME: Service users receive a wholesome, appealing, balanced diet in pleasing surroundings at times convenient to them.
Key findings/Evidence:

The menus are varied and are planned on a 3-week rotation. The 4th week continues to be chosen jointly by the residents and the chef to include the residents' favourite dishes; chef has individual discussions with residents, which is excellent and further demonstrates that the chef understands the needs of his clients. The menu is displayed daily in the dining room from early in the morning that day. The home's chef provides excellent quality food all freshly cooked each day and all soups are homemade (14 different soups made each week). He liaises with the dietician from within HSC to ensure that the menu is nutritious and suitable for his client group. Three meals are offered a day with a cooked main meal served at lunchtime and at tea time (residents have a choice of a cooked meal at either lunch time or tea time, or both if they choose). In addition to the main meal of the day, there is an alternative choice although the chef often provides specific dishes at resident's request; therefore he is often cooking several different meals at any one time. The chef often walks around the dining room to speak to the residents to see if they have enjoyed their meal and makes notes of feedback, which he then actions. There is also an apprentice chef (supported by the home). The apprentice chef won the student of the year award at the College of Further Education in 2017.

When the food is sent out to Cedar wing the chef also visits to ensure that the dish is being served correctly. None of the residents who were spoken to had any issues regarding the catering in the home. Unfortunately there were several residents that I was unable to talk to due to their mental ability. Relatives spoken to have not visited at meal time so could not provide feedback in this area.

Residents' likes and dislikes are recorded in their care plan and the chef also caters for residents who require a therapeutic meal; for example diabetic, gluten free, known allergies or pureed etc. If a resident has special dietary requirements the resident's NOK is involved with developing their individual menus. Two residents are vegetarian and have their own individual menus to meet their needs and preferences.

Hot or cold drinks are served frequently throughout the day; however if a resident required a drink at any time, they only have to ask or this will be noticed by the care staff and this will be provided (observed during the inspection). If a resident required a snack in between meals, there is always fresh fruit, sandwiches, biscuits and yoghurts etc available during the day and at night. The chef prepares anything that is asked for as long as he has it in the fridge to do, or would plan to order it and the resident could have it on another day.

The dining areas in both Maple wing and Cedar wing were laid up with attractive crockery with most of the residents sat at a table. Having a table pleasantly laid contributes to the ambience, making mealtimes into "an event," something for the residents to look forward to during their day. The dining room in the residential wing provides a bright, attractive dining area with wooden flooring. Mealtime is an unhurried social occasion and residents are provided with assistance from the carers where needed. Residents with the same level of dementia sit together, which continues to work well. While residents are waiting in the dining room for lunch to be served, one of the activity assistants often plays some calming music on the piano. The Care Manager said this seems to have a good effect for encouraging some residents to eat (originally initiated through research for people with dementia). The activity assistant also has a mobile piano so that she can play music for residents in their

STANDARD 16: COMPLAINTS
OUTCOME: Service users and their relatives are confident that their complaints will be listened to, taken seriously and acted upon.
Key findings/Evidence:
There is a written procedure for making a complaint and this is also discussed in the resident's handbook and a copy is displayed on the notice board outside of the Care Manager's office. The procedure discusses who will manage the complaint and there is a timescale for correspondence for a more formal complaint. There is also information on the notice board for referring a complaint to the Registration and Inspection Officer from within HSC, if a complaint cannot be resolved by the management. The Care Manager aims to have all complaints investigated and responded to within a couple of days and organises to meet with the complainant. Both the Care Manager and his deputy are visible around the home and speak to both residents and their relatives on a daily basis. Any issues which arise are generally dealt with at that time, which is good practice and demonstrates that the home is pro-actively managing a potential concern before it develops into a formal complaint (formal complaints managed appropriately and logged). A copy is then kept in the resident's file or in a staff file if the complaint is concerning a member of staff.

STANDARD 17: RIGHTS
OUTCOME: Service user's legal rights are protected.
Key findings/Evidence:
Residents are able to take part in political processes if they wish and have access to local advocate services if required. Staff are aware of the importance for maintaining confidentiality of information concerning residents within the home and the Care Manager has adult protection policies in place (Croner) of which all staff have access to.

