HC-One Oval Limited

The Hyde Care Home

Inspection report

Walditch
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 4 April 2018 and was unannounced. This was the services first inspection since the transfer of the service to a new provider on 15 December 2017. At the time of the inspection the new provider was in the process of changing new systems, including uniforms and new files

The Hyde is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This was the services first inspection since the transfer of the service to a new provider on 15 December 2017. At the time of the inspection the new provider was in the process of changing new systems with regards to records and files.

The Hyde Care Home (known locally as 'The Hyde') is registered to provide residential care without nursing for up to 28 older people. At the time of our inspection there were 12 people in the home. People are supported over four floors, people had access to floors by way of a lift and stair lifts. Some rooms have en suite facilities and can accommodate married couples. The Hyde is set in a rural location in Bridport. Communal facilities include specialist bathrooms, lounges, a dining room, quiet social areas and an accessible garden.

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

The registered manager had been in position since October 2017. They were supported by a deputy manager and a staff structure which allowed them to have oversight of the service. We had discussions with the area quality director, who represented the provider at the inspection following the recent change in registration.

People described the care as safe and were supported by staff who understood how to recognise signs of abuse and the actions needed if abuse was suspected.

There were enough staff to meet people's care and support needs. Staff had been recruited safely including full employment history and disclosure and barring checks. Induction and on-going training provided staff with the skills needed to carry out their roles effectively.

Staff were supported and had opportunities to meet with senior staff and discuss their role and professional development.

People had their risks assessed and actions were in place to minimise the risk of any avoidable harm. This included risks associated with swallowing, falls, skin damage and malnutrition. Staff were able to explain to

us how people's needs and choices were met and their role in reducing risks people lived with.

People had their medicines ordered, stored, administered and recorded safely. When people self-administered their medicines risk assessments were in place which were regularly reviewed to ensure safety.

People were confident that at the end of their lives they would be cared for with kindness and compassion and their comfort would be maintained. Staff worked with other organisations to make sure high standards of care were provided and people received the support and treatment they wished for at the end of their lives

Staff had completed infection control training and demonstrated practice that reduced the risk of avoidable infections. When things went wrong lessons were learnt and actions put in place to improve safety.

Pre admission assessments were completed and formed care and support plans that were reviewed regularly. Care plans were person centred and people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

If people needed to make a complaint they were aware of the process and felt the registered manager was a good listener and would put things right. A complaints log was kept and records showed that when complaints had been received they were investigated in a timely way and outcomes shared with the complainant.

Staff were well informed about changes as they happened because there were effective communication processes. A range of meetings with staff, people and their families provided opportunities for engagement and involvement in service development. Quality assurance systems were robust and effective in identifying areas of service delivery that required improvement. Partnerships with other agencies and organisations enabled appropriate sharing of information that in turn provided seamless care for people.

The registered manager was also under a new management structure. They told us, they already felt fully supported by the new provider and senior managers. They said, "I feel very supported by senior managers and my team, we are all learning together".

The registered manager had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal responsibilities. Where concerns had been raised with them they had sought advice and shared information with the CQC and the commissioners of the service.

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 were supported by staff that had been trained to recognise signs of abuse and the actions needed if abuse was suspected.

People had their risks assessed and regularly reviewed with actions in place to minimise avoidable harm.

People were supported by enough staff to meet their needs and choices and had been recruited with checks in place to ensure they were suitable to work with vulnerable adults.

Medicines were ordered, stored, administered and recorded safely.

People were protected from avoidable infections.

When things went wrong lessons were learnt and changes introduced to improve safety

Is the service effective?

Good

The service was effective.

Assessments of peoples care and support needs were carried out in line with current legislation and best practice guidance.

People were supported by staff who had completed an induction and on going training that enabled them to carry out their roles effectively.

People had their eating and drinking needs met.

People had access to planned and emergency healthcare when needed.

Working with other professionals enabled effective outcomes for people.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring and provided emotional support appropriately.

People had their individual communication skills understood which enabled them to be involved in day to day decisions about their care.

People had their dignity, privacy and independence respected.

Is the service responsive?

Good

The service was responsive.

Care and support plans were person centred reflecting a person's diversity, were reviewed regularly and followed by the staff team.

A complaints process was in place which people and their families felt able to use if needed, felt they would be listened to and appropriate actions taken.

