Oakray Care (Little Hayes) Ltd

Little Hayes

Inspection report

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15 June 2017

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 13 and 15 June 2017 and was unannounced. The home provides accommodation for up to 32 people, including some people living with dementia care needs. There were 26 people living at the home when we visited. The home was based on two floors connected by two passenger lifts; there was a good choice of communal spaces where people were able to socialise; all bedrooms had en-suite facilities.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People had access to a range of activities, but we found these were limited and were not tailored to meet people's individual interests. The registered manager acknowledged that activity provision was an area for improvement and was trying to recruit an activity coordinator.

Most people told us staff encouraged them to make choices, although two people said their preferences for their daily routines were not always met. The registered manager took immediate action to address this.

People felt safe living at Little Hayes. Staff knew how to identify, prevent and report abuse. They assessed and managed individual and environmental risks effectively.

There were enough staff to meet people's needs in a timely way. Appropriate recruitment procedures were in place and most pre-employment checks had been completed fully before staff started working with people.

Arrangements were in place for the safe management of medicines. People received their medicines at the right time and as prescribed. The home was clean and staff followed appropriate procedures to prevent and control the risk of infection.

People and relatives praised the standard of care delivered and the quality of the meals. People's dietary needs were met and they received appropriate support to eat and drink enough.

Staffed received regular training and felt supported in their role by managers. They followed legislation designed to protect people's rights and freedom and supported people to access healthcare services when needed.

People were cared for with kindness and compassion. Staff protected people's privacy and dignity. They encouraged people to remain as independent as possible and involved them in planning the care and support they received.

People's personal care needs were met in a personalised way. Each person had a comprehensive care plan centred on their individual needs. The provider sought and acted on feedback from people. People knew how to make a complaint, though no complaints had been recorded.

People and their relatives felt the service was run well. There was a clear management structure in place. Staff enjoyed working at the home and told us they felt valued and listened to by management, who they described as "approachable".

A quality assurance process was in place to assess and monitor the service. There was an open and transparent culture where visitors were welcomed at any time. Staff enjoyed positive working relationships with external professions and the provider notified CQC of all significant events.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe and staff had received training in safeguarding adults. Individual and environmental risks to people were managed effectively.

There were enough staff to meet people's needs and recruitment practices helped ensure only suitable staff were employed.

Medicines were managed safely and people received their medicines as prescribed.

All areas of the home were clean and there were appropriate policies and procedures in place to control the risk of infection.

Is the service effective?

Good

The service was effective.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

People received effective care from staff who were suitably trained and supported in their roles.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists when needed.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They interacted positively with people and promoted their independence.

People were involved in planning the care and support they received.

Staff protected people's privacy, respected their dignity and

supported them to follow their faith.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Activity provision was limited and not tailored to people's individual interests.

People were encouraged to make choices about aspects of their lives, but the personal preferences of two people were not always followed.

People's personal care needs were met in an individualised way.

The provider sought and acted on feedback from people to help improve the service. There was an appropriate complaints policy in place.

Is the service well-led?

Good

The service was well-led.

People were happy living at Little Hayes and had confidence in the management. There was a clear management structure in place. Staff understood their roles and worked well as a team.

A quality assurance process was in place to assess and monitor the service.

There was an open and transparent culture. Visitors were welcomed at any time and there were positive working relationships with external professionals.

Little Hayes

Detailed findings

Background to this inspection

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

This was the first inspection of the service since it was registered with the current provider in August 2016. The inspection took place on 13 and 15 June 2017. It was unannounced and was conducted by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the service including reports of inspections conducted under the previous provider, as there was continuity in the people managing and delivering the service. We also reviewed notifications we had received from the service. A notification is information about important events which providers are required to send us by law.

We spoke with 10 people living at the home and nine family members. We spoke with the registered manager, the deputy manager, the provider's compliance manager, seven care staff, two cooks and a housekeeper. We looked at care plans and associated records for seven people, staff duty records, recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas of the home. We also spoke with a visiting nurse consultant who had regular contact with the home.

Good

Is the service safe?