STANDARD 18: PROTECTION
OUTCOME: Service users are protected from abuse.
Key findings/Evidence:

The Care Manager has policies in place for the protection of vulnerable adults, inappropriate restraint, whistle-blowing, non-acceptance of gifts, the safe storage of money and valuables and for staff non-involvement in a resident's financial affairs (Croner + in-house policies and procedures). Whistle-blowing is also discussed at every staff meeting. The Care Manager also has a certificate to provide training for safeguarding and therefore provides this training in-house for all staff. He also uses incidents/accidents in the home for staff to reflect on in order to further develop their practice, and also poor practice cases that occur in the UK.

Allegations of abuse are investigated, actioned and recorded. If the Care Manager has concerns regarding a person's suitability to work with vulnerable adults, he would report this to the Registration and Inspection Officer from within HSC.

STANDARD 19: PREMISES
OUTCOME: Service users live in a safe, well- maintained environment.
Key findings/Evidence:

Highfield House Care Home has facilities that are safely accessible to the residents. There is a lovely secure garden at the back where the residents are able to wander freely on a loop system, which is excellent. The risk of a resident wandering out into the road through the entrances to the home is minimised by the use of a keypad system.

Highfield House has undergone refurbishment in several areas of the home and the environment is comfortable and homely and is bright and cheerful. All furniture, fixtures and fittings are in good order and the furniture is suitable for the client group with varying degrees of ability. On the day of inspection the home was clean and tidy and free from any unpleasant odours.

The insurance certificate was in date and this is displayed on the wall outside of the Care Manager's office.

All fire fighting equipment, electrical equipment and boilers etc are regularly checked and maintained (records kept – dates provided).

Work which has been completed within the last year includes;

- Ongoing programme of decoration and replacement of furniture, soft furnishings and carpet as necessary throughout the home. Maple House (residential wing) – lounges have been re-decorated, re-carpeted and new armchairs have been purchased
- Conversion of the two double rooms on the 2nd floor to provide 3 single en-suite rooms

Work being undertaken or in the future plans and timetabled in, includes;

- Proposed extension for 20 beds for nursing care

The Care Manager undertakes a monthly informal walk-through the home for health & safety monitoring and also to monitor and action environmental repairs and replacements; a more formal audit is documented twice per year and is also forwarded to the provider. A person from the UK who is trained in Quality Compliance also visits the home to undertake an audit every 2 months, which is a good initiative for quality monitoring.

STANDARD 20: SHARED FACILITIES
OUTCOME. Service users have access to safe and comfortable indoor and outdoor communal facilities.
Key findings/Evidence:

The Care Manager has a smoking policy for the home; residents and staff can smoke outside of the building only.

The furnishings in the communal areas are non-institutional and are suitable for the client group. The communal areas are clean and tidy and were free from any unpleasant odours on the day of inspection.

There is a large garden which has pathways on a loop system; therefore residents are able to wander safely outside and there are seating areas in various areas of the garden and the garden is well-maintained and is wheelchair friendly.

STANDARD 21: LAVATORIES AND WASHING FACILITIES
OUTCOME: Service users have sufficient and suitable lavatories and washing facilities.
Key findings/Evidence:
Each bedroom is now en-suite following the conversion of the rooms on the 2nd floor. Communal toilets are also available within close proximity to the dining rooms and lounge areas. There is personal protective equipment available in these areas for staff to use for infection control. There are 3 walk-in showers available (2 in Cedar wing and 1 in Maple wing) and there are 2 assisted baths in the communal bathrooms (2 baths in Cedar wing). Every room has a call bell.

STANDARD 22: ADAPTATIONS AND EQUIPMENT
OUTCOME: Service users have the specialist equipment they require to maximise independence.
Key findings/ Evidence:

There are ramps and grab rails appropriately situated throughout Highfield House and the home has 2 passenger lifts, which service the ground and 1st floors. There are also 2 chairlifts in the home. There is various pieces of equipment to assist residents with their care needs, this includes; raised toilet seats, wheelchairs, airwave mattresses and cushions, sit on scales, suction machine, variable height chairs and profile beds. There is a hoist situated on each floor with slings; including a spare sling for each resident. All residents who have a need for the use of bedrails have bumpers fitted to reduce the risk of injury to the resident (risk assessment completed before use) and sensor mats are also in place where required. All of the necessary moving and handling equipment have received the necessary maintenance and inspections (information provided).