People were fully consulted about their care which reflected their physical, mental, emotional and social needs, including on the grounds of protected characteristics under the Equality Act.

People had their end of life wishes respected.

People had access to a variety of activities both inside the home and within their local community

Is the service well-led?

Good

The service was well led.

The management team provided a positive, open culture that empowered people, their families and staff to share ideas and concerns.

Systems and processes were in place that enabled effective communication with the staff team keeping them abreast of changes.

Systems and processes were in place to promote engagement with people, families, staff and the community.

Quality assurance systems were effective in driving continual improvements.

Partnerships with other agencies and sharing of information appropriately ensured positive, seamless care for people.

The Hyde Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on the 4 April 2018 was unannounced and the inspection team consisted of an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who used this type of care service.

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

The provider was asked to complete a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we spoke with seven people who used the service and one relative. We spoke with the registered manager, deputy manager area quality director, team leader, four care workers, the chef, activity coordinator and one visiting health professional. We reviewed six peoples care files and discussed with them and care workers their accuracy.

We checked five staff files, care records and medication records, management audits, staff and resident meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

Good

Is the service safe?

Our findings

People were protected by staff that had a good understanding of what constituted harm and how to protect them. Staff had received training in protecting people from the risk of harm and understood the different possible signs of abuse and how to raise an alert.

One person told us, "They [staff] explain things to me, they are so reassuring. They are really marvellous. They are just there if there's anything I need. They notice if I am a bit low." People told us staff checked they had pendent alarms on to keep them safe. One person said, "There's one by your bed, or we put them around our neck when we leave the room. Staff check if I am wearing it."

When incidents had occurred, the provider worked with the local authority to investigate any concerns. Lessons were learnt when things went wrong and actions taken to reduce the risk. For example, a recent safeguarding concern into a medicine error had identified a risk around the safe storage of controlled drugs. Improvements had been implemented to ensure medicines were stored safely in secure individual containers with individual photographs. This meant staff could be sure the correct person was receiving their medicines. One senior member of staff told us, "We have new improved systems in place, which included checking the controlled drugs twice a day and recording on new forms".

We observed staff administering medicines and we checked the storage of medicines and how the stock was managed. We observed people when they received their medicine, this was completed on a person by person basis. The staff explained the medicine and took time to ensure the person had taken their medicine. All the staff required to give medicines had received training in safe administration and their competency was reviewed. However we observed medicines were not stored securely in the medicine cabinets, as had previously been identified as a safeguarding concern within the storage of controlled drugs. Within the control drugs cabinet. We addressed our concerns with the registered manager. Following the inspection the registered manager sent us photographic evidence that all storage containers in the medicine cabinets had been updated to mitigate any further risk.

Risks to people were assessed and their safety monitored and managed so they were supported to stay safe and have their freedom respected. Actions were in place to minimise the risk of any avoidable harm. This included risks associated with swallowing, falls, skin damage and malnutrition. Equipment was used to support people to remain mobile and move from floor to floor, such as lifts and chair lifts. Sensor beams were used to alert staff if someone moved in their room who was identified as at risk of falls. People were able to leave the home independently, but told us staff always ensured their safety before they left, by knowing where they were going and approximately what time they were returning. One person told us, "We all have our walking frames decorated differently it's something nice to look at." The deputy manager told, "Falls have reduced since decorating the frames".

There were sufficient numbers of staff to support people's needs. One relative told us, "I do feel there are enough staff around, there is always calmness about the place". The registered manager had a dependency tool which reflected on people's level of need. This was reviewed monthly or when changes occurred. Staff

told us they felt there were enough staff to support people safely. Relevant checks were undertaken before people started work. For example references were obtained and checks were made with the Disclosure and Barring Service to ensure that staff were safe to work with vulnerable adults.

The home was clean and hygienic which reduced the risk of infection. We saw there was cleaning schedules which had been followed and staff used protective equipment like gloves and aprons when they provided personal care or served food. Two of the bathrooms were out of action at the time of the inspection. Some of the flooring in the bathrooms looked stained, some bath aids were also stained. Some people relied on the bathrooms for personal care as they did not have en suite facilities in their rooms. One person told us, "The bath is broken, so I am waiting for a bath. I like a bath really, and you can have one every day if you want to. I have to wash in my bathroom, which I don't like as much". The registered manager told us refurbishment plans were in place which included the bathrooms, library and floors. At the time of the inspection these refurbishments were already underway.