Our findings

People told us they felt safe living at Little Hayes. One person said, "It's very good. At night, two care workers go round outside to make sure everything's locked." A family member told us "[My relative] is very safe here."

Staff had the necessary knowledge to enable them to respond appropriately to concerns about people's safety and were aware of people who were at risk of abuse. All staff had received safeguarding training; they knew how to raise concerns and were confident the managers would take appropriate action. One staff member told us, "I'd report anything to [the registered manager]. She would want to know and would sort it out." Records showed that a safeguarding concern had been investigated thoroughly and promptly by a director of the provider's company in liaison with the local safeguarding authority.

Individual risks to people were assessed and control measures put in place to reduce the likelihood of harm. Some people were at risk of falling and had been given walking aids; staff made sure these were accessible and prompted people to use them safely. Where people had experienced more than one fall, staff completed multi-factorial risk assessments. These looked at a wide range of factors that might put the person at increased risk of falling and helped identify appropriate safety measures. For example, one person had a history of falling out of bed, so a special bed had been sourced that could be lowered to the floor; this had proved effective and had significantly reduced the person's risk of injury.

The risk of people developing pressure injuries had been assessed using a nationally recognised tool and appropriate action was taken when people were identified as at high risk. For example, they were provided with special pressure relieving, cushions and mattresses; the mattresses were set correctly, according to the person's weight, and a clear process was in place to help ensure they remained at the right setting. A family member told us, "[My relative] had a minor pressure injury, but [staff] spotted it and dealt with it early so it didn't develop."

Environmental risks were also managed effectively. Regular checks of gas and electrical equipment were conducted. All upper floor windows had restrictors in place to prevent people falling through them. There was a process in place to check fire safety equipment regularly and staff had received fire safety training. Personal emergency evacuation plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency; these were kept in an accessible 'grab bag', together with other emergency equipment and information. Staff were knowledgeable about people's evacuation plans and had been trained to administer first aid. The home also had an automatic external defibrillator (AED) which staff had been trained to use. This was available to people living in the home and to people in the local community in the event of an emergency.

There were enough staff to meet people's care needs and provide a supportive presence in communal areas, although we received mixed views from people about this. For example, one person told us, "Well, they are short sometimes and you have to wait longer"; but another person said of the staff, "[When I press my call bell] they come quite quickly]. In no time they're here." Care staff felt there were usually enough staff deployed to meet people's needs. One of them told us, "Generally we have enough staff. Sometimes it's a bit

tight when someone goes sick, but we get by and make sure people don't miss out."

The deputy manager told us staffing levels were based on people's needs, together with feedback from staff, people and their relatives. They monitored call bell response times from a display screen in their office and could analyse the system to identify any delays. We viewed a sample of the available data from the system which showed the vast majority of call bells were responded to within three minutes. The registered manager told us they were recruiting additional staff to enable them to increase the staffing levels at night to help ensure people's needs were met consistently.

The provider had appropriate recruitment procedures in place, which included seeking references and obtaining a full employment history for applicants. The employment history for one of the four staff members whose files we viewed was not complete, but the compliance manager took immediate steps to rectify this. Checks were also made with the Disclosure and Barring Service (DBS) before new staff were employed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these checks were completed before they started working with people.

People were supported to receive their medicines safely. There were appropriate arrangements in place for obtaining, storing, administering and disposing of medicines. We saw medicines were administered in a safe way, by staff who were suitably trained and competent. The staff member gained verbal consent from the person and explained what the medicine was for; they then remained with the person to ensure the medicine had been swallowed.

Medicines administration records (MAR) were fully completed. These recorded when each person had received their medicines. There were no gaps in the MAR charts, which indicated that people had received all their medicines as prescribed. There was an effective process in place to help ensure topical creams were not used beyond their 'use by' date. Comprehensive information was available to guide staff when administering 'as required' (PRN) medicines, such as pain relief and sedatives, to help ensure they were given in a consistent way. One person was prescribed a PRN medicine to help reduce their level of pain when being treated by a community nurse and records confirmed this was given every day, shortly before the nurse arrived.