There is information around the home indicating the procedure in the event of a fire and there are clear signs over all fire exits, which provided clear access.

STANDARD 23: INDIVIDUAL ACCOMMODATION - SPACE REQUIREMENTS

OUTCOME: Service users own rooms suit their needs.

Key findings/Evidence:

Apart from 2 rooms, the remaining rooms at Highfield House are single occupancy. The 2 shared rooms have a division of space and there are portable screens available to ensure privacy when a resident is washing and dressing, however, these 2 rooms are en-suite. Residents are able to choose the layout of their room taking into account mobility needs and health and safety issues etc.

Each time a room becomes vacant it is re-decorated and new flooring is laid if this is necessary. Residents who occupy a shared room are always offered transfer to a single room (in consultation with a resident's NOK where appropriate), if this is appropriate and is subject to the resident's/NOK choice, safety of the resident and finances).

STANDARD 24: FURNITURE AND FITTINGS

OUTCOME: Service users live in safe, comfortable bedrooms with their own possessions around them.

Key findings/Evidence:

Residents are able to bring in some of their own small pieces of furniture and are encouraged to personalise their room with pictures, photographs and ornaments if they wish. Each resident has a picture on the outside of their door so that they can familiarise themselves with which is their room in the home.

There are height adjustable beds (some lower right down to the floor – falls bed) for all residents who require nursing care and some of the residents in the residential part of the home also have profile beds (additional profile beds are purchased on a rolling programme). There are telephone points and televisions in each resident's room and grab rails are fitted strategically throughout the home and in all toilets and there is a call bell.

All of the resident's rooms that were examined on inspection were clean and tidy and free from any unpleasant odours. There is a lock on resident's doors (where relevant) and there is a lockable drawer available for valuables or for medication for residents who are able to self-medicate.

Bed linen and towels are changed as required, at least weekly; however, many of the residents have these items changed every day.

STANDARD 25: SERVICES - HEATING AND LIGHTING

OUTCOME: Service users live in safe, comfortable surroundings.

Key findings/Evidence:

Temperature restrictor valves are fitted to all taps in areas where residents have access; the Care Manager said monthly checks for maintaining the temperature at a maximum of 43˚C are undertaken and records are kept for this. All radiators are low surface temperature; several of the rooms in Cedar wing have under floor heating. The choice of installing under floor heating demonstrates the home's commitment in providing a comfortable, safe environment for the residents where possible. There is adequate heating, hot water and ventilation throughout the home.

The Care Manager said there is a programme in place for the prevention of Legionella and an asbestos survey has been completed and the Care Manager has a copy of the register.

STANDARD 26: HYGIENE & CONTROL OF INFECTION

OUTCOME: The home is clean, pleasant and hygienic.
Key findings/Evidence:
The domestic staff have cleaning schedules to follow and are to be commended for keeping the home clean, pleasant and odour-free. The laundry is located in a building, which is separate to the main building and infection control policies are in place along with personal protective equipment for the staff for infection control. Staff uniforms are washed in-house, separate from other laundry. Clinical waste is stored and collected weekly by an outside waste management company. All resident's armchairs are checked and cleaned nightly by the night staff and all carpets throughout the home are shampooed each week; unless it is necessary for a carpet to be cleaned before this time (spillages etc are spot cleaned as necessary). Highfield House had an infection control audit undertaken in June 2017 by the infection control specialist nurse from within HSC and a score of 96% was achieved; demonstrating that staff have a clear understanding of infection control within the home. The Care Manager has policies and procedures for the safe handling of clinical waste, HSC infection control guidelines, hand washing, dealing with spillages and for the provision of protective clothing.