People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency. Systems were in place to ensure equipment such as hoists, slings, fire equipment and lifts were in good order and serviced appropriately.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Care records showed when people were unable to make decisions; these were reflected in a capacity assessment. Any decisions had been made through a best interest meeting and included professionals and people of importance to the person and the decision.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us that there were currently two people living at The Hyde who required a DoLs assessment, the registered manager had applied to the local authority in May 2017, and confirmed the people remained, "Happy and content" living at The Hyde.

Staff we observed throughout the day interacted well with people and provided safe and effective support. People were offered the same choices and received the support they required showing there was no discrimination based on people's perceived abilities People told us, and we observed that staff assisted them to make their own decisions. People's consent was obtained before they provided support and the person's decision was respected. For example, one person told us they were always asked if they were ok to receive support. They said, "They leave it for me to advise asking 'what do you want done?". The registered manager discussed plans to convert a room into a twin room with separate living area for people wishing to live together, they told us. "We welcome any couple regardless of their sexual orientation to live together, if we have a room available to support them". They gave examples of previous experiences of supporting people from Lesbian, Gay, Bisexual and Transgender (LGBT).

People told us and relatives confirmed their needs were consistently met by competent staff. People spoke very highly of the service. People told us they felt well cared for and received the care and treatment they needed to meet their needs and respect their wishes.

Staff had received a range of training for their role. Staff completed an induction and on-going training that provided them with the skills to carry out their roles. Training included person-centred care, emergency first aid, health and safety and moving and handling. A staff member told us their induction had included completing the Care Certificate. The Care Certificate is a national induction for people working in health and social care who do not already have relevant training. Training had also been completed which was specific

to people living at the home. The registered manager told us, "If there is a need for any learning or development outside our normal training schedule we can arrange it. For example syringe drivers, role play."

Staff told us they felt supported and had received supervisions [one to one meetings] with more senior staff. Supervisions enabled them to discuss any training needs or concerns they had. Staff were also supported to develop and reflect on their practice through yearly appraisals. Records showed that supervisions and appraisals had taken place and were scheduled throughout the year.

People had their eating and drinking needs met. People had personalised, laminated place mats which they had helped to design. The deputy manager told us, "These are good for getting conversations started around the table". Another initiative was the introduction of 'green place mats' for people who need to be encouraged to drink more. The registered manager told us, "They act as a discreet reminder for staff, if they see the person with the mat encourage that person to drink more throughout the day".

The chef knew people by name and was knowledgeable about their allergies, likes and dislikes, cultural requirements and special diets. People told us they had choices throughout the day for food, drinks and snacks. Comments included, "There's a choice. There's a menu each day and if you don't want any of it you can probably order something else. I love eggs of all sorts – omelette, poached. I have breakfast in my room", "I have seen hundreds of meals. I have never seen a meal that wasn't delicious."

Staff monitored people's health and worked closely with other professionals to make sure care and treatment provided good outcomes for people. The provider told us in their PIR, "The home works closely with local GP practices and community nursing services. The home also has close working relationships with the tissue viability nurse / falls team / continence specialist / mental health services, to ensure residents have access to specialist healthcare when required." One visiting health professional told us, The staff follow our instructions, there is good communication and they contact us if there are any concerns. Everything is in place that should be".

The home was ample space for people who used wheelchairs or mobility aids. Communal areas were set out with easy chairs, televisions or radios were available for people to watch or listen to. Signage was in place for people to navigate their way around the home, such as toilet signage and exits. People had personalised their rooms and they were decorated as they wished. People had access to attractive gardens, and told us they enjoyed walking around the grounds. The home was noted to be clean and without any unpleasant odours.

Good

Is the service caring?

Our findings

People were valued and treated with compassion and kindness by a highly motivated and dedicated staff team. Staff had built strong caring relationships with people, interactions were person centred and respectful. People comments included, "Yes, the carers are very caring", "I am quite happy with whatever the carers do for me", "It a nice home, if you have nothing to worry about, you don't."

Staff checked on people's well-being throughout the day. We observed that people enjoyed starting conversations with staff and engaging with them. People had established meaningful friendships and these relationships were supported, through seating arrangements and encouraging similar interests of small groups. One person said, "We all get on so well, I have made lots of friends since moving here its lovely".