There were appropriate policies and procedures in place to control the risk of infection. All areas of the home were clean. One person told us "It's spotlessly clean. They do a lot of cleaning." Another person described the home as "Immaculate". A family member said, "There are never any unpleasant odours; everywhere is always clean." The laundry had recently been refurbished and an additional washing machine had been installed to help staff cope with the volume of laundry. Staff had received infection control training, were clear about the procedures for handling soiled linen and had access to disposable gloves and aprons. Cleaning schedules were in place, together with check sheets which staff used to confirm that all necessary cleaning had been completed.

Good

Is the service effective?

Our findings

Staff had the skills and competence to enable them to support people effectively. One person said of the staff, "They're great. I can't think of one who isn't." Another person told us, "Staff are well trained and the discipline is good." Family members echoed these comments; for example, one said, "I'm happy with the care. [My relative] has improved a lot since moving here. He gets all the help he needs and [staff] monitor [his weight] well." A community nurse consultant told us, "The care here is amazing. There's always a senior [staff member] on duty and they are very good."

New staff completed an effective induction into their role and were supported to undertake training that met the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. Following this, new staff spent a period of time working alongside a more experienced member of staff and their competence was then assessed by one of the managers. A staff member told us, "My induction and training were good. I shadowed for two to three weeks which helped. It helped me get into the routine and get to know the residents."

Records showed staff received regular training in all relevant subjects. A staff member told us, "We get on-going training. I enjoy it. You always learn something new; it's good." Experienced staff were encouraged to obtain vocational qualifications relevant to their role. They were also supported to attend additional training that would benefit people, such as nutrition, falls awareness and end of life care.

Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, when supporting people to move, they used appropriate techniques. They also explained how they communicated with people living with dementia by remaining patient, asking simple questions and providing continuous reassurance. One staff member told us, "[One person] will often say they haven't had breakfast and asks for it again. We never argue or refuse and give them another slice of toast or something."

People were cared for by staff who were appropriately supported in their role. All staff received one-to-one sessions of supervision, which were recorded. These provided an opportunity for the manager to meet with staff, discuss their training needs, identify any concerns, and offer support. In addition, staff told us managers were always available for support. One staff member said, "If I need help, I can always go to [the registered manager]." A senior staff member told us, "[The registered manager] was really supportive when I started the role. I did my NVQ3 [a vocational qualification], they did some one-to-one training with me about medicines and paperwork and let me shadow some other seniors. I wasn't just thrown in the deep end."

Staff protected people's rights by following the Mental Capacity Act, 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Care records confirmed that where people lacked capacity to make decisions, in all but one case, staff had completed assessments using the recommended two-stage test. They consulted with family members and made decisions in the best

interests of people. These included decisions relating to the administration of people's medicines and the provision of personal care and were recorded on specially designed forms. One person's MCA assessment and best interests decisions had not been recorded; we drew this to the attention of the registered manager and by the end of the inspection this had been completed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). 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. We found the service was following the necessary requirements. DoLS applications had been submitted for two people and the registered manager was reviewing people's needs to consider whether additional applications may be needed. Most staff knew how to keep people safe in the least restrictive way, although some were not clear whether any DoLS authorisations were in place or not. We drew this to the attention of the registered manager, who undertook to update staff about the status of the DoLS applications that were in progress and the action they needed to take.

People were complementary about the meals. One person told us, "The food is always good and if you want something different they just do it for you; like soup or something. It's never a bother." Another person confirmed this and said, "They [kitchen staff] come and say what they are going to [cook]. Mostly what they say is very nice, but they had corned beef hash [today]. I'd had that before here and I didn't like it. I said 'Can I have something else?' They said 'Of course you can', straight away with no bother." A further person told us, "The meals are very good, very balanced."

Lunchtime was a social occasion. People sat together at small tables with people whose company they enjoyed. Tables were laid with tablecloths, flowers and condiments. People greeted one another warmly, interacted positively and clearly enjoyed the experience. Each person had a nutritional care plan detailing their needs and food preferences and staff were clear about how to meet these needs.

Some people had chosen to have smaller portions on smaller plates, so they did not feel overwhelmed by their meals and we saw these were provided. Three people needed their meals to be pureed and these were presented in an attractive way that allowed the person to distinguish the individual food items. One person needed their drinks thickened, as they were at risk of choking and all staff were clear about how much thickening agent should be added to each drink.