STANDARD 27: STAFF COMPLEMENT
OUTCOME: **Service user's needs are met by the numbers and skill mix of staff.**
Key findings/Evidence:

The Care Manager is supernumerary and works mainly office hours (9am – 5.30pm); however, this is flexible as he periodically undertakes some clinical shifts for night duty or at a weekend so that he has an understanding of the residents and staff needs during that period and also to provide cover for sickness and holidays when needed.

From examining the off-duty the staffing level is as follows - during a morning shift the Care Manager is on duty with 1 RN and 6 carers (4 carers nursing, 2 carers residential). During the afternoon the Care Manager is on duty with 1 RN and 4 carers (2 carers nursing, 2 carers residential). During the evening shift a RN is on duty with 5 carers (2 nursing, 2 residential and 1 carer twilight shift working between the 2 wings) and at night a RN is on duty with 4 carers (2 nursing, 2 residential). On the previous inspection, discussion with staff, residents and relatives resulted in some concerns being raised in relation to staffing levels at certain times of the day, which was discussed in detail with the Care Manager at that time. As a result some of the systems of work have been reviewed and re-organised to free up time for the RN on the morning shift and for carers to provide additional supervision in the Cedar lounge. These issues were not raised on this inspection however, the Care Manager must continue to monitor and increase staffing levels accordingly to ensure residents' care needs continue to be met. The Care Manager said that extra staff are rostered on duty when there is an admission to the home, when needed for activities taking place or an increase in the dependency for short periods of time when the home is busy.

The care team are supported by; activity assistants x 2, catering staff - qualified chef, apprentice chef & KP and housekeeping staff x 2. Carers that were spoken to said there is generally sufficient staff on each shift to enable them to manage their workload effectively, as long as there is a full team. Residents confirmed that call bells are answered promptly on most occasions (sometimes slower during the busy periods – morning and evening). On most occasions residents did not feel that they were being rushed when being attended to and generally the staff were cheerful, patient and kind when attending to them. A dependency scoring system for the residents is also used as a continual tool for monitoring staffing levels in the home, which is good practice.

STANDARD 28: QUALIFICATIONS
OUTCOME: Service users are in safe hands at all times.
Key findings/Evidence:

The Care Manager is a Registered General Nurse (RGN). He has completed in-depth training for the management of people with dementia and is a trainer for Dementia Awareness Guernsey. He also holds a certificate as an adult safeguard trainer. As Highfield House is a dual registered care home providing both nursing and residential care, there is a registered nurse on duty at all times of the day and at night.

The Deputy Care Manager has recently completed the VQ diploma at level 5 for Leadership and Management and has also successfully completed an Ergocoach course, which, as a qualified Ergocoach, enables her to train all of the staff, in-house, for moving and handling.

Two RGNs are VQ Assessors and one carer has a VQ award at level 3 with another carer currently undertaking this award. One carer has a VQ award at level 2 and another carer is also currently undertaking this award. Carers are supported to attend the underpinning sessions for these awards that are offered by the IHSCS. A number of other carers have indicated an interest to undertake this award in the future.

STANDARD 29: RECRUITMENT

OUTCOME: Service users are protected by the home's recruitment policy and practices.

Key findings/Evidence:

The Care Manager obtains enhanced DBS checks for all nurses and carers (basic checks for other employees) and 2 written references are requested; one from the person's most recent employer. Gaps in employment are investigated and an employee's health declaration is incorporated into the employee job application form. For the employment of a registered nurse, the Care Manager has access to the Nursing and Midwifery Council register (NMC) to ensure the nurse's registration is current and the person is on the 'fitness to practice' register (3-yearly revalidation).

The Care Manager has developed a personal staff file system, which is kept in a locked cabinet and only the Care Manager has access to these records.

Policies and procedures are in place for health and safety, dealing with fire and emergencies, confidentiality, whistle-blowing, non-receipt of gifts or for witnessing legal documents and adult protection (Croner + in-house).

STANDARD 30: STAFF TRAINING + DEMENTIA STANDARD 6 - STAFF TRAINING

OUTCOME: Staff are trained and competent to do their jobs.