Staff had time to sit with people; touch was used in an affectionate and appropriate way. For example, bending down to people eye level asking if they were "Ok", or "Can I get anyone anything". Relatives we spoke with identified examples of exceptional care. One relative told us "We always thought [loved one] would never be happy again, This home has given [title] happiness again for their final years".

People told us that staff respected their privacy, dignity and independence. One person said, "I feel included, the [staff] always ask me first". People were supported to maintain their diverse cultural, gender and spiritual choices. Information was obtained during their initial assessment and reviewed as relationships developed. Dignity stones were placed in the large fire place in the hall were people had shared their own values in regards being treated with dignity and respect.

Different methods of communication were used to support people. The registered manager told us how they supported people who were hard of hearing. They told us, "When we have resident and family meetings we have staff or family sat next to them to relay information they may struggle to hear. One person told us following the resident meeting the day prior to the inspection "I can't hear, but my son and daughter were there. My son said 'speak up' to [deputy manager], but she didn't". We discussed with the registered manager how they support people with their communication difficulties, they told us, they recognised that some people may find it difficult to hear in crowded rooms or meetings, due to the size of rooms. They told us they planned to discuss having a loop system installed within the home to aid communication needs with the provider.

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

People living at the home told us they felt they were listened to. Comments included, "It's pretty good on the whole. There are little things that niggle, but I don't bother about them. If I know a carer and if I have anything I am bothered about I tell them and they pass it on". One relative said when her parent had moved

to the home following the loss of her spouse. "They gave much kindness, love, they let them cry and grieve. They instantly welcomed us as a family, reassured us things would be okay, gave [title] so much support, to make them feel it was their home." " As soon as I came here I felt it welcomed me. The sun was shining, I felt at home. The people were welcoming and pleasant. I came to stay a few times and each time I did not want to go home. I saw the rooms. It is my home." People who needed an independent representative to speak on their behalf had access to an advocacy service.

Staff had a good understanding of people's interests, likes and dislikes. Life story books had been completed and included information about significant events in people's life, wishes and aspirations, careers and the things that make them happy. This meant that staff could have conversations with people about things that were important and of interest to them. Families were able to visit at any time and described staff as welcoming.

People's spiritual needs were met. For example, the home had regular monthly visits from Church ministers. One person told us, The local vicar comes and does a service. I used to be very involved. I have done all that. I believe there's one [service] this afternoon. I don't go often, but I get a touch of the outside world." The registered manager told us, "We might have to look and learn about a culture but we would always meet individual request".

Good

Is the service responsive?

Our findings

People were consulted about their care requirements. One person told us, "I feel involved in my care and support". One relative told us, "They [staff] move us through the changes and prepare us for changes through reviews and emails."

People had care plans which reflected their personal care needs and choices, and were reviewed. Care staff were able to tell us about their role in supporting people and were knowledgeable about how people liked to receive their care and their communication needs. People told us they felt involved in their care and any changes to their care. One daily record reflected a person had been upset, and had apologised to the care worker. It was recorded the person had been reminded they did not have to apologise and had been given lots of reassurance.

Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. The plans contained clear information about people's assessed needs and the actions staff needed to take to support people. Care plans had been developed in line with current legislation, standards and good practice guidance. This meant people had their rights, equality and diversity protected. Assessments included any equipment that was required to provide effective care such as specialist mattresses, sensor beams, or hoists.

Staff received a handover before they commenced their shift, and head of departments attended daily 'flash meetings'. One staff member told us, "It about the whole home. We all have a part to play." We attended a flash meeting. Staff were informed to consider and respect one person's right to refuse the aid of equipment to prevent pressure sores, but were advised to give gentle reminder of the benefits of using the equipment. A 'resident of the day' programme was in place which provided people with an opportunity to provide feedback about all aspects of the service, this was discussed at the flash meeting. However people we spoke to were unsure what being a 'resident of the day' meant. Comments included, "I have heard something about it, but I don't know what it means", "It doesn't mean anything" "I did not hear the expression until yesterday. I don't know what they mean by that", "It was mentioned at the residents and family meeting yesterday."