When people struggled to eat independently staff were supportive and offered assistance in a patient and dignified way. For example, a person living with dementia was encouraged to eat, but when this did not work, a staff member sat with them and supported them on a one-to-one basis. People were weighed regularly to help identify any unplanned weight loss. When this occurred, staff took appropriate action, including referring people to their GP, fortifying their meals with extra calories and providing regular snacks.

A range of hot and cold drinks was provided and we heard staff encouraging people to drink throughout the day. When asked if they were offered enough to drink, one person told us, "I would say so. I'm awash sometimes; I'm up to my plimsoll line!"

People were supported to access healthcare services when needed. One person told us, "The doctor comes quickly; you don't have to wait like you do if you go to the surgery." Records showed people were seen regularly by doctors, specialist nurses and chiropodists. For example, one person was seen daily by a community nurse for dressing changes. A community nurse consultant who had regular contact with the home told us, "[Staff] always follow our advice and if they're not sure will call back."

The home was piloting a 'Telehealth' scheme in partnership with a local doctor's surgery. This allowed staff to monitor people's health using handheld computers and to transfer the data electronically directly to the surgery for analysis. This had led to quicker diagnosis of conditions and earlier treatment. A staff member told us, "[One person] hasn't been well, so we're monitoring their blood pressure more closely and sending the results to the GP twice daily. When the GP comes, it saves them time but also gives people a quicker diagnosis."

Good

Is the service caring?

Our findings

People told us they were cared for with kindness and compassion. Comments from people about the staff included: "The staff are very patient and very good. They say 'Shall I do this or that for you? Shall I post that letter for you?'"; "They are very, very caring. They do look after you, no doubt"; and "They're good; they're nice girls". A family member told us, "Staff are always smiling and always very respectful whenever they deal with [my relative]." A community nurse consultant told us, "The registered manager really cares [about people] and [staff] are very respectful of patients."

Responses to a survey of people and relatives, conducted by the provider, also showed staff were consistently caring. Comments included: "I smile when I see my carers"; "Staff are all lovely. Sometimes I can be a little stubborn but the staff are amazing and caring with me"; and "Everyone seems to know their role and are genuinely concerned and caring to the residents".

The registered manager told us, "You have to give plenty of TLC [tender loving care] when people first come in to make them feel welcome and build up trust." They later demonstrated this on the second day of the inspection when a new person arrived at the home. They made sure the person's room was ready, assigned a staff member to help them settle in and spent time introducing them to other people living at the home with similar interests and backgrounds.

Without exception, all staff interactions with people that we observed were good humoured and positive. Staff used touch appropriately to reassure and show affection to people. They clearly knew people well and were able to engage them about topics they were interested in. For example, when a cat appeared in the garden, a staff member pointed it out to a person who liked cats. This prompted a conversation between them about cats. Staff knew that one person used to particularly enjoy dancing. When they supported the person to walk, they sang a song and gently skipped along with them, bringing a smile to the person's face.

A family member told us staff always "make a fuss" of people on their birthdays and provide a birthday cake. They said their relative had asked for people to be offered fruit meringues instead of cake on their birthday and these had been provided. They told us, "Staff are caring; they're very chatty with [my relative] and accommodate whatever [my relative] wants."

Staff encouraged people to remain as independent as possible within their abilities. One person told us, "A carer was always with me at first when I went to the bathroom, but now I'm more confident. I don't need them to be in the bathroom with me now, but they have to be in the vicinity. The more you can do for yourself, the better." People's care plans specified the need for staff to promote independence. For example, one said, "Encourage and prompt me to manage as much of my own care as I can to maintain a good level of independence" and another said, "[The person] can brush their own teeth if staff put the toothpaste on my toothbrush".

People and relatives told us they were involved in discussing and making decisions about the care and support they received. For example, a family member told us, "[My relative] had a review last year. We went

through things with the manager." Another family member said, "I've read [my relative's] care plan. They showed me her story [information about the person's life and background]; there's a copy of it in her room and most staff have some understanding of it.