Key findings/Evidence:

Highfield House has a very informative induction programme for all staff and the programme is signed off by the employee, their mentor and the Care Manager once it has been successfully completed, which is good practice. The induction programme includes a section for managing a variety of behaviour which people with dementia may experience. There are scenarios for staff to work through to assist with their understanding and techniques which can be used to assist both a resident and their nurse or carer, to understand why this frustrating behaviour occurs and to help a resident to manage the situation. The induction programme also includes; residents' rights, choice, privacy and dignity, attitude, safeguarding, confidentiality, health and safety and the policies and procedures for the home.

A refresher session for dementia care was provided for all of the staff in March 2017 by the Care Manager. The Care Manager is to be commended for having the information for the training translated into Portuguese, Latvian and Romanian to ensure that the carers of these nationalities have a clear understanding of all elements of the programme, as English is not their first language. The Care Manager also has a link to Dr Gemma Jones (Dementia Consultant – UK). The Care Manager is a Dementia Awareness trainer and has also undertaken this training with staff and many relatives of residents in the home.

Accredited trainers from the IHSCS provide updates and training for the RNs for basic life support and emergency first aid at work and for infection control. One RN has completed the Ergocoach training through the IHSCS and is therefore able to undertake in-house training with all of the team. Customer care training continues and the Care Manager said this also includes methods of communication. Skills for Care units are also offered to care assistants as 'tasters' prior to declaring their interest in undertaking a VQ award. Staff have also completed training for fire safety and for infection control.

Staff who are employed for night duty are required to undertake a period of day duty to ensure that sufficient training is provided before they take up their position on night duty, which is excellent. All staff receive a minimum of 3 days training per year (pro rata for part time) of both formal and informal training (list of training and dates provided). Training sessions are repeated several times so that a suitable time can be organised for both day and night staff to attend. There is also time set aside each month for in-house staff training. The sessions cover topics such as moving and handling and using appropriate equipment, diet and hydration (including during a heat wave), diabetes, dementia care, pressure relief and pressure sores, stroke management, teamwork, infection control and fire safety (ongoing). The Care Manager and the registered nurses continue to make good progress with staff training and ongoing personal and professional development; NVQ/VQ programmes are encouraged and are supported by the management. The activity assistants also attended an occupational therapy course through HSC (2016) for re-enablement activities.

STANDARD 31: STAFF SUPERVISION + DEMENTIA STANDARD 7 - STAFF DEVELOPMENT SUPPORT AND PERFORMANCE

OUTCOME: Staff are appropriately supervised. Staff are supported to deliver quality care through regular opportunities for supervision and role models.

Key findings/Evidence:

As previously discussed in this report there is a very informative induction programme. The Care Manager holds 3-4 monthly staff meetings. The minutes of the meetings are displayed on the staff notice board. This is important as this avoids situations when staff claim not to have been informed of various issues. The minutes include items such as practice issues and the general home operation and communications etc. The nurses and carers have separate meetings with the Care Manager to ensure that each party feels comfortable with giving feedback and for raising concerns.

The Care Manager has an appraisal system in place. Each staff member has an annual appraisal in order to inform ongoing training and development within the team. The Care Manager undertakes an appraisal for the nurses and allocated staff and the Deputy Care Manager undertakes appraisal for the VQ candidates as she is working with them through their units and is able to identify training needs during this activity. Documented supervision sessions are in place for the RN as part of the revalidation process with the Nursing & Midwifery Council (NMC – nurses' regulatory board) and with the carers who are undertaking the VQ awards. Carers have daily informal supervision as the RNs 'work on the floor' and provide opportunistic supervision with individuals or as a group as needed.

The Care Manager is always visible throughout the home whenever he is on duty as he is frequently talking with residents and their relatives and he is also involved with supervising staff on the floor (formal supervision documented). He also makes periodic unannounced visits to the home at various times of the day and during the evenings and also undertakes some clinical night shifts to cover for sickness and holidays where needed.

STANDARD 32: MANAGEMENT AND ADMINISTRATION

OUTCOME: Service users live in a home which is run and managed by a person who is fit to be in charge, of good character and able to discharge his/her responsibilities fully.