People had been offered opportunities to follow areas of interest or join in activities. There was a varied programme of activities which were displayed on the notice board on tables around the home and in people's rooms, people told us they enjoyed the activities that were on offer. Some people chose to join in the activity and then returned to their room, other people enjoyed the social company within the lounge. Activities included painting, flower arranging, external entertainers. During our inspection we observed people participating in exercise sessions, singing, and painting.

A complaints procedure was in place and people and their families were aware of it and felt able to use it if needed. A complaints log was kept and records showed that when complaints had been received they were investigated in a timely way and outcomes shared with the complainant. People and their families knew how to make complaints, and told us they felt sure they would be supported and listen to if they needed to

use the procedure.

People were confident that at the end of their lives they would be cared for with kindness and compassion and their comfort would be maintained. The service had been accredited with a comprehensive quality assurance system which enables care homes to provide quality care to people nearing the end of their lives. People had an opportunity to develop care and support plans detailing their end of life wishes which included any cultural requirements and decisions on whether they would or would not want resuscitation to be attempted. The deputy manager told us, "We capture wishes, involve family, GP and district nurses and produce a palliative care file. We have captured our resident wishes within our dignity stones where our resident words are on the stones". The registered manager told us they were planning to create a rockery from the dignity stones and plans are in place for a memorial garden with a bench for people and their family to sit and reflect.

Good

Is the service well-led?

Our findings

The Hyde had a registered manager who had been in position since October 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was also under a new management structure. They told us, they already felt fully supported by the new provider and senior managers. They said, "I feel very supported by senior managers and my team, we are all learning together". Staff were clear about the changes to the home in regards the change of provider and registered manager. One staff member said, "The new manager is lovely, very dedicated and always around".

People and their relatives had been consulted about the recent change of provider. One person said, "It's a very happy home. There has been a change of management, but I think everything will settle down." One person said about the new registered manager, "I think [name] knows about family affairs. I have spoken to them once or twice about concerns. I have trust in them and am much happier with them as the manager than where I was before. They have her methods of doing things and I have confidence in them." Another person commented on the new registered manager, "I get on very well. I think we are very lucky to have them. They go around and chat with us in a very casual way. I feel I can talk about almost anything if I need to." As part of 'getting to know the new manager' a monthly surgery had been set up for anyone to have one to one time with the registered manager.

The registered manager had a clear vision for the home which was to "Ensure people received quality care that provided the kindness care this will ensure the best outcomes for people". A relative informed us, "We have had lots of consultation about the changes in the provider and management, face to face and email. I didn't attend the recent meeting as I felt I had enough information".

There was a clear vision and a positive culture was promoted. Without exception said it was a great place to work. The home used methods to drive improvements. These included audits, feedback from people, relatives and professionals in addition to their own learning from events or training. When an audit had been completed any actions were followed up and checked that they had been completed.

There were effective systems to monitor and review the quality of the home. The registered manager told us they worked to continuously improve services and provide an increased quality of life for people who lived in the home based on the feedback that they regularly sought from people. This feedback was gathered both informally through chatting with people on a daily basis and more formally through surveys, reviews and meetings. The registered manager told us they felt fully supported by the provider and met with other managers locally once a month for support and learning.

The registered manager had good links with the local community and constantly looked at ways to expand

these to support people to stay connected with the community. Pre-school and older school children visited the home. Staff told us they "Often brought along their children to join in with activities. On the day of the inspection, children were seen singing with the people in their morning activity session.

Quality assurance systems were robust and effective in identifying areas of service delivery that required improvement. Partnerships with other agencies and organisations enabled appropriate sharing of information that in turn provided seamless care for people.

Staff described communication as effective. The daily flash meetings were held with a member of staff from each department such as cook, housekeeper, and activity planner. Information discussed was then shared with all the staff team and recorded for staff to refer to if needed. The deputy manager told us, "As well as the flash meetings we have a communication book, daily diary and recorded handovers". Staff told us they received regular supervision and staff meetings whereby they could ask any question or raise concerns. Staff told us they felt appreciated in their roles and spoke enthusiastically about both the people they cared for and their work colleagues.

The home had a warm friendly environment as identified by all those we spoke with. There was information on walls and tables throughout the large reception area of the home. Guidance was provided in relation to the home and how to access other services for example, safeguarding or advocacy services. Updated information was available on the menu of the day, planned activities and events. Information in relation to the new provider, statement of purpose.

The registered manager had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner.

The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. The previous rating was displayed in the home and on the provider's website in line with our requirements.