Staff protected people's privacy and respected their dignity. We saw staff took care to make sure toilet and bathroom doors were closed when they were in use. They described practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible, explaining what they were about to do and checking people were ready and willing to receive the proposed care and support. When staff asked if people wished to use the bathroom, they did so quietly and discreetly so as not to cause any embarrassment. Staff used two-way radios to communicate with one another and were careful to only refer to the room number of the person who needed support rather than their name. This helped ensure the person's dignity would not be compromised if the radios were overheard.

People told us they could choose the gender of the care staff member, or request a particular staff member, to support them with personal care. This information was included in care plans, known to staff and followed.

Staff supported people to practise their faith. One person was supported to receive Holy Communion from a visiting minister every week. In addition, a church service was held at the home every four weeks and the registered manager knew how to contact leaders of other faith groups.

Requires Improvement

Is the service responsive?

Our findings

A mixed range of activities was provided for people at Little Hayes, including external entertainers three times a week and staff-led activities each afternoon, such as games, singing, crafts and puzzles. However, we found the staff-led activities were very limited, were generally not advertised and were poorly organised and attended. A care staff member was designated to run the afternoon activity session for around an hour each day, which we observed. Only five of the 26 people living at the home attended. It started with a session of reminiscence, but some people were not given time to tell their stories and others could not follow the conversations because they were distracted by the background music that was playing. This was followed by a game of beanbag throwing which was more successful and people enjoyed.

Most people were not aware of the activities that were being run. There was no evidence to show that people had been involved in planning the activities or that those provided met people's individual interests. One person told us, "I don't know if they have them [activities]. They used to have entertainment and quizzes. They were by public demand; maybe there isn't the demand lately?" Another person said, "They do the games on the floor and arts and crafts, but it's no good for me. I can't get down to it and I can't see." A family member told us, "My only criticism of [the home] is the lack of activities. [My relative] feels a bit cooped up; there's no stimulus for them."

We discussed activity provision with the registered manager. They acknowledged that this was an area for improvement and were attempting to recruit an activity coordinator to organise and run activities. They said they had advertised the position several times, but had not been able to fill it. They were reviewing the job description to ensure it was appropriate for the role, before re-advertising.

Most people told us staff encouraged them to make choices about aspects of their lives. The need for staff to do this was reinforced in people's care plans. For example, one care plan said, "I prefer to wear skirts, but give me a choice of which to wear." A staff member told us how they supported a person to make choices when they were not able to communicate verbally. They said, "We know what [the person] likes to eat, so we offer this, but if they don't eat it we offer another favourite. For example, yesterday I gave them an egg sandwich which [the person] likes, but didn't eat, so I made tomato soup with bread and butter and they ate most of it."

However, two people said their preferences were not always met as they had not been consulted about aspects of their care. One of them told us staff helped them get ready for bed early, even though they did not go to bed until much later. They said, "They [staff] put my pyjamas on about 6.00pm. I don't like it. I'd be more comfortable in my clothes. I've said about it to them; they say it's better for the night staff because they're busy." The other person said they used to go downstairs for breakfast but it was now served in their room. They told us they didn't understand why the change had been made and said it had not been discussed with them. The registered manager told us staff should always accommodate people's preferences, wherever possible and undertook to address these issues immediately.

Other people told us their personal care needs were met in an individualised way. For example, one person

told us, "I have a bath twice a week which suits me; and they get you into bed, then come back to check you're okay."

Each person had a care plan that had been created in discussion with them (and their relatives, where appropriate). The care plans were well organised, followed a clear format and provided comprehensive information to enable staff to deliver care and support in a personalised way. They were centred on the needs of each person and took account of their medical history and how people wished to receive care and support. They included information about people's medicines; continence; skin integrity; nutrition; and mobility needs.

Staff demonstrated a good awareness of the individual support needs of each person living at Little Hayes. One staff member told us, "Each resident is different and likes things done differently; like how they put a top on. For example, [one person] had a broken elbow, so we have to put their right arm in first. That's why we do shadowing, to get to know people's preferences." Staff spoke positively about the quality of the care plans. For example, one staff member told us, "They are really helpful and have all the information you need. I like the section on their background as a lot of people have dementia and knowing what's important to them gives you something to talk about and prompts memories for them."