Key findings/Evidence:

The Care Manager is a Registered General Nurse and has a Diploma of Higher Education in Adult Nursing. He has undertaken in-depth training for the management of people with dementia and he is also a Dementia Awareness trainer and has also undertaken training to become an adult safeguarding trainer. Since the previous inspection, the Care Manager has commenced a VQ award at level 5 for leadership & management.

The Care Manager is aware of his lines of accountability and reports regularly to the provider. He undertakes periodic training to ensure that his clinical skills in the home are kept updated (Care Manager maintains a professional portfolio for his NMC registration - revalidation). He also undertakes self-directed study relevant to his position and has access to the internet where he undertakes frequent research for development and practice in the field of dementia care and has a link to Dr Gemma Jones (Dementia Care Consultant – UK).

STANDARD 33: MANAGEMENT AND ADMINISTRATION - ETHOS

OUTCOME: Service users benefit from the ethos, leadership and management approach of the home.

Key findings/Evidence:

The Care Manager and the Deputy Care Manager have an open approach and a very positive and motivated attitude. They demonstrate good leadership skills and staff felt that they are valued. Staff, residents and relatives are able to approach either of them at any time; although they both make a point of seeing residents each day. Relatives that were spoken to said the management are approachable and said that they were confident that issues or concerns that were brought to their attention would be addressed promptly; one relative was able to give a good example of this.

The Care Manager continues to seek ways of assessing quality assurance. This is evident in the process of audit that is in place to continue to drive standards higher. The employment of an Administrative Assistant in the home would be of benefit to support the Care Manager as it was identified that he also undertakes all of the administrative needs for the home and the amount of paperwork required in a care environment continues to increase. Consideration should also be given to the provision of a larger office as there is no dedicated private area for the Care Manager to hold a meeting with a resident, relatives or visiting healthcare professionals without interruption.

STANDARD 34: QUALITY ASSURANCE

OUTCOME: The home is run in the best interest of service users.

Key findings/Evidence:

On the day of inspection several residents and their relatives were spoken to and the feedback was positive. Residents said they enjoyed the activities in the home. In-depth discussion with one of the activity assistants demonstrated that the activity assistants are continually looking at ways to meet the social needs of individuals and really go that extra mile to support interests and activities in the home. The Care Manager continues to evaluate this service as he said activities offer residents rich opportunities which are meaningful, enjoyable and therapeutic. Resident said that they particularly liked musical sessions and several enjoyed the garden in the fine weather.

The Care Manager regularly asks residents and relatives how they are and whether they have anything they wish to discuss or would like to make suggestions etc. The Care Manager and his deputy try to keep the residents and their families informed of what is going on; there is a notice board outside of the Care Manager's office, which also has details of the activities/events that are taking place. Relatives meetings are held approximately every 4 months and are well supported and minutes are recorded of the meetings. At the following meeting relatives are informed of the action that was taken as a result of previous issues raised. There is also a training toolkit, which is kept in the entrance to the home for relatives to use to support them with the understanding of activities for dementia care.

Residents are involved when re-decoration of their room or any of the communal areas are being planned; colour, furniture and fittings etc as the Care Manager said this is their home.

The management are keen to continue to develop the home. A person from the UK who has vast experience for compliance monitoring visits the home every 2 months to undertake an audit of care and services in the home. Feedback is then given to the Care Manager for him to action any necessary areas. The Care Manager stated that he sends a daily report to the provider, to ensure he is aware of any ongoing operational issues. They can then work together to resolve them.

The policies and procedures for Highfield House consist of a combination of Croner + in-house documentation. The Care Manager is aware that the policies and procedures that are developed in-house need to be reviewed at least every 3 years unless changes in practice indicate changes should be made sooner and this is currently being done. Regular audits are undertaken for record keeping and for environmental safety and the audits are formally documented.

The Care Manager also uses feedback from inspections and audits from outside providers to further develop the care and facilities in the home, for example care standards inspections, pharmacy inspection, infection control inspection, fire safety inspection and food hygiene inspection. Feedback is also provided by other visiting healthcare professionals, for example GPs, community nurses, social workers and the psychiatric team. This demonstrates that the home is actively seeking to engage all parties in the pursuit of person-centred care. The Care Manager said it is also important for relatives to speak to either himself or his deputies as reassurance and education plays a large part in understanding how a relative feels and enables the team to support relatives with understanding dementia and risk taking to facilitate fulfilment of quality of life (nurses work closely with some relatives to support them with undertaking quality activities during visiting times).

STANDARD 35: FINANCIAL PROCEDURES
OUTCOME: Service users are safeguarded by the accounting and financial procedures of the home.
Key findings/Evidence:
Employment & Social Security receive annual accounts from the company and an accountancy firm audits the home's accounts annually. The certificate of insurance is on display in the home and is current.

STANDARD 36: SERVICE USERS MONEY
OUTCOME: Service user's financial interests are safeguarded.
Key findings/Evidence:
Residents (if able), their NOK or an advocate manages a resident's finances and there are facilities accessible to residents in their own room for the safekeeping of money and valuables. The Care Manager has a safe but the safekeeping of resident's money is not encouraged and is avoided where possible (none currently held). The Care Manager advises residents or their NOK to take valuables or large amounts of money home for safekeeping. For services such as hairdresser or chiropody residents are individually invoiced.

STANDARD 37: RECORD KEEPING
OUTCOME: Service user's rights and best interests are safeguarded by the home's record keeping policies and procedures.
Key findings/Evidence:

The Care Manager has a record keeping policy and the residents' records that were examined were comprehensive. Following the introduction of regular audit, the gaps in the care plan documentation appear to be being captured and addressed. The resident's records are kept together, for example their whole record; care plan, risk assessments, GP communication etc is kept in a separate file for each resident. This documentation is held at the nurse's station as the records need to be easily available for staff, yet are kept secure in a locked room.

Care reviews are routinely undertaken 3-monthly; however, generally this occurs more frequently as the care plan is altered at the times that care needs change. If a resident requested access to their care record the Care Manager or his deputy would organise for this to be done. All staff receive training for confidentiality and for data protection during their induction (confirmed in conversation with carers).

STANDARD 38: SAFE WORKING PRACTICES
OUTCOME: The health, safety and welfare of service users and staff are promoted and protected.
Key findings/Evidence:

Accidents or incidents that occur in the home are recorded, investigated and are actioned and records are kept for this. The documentation also includes information for the action taken at the time, action to prevent a recurrence and follow-up action, which is good practice. The Care Manager continues to use a traffic light system for the classification of accidents. Staff are required to complete an accident form for bruises and scratches noted; even if they do not know how they occurred so that possible trends can be identified, investigated and resolved. An audit for individual accident reports is formally reviewed by the Care Manager each month (spread sheet maintained). Risk assessments have been completed for residents where required e.g. use of bedrails. The Care Manager provides a weekly update to the provider for accidents and incidents that have occurred, also for complaints and compliments received.

Highfield House has first aid boxes available in the kitchen, office, Cedar wing and in Maple wing of the home. The first aid boxes are taken up to St John Ambulance by the Care Manager for re-stocking every 6 months; unless required sooner due to depletion of stocks.

There is an effective programme of ongoing training in the home and safeguarding policies and procedures are in place, which form part of the induction programme for all new employees: supervision (formal + informal) is provided as needed.

There are fire procedures on display around the home and the staff undertake in-house fire safety training sessions annually. The fire alarms are tested weekly and a log is kept for this.

The management have implemented a good programme of equipment maintenance and checks and have completed a programme of refurbishment of some of the areas in the home (ongoing). When a resident moves in to the home a visual check of electrical items in undertaken and then a 5-yearly check for small appliances continues.

The building both inside and outside appear to be kept well maintained. The gardens are safe and are easily accessible for all of the residents with varying degrees of mobility (residents who are allowed to wander around the garden have been risk assessed).

All hazardous substances are kept in a locked cupboard in compliance with regulations and care home standards. A Legionella programme is in place and the home has had an asbestos survey (register in place).

All windows on the first floor and above where the residents have access have been fitted with window restrictors. All taps have temperature restrictor valves so that the water does not exceed 43˚C and the radiators are low surface temperature. The rooms in Cedar wing have under floor heating. There is a security system for the front door entry and the back gate into the garden; also a secure entry/exit as the back entrance leading out into the garden, which is on a loop system, as previously discussed in this report.