Care plans were reviewed monthly by senior staff help ensure they reflected people's current needs. One person was supported to exercise to regain their mobility following a stroke. The staff member supporting the person explained the plan and how far it was hoped they would walk in each session. This pleased the person and motivated them to continue. Records of the daily care provided confirmed that people had been supported in accordance with their identified needs.

The provider sought feedback from people, including through the use of survey questionnaires and 'residents' meetings'. These showed people and their relatives were satisfied with most aspects of the care provided. Comments from people were used to improve the service. For example, people had commented that they wished to see more colour in the garden, so hanging baskets had been ordered. Visitors had commented about a toilet next to the front door that did not give a positive first impression of the home and plans were in place to convert this to a store room.

People and their relatives told us the registered manager and deputy manager were approachable to discuss any concerns. A family member told us, "We had a problem with [my relative's] loo and it was sorted out." There was a complaints procedure in place which was advertised on the home's notice board, though no complaints had been made.

Good

Is the service well-led?

Our findings

People were happy living at Little Hayes and felt it was run well. A family member told us, "The manager keeps high standards. If things slip, over time, mention it to her and she deals with it." Other comments from family members included: "[For our relative], we wanted somewhere safe, where they would be well fed and treated with dignity; we found that here and we couldn't have asked for more"; "Staff seem happy and content. There's been a core of long-term staff and they get picked up if they don't do things right"; and "The manager is nearly always here and available, as is the deputy. There's a positive culture".

There was a clear management structure in place. This comprised of the providers, the registered manager, the deputy manager and senior care staff. Each had specific responsibilities and understood their roles. During the inspection, we saw and heard the managers providing clear direction and support for staff. An 'on-call manager' system was also in place so staff could access advice and guidance out of hours. Staff enjoyed working at the home and told us they felt valued and listened to by management, who they described as "approachable". One staff member said, "The managers are really supportive; whichever one you go to, they would find the answer [to your problem]." Another told us, "I can go to the manager anytime and she would do her best by me. She praises you, which is so important. It makes you feel valued and appreciated." A further staff member said, "The managers are very good. They're very fair; but if you've done something wrong, they'll let you know."

A quality assurance process was in place to assess and monitor the service. This was based on a range of audits conducted by the registered manager, the deputy manager and the provider's compliance manager. The audits covered all aspects of the service including care planning, medicines management, health and safety, infection control and staffing. Where improvements were identified, these were usually addressed promptly. For example, the infection control audit identified the need for a bath panel to be repaired and we saw this had been done; the health and safety audit identified the need for additional emergency lighting outside the home and this was in hand. The provider had recognised the need to enhance the activity provision and was trying to address this through the recruitment of dedicated activity staff.

There was an open and transparent culture within the home. Visitors were welcomed at any time and could stay as long as they wished. A family member told us, "I can come anytime and I'm always made welcome." Another family member said, "They give visitors tea or coffee; always a hot drink. And get them another chair; no fuss, no bother." The CQC rating from the inspection of the home under the previous provider was displayed in the hall. This was relevant as there had been continuity in the managers and staff delivering the service. The provider notified CQC of all significant events and external professionals told us they enjoyed positive working relationships with staff. A community nurse consultant who had regular contact with the home told us, "[The registered manager] is brilliant at identifying anything that's not right; she understands her residents."

A duty of candour policy had been developed, and was being followed, to help ensure staff acted in an open and honest way when accidents occurred. A family member told us, "When [my relative] had a fall, they [staff] called me immediately. They told me exactly what had happened. Someone stayed with [my relative]

all the time while waiting for an ambulance. When they returned [from hospital], they explained that they would wake her every half hour to check her."

The registered manager and deputy manager told us they kept up to date with best practice and developments in the sector by reading publications and reports from CQC and relevant trade bodies. They also belonged to a support network for managers of local homes which met regularly to share information and best practice. The next meeting of the group was due to be held at Little Hayes and a guest speaker had been invited to talk to managers about supporting people with swallowing difficulties.