Policies and procedures are in place for safe working practices in the home (Croner + in-house).

DEMENTIA STANDARD 8 + 9 - ENVIRONMENT AND GARDEN/OUTDOOR SPACE
OUTCOME: The garden is viewed as a therapeutic environment and the design of the building enhances quality of life and care.
Key findings/Evidence:
Residents in both Cedar wing and Maple wing are able to walk freely around the home and are able to have their meals in the dining area in either wing. Areas are sign posted for easy identification for example the bathrooms and the toilets and each resident's room has a photograph on the outside of the door so that this will assist a resident with memory problems, to recognise their own room (resident's choice). The furnishings, fixtures and fittings of the home take into account the needs of people with dementia and there are various diversions around the home to help make walking around the home more interesting; for example large pictures on the wall, various seating areas and magazines around the home. The design of the garden between Cedar and Maple wing has been well thought out. It has attractive well laid out paths and colourful planting. There are areas where residents are almost encouraged by its design to sit and contemplate and the garden provides a loop rather than the creation of a dead end, which can be frustrating for people with dementia. The garden is kept secure by an attractive iron gate, which is kept locked, and the staff can easily observe residents in this part of the garden from various areas of the home. Additionally there is a lovely large lawn area at the back of the home; however, this is rarely used as residents prefer to walk around the paved courtyard garden where there is more activity in and out of the home. On the day of inspection the garden was busy with residents and carers or visitors sitting in the seating areas chatting together, or walking around the paths admiring the gardens or the dog playing with its toys.

Registration and Inspection Officer's comments

Highfield House Care Home provides a comfortable environment for people who require care and support due to dementia. Residents who I was able to verbally communicate with said that the staff treat them with dignity and respect and are kind and helpful. This was also observed on a walkthrough the home during the day where time was spent in the lounges observing resident and staff interactions.

Discussion with the Deputy Care Manager and a registered nurse following examination of the care plans, confirmed that the care in the care plan was the care that the individual residents were receiving. The information in the care plan had been reviewed and referrals to other healthcare professionals from within the multi-disciplinary team had been generated when

needed. The necessary equipment had also been sought and was in place for individual residents who needed it.

There is a good programme of in-house activities in the home and the activity programme also incorporates visits from outside providers; including for pet therapy. The Care Manager said that pet therapy has had a very positive effect both emotionally and physically for several residents. As a result the Care Manager now takes his dog to work each day, which really motivates residents and they spend time stroking the dog, watching it play and jovial discussions were observed between residents.

There is a good programme of training and development in place and the Care Manager and his deputy undertake a number of audits in the home to support quality assurance. This includes an auditor from the UK who visits the home every 2 months to audit areas of care and services in the home, which is a good initiative of the home management.

Vanessa Penney
Registration and Inspection Officer

HOME MANAGER/PROVIDERS RESPONSE

Please provide the Inspection unit of the Health & Social Services Department with an Action Plan, which indicates how requirements and recommendations are to be addressed and a completion date within the stated timetable.

No.	**Recommended works**	**Action being taken to address requirements**	**Estimated completion date**

No.	Recommended practice developments	Action being taken to address recommendations	Estimated completion date

REGISTERED PERSON'S AGREEMENT

Registered person(s) comments/confirmation relating to the content and accuracy of the report for the above inspection.

I would welcome comments on the content of this report relating to the inspection conducted on **31/07/18** and any factual inaccuracies:

Registered Person's statement of agreement/comments: Please complete the relevant section that applies.

I of confirm that the contents of this report are a fair and accurate representation of the facts relating to the inspection conducted on the above date(s) and that I agree with the requirements made and will seek to comply with these.

Or

I of am unable to confirm that the contents of this report are a fair and accurate representation of the facts relating to the inspection conducted on the above date(s) for the following reasons:

Signed:

Designation:

Date:

Note:
In instances where there is a profound difference of view between the Inspector and the registered person both views will be reported. Please attach any extra pages, as applicable.

July 2018