Oakray Care (Little Hayes) Ltd

Little Hayes

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Little Hayes 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. Little Hayes is registered to provide accommodation and personal care for up to 34. At the time of the inspection there were 18 people living at the service, most of whom were living with dementia.

What life is like for people using this service:
• We found further improvement was needed to the home's environment to make it safe and more supportive of the people who lived there. Staff did not always follow best practice guidance for managing medicines. Some people were at risk of being deprived of their liberty unlawfully and more information was needed to help ensure people's end of life wishes and preferences would be met.
• There was a new management team in place. Quality assurance systems were still being developed and further time was needed for them to become fully effective.
• However, people were happy living at Little Hayes. They told us their needs were met in a personalised way by staff who were competent, kind and caring. They said the culture of the service had improved and was more person-centred.
• People were empowered to make all their own choices and decisions. They were involved in the development of their personalised care plans that were reviewed regularly.
• People knew how to raise concerns. They had confidence in the home manager and told us they would recommend the home to others.
• The service has been rated requires improvement as it met the characteristics for this rating in three of the five key questions. More information is in the full report, which is on the CQC website at: www.cqc.org.uk

Rating at last inspection:
The service was rated as requires improvement at the last full comprehensive inspection, the report for which was published on 27 February 2018.

Why we inspected:
This was a planned inspection based on the previous inspection rating.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-led findings below.

Little Hayes

Detailed findings

Background to this inspection

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

Inspection team:
The inspection was conducted by two inspectors 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.

Service and service type:
Little Hayes is a care home registered to accommodate up to 34 people who need support with personal care. The service did not have a manager registered with the Care Quality Commission. However, by the end of the inspection the home manager had started the application process.

Notice of inspection:
We did not give notice of our inspection.

What we did:
Before the inspection, we reviewed information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information the provider sent us in the Provider Information Return. 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.

During the inspection, we gathered information from:

- 10 people who used the service
- Two relatives of people who used the service
- A healthcare professional who had regular contact with the service

- Five people's care records
- Records of accidents, incidents and complaints
- Audits and quality assurance reports
- The home manager
- The deputy manager
- Seven members of care staff
- Three housekeepers
- The chef
- The activities coordinator
- The maintenance manager
- The provider's quality performance manager
- The provider's regional manager
- The provider's nominated individual

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management:
• At our previous inspection in January 2018 we found individual and environmental risks were not always managed safely. This was a breach of regulations. At this inspection we found action had been taken, although some further improvement was still needed.
• Two upper floor windows did not have restrictors in place to prevent people falling through them; an unlagged hot water cylinder in an unlocked cupboard and two uncovered radiators in a main corridor put people at risk of burns; and hazardous liquids stored in an unlocked room put people with cognitive impairment at risk of poisoning. We discussed this with the home manager who took immediate action to address these concerns.
• Fire detection and management systems were monitored regularly and people had individual evacuation plans in place. However, two staff members were unclear about the evacuation procedures. We raised this with the home manager, who undertook to deliver additional fire safety training to staff.
• Risk assessments were in place for individual risks to people, such as the risk of skin breakdown and the risk of falling. When people experienced falls, enhanced risk assessments were completed, which considered extra factors that put the person at risk. These did not include environmental factors, such as the layout of the person's room or lighting levels; however, the home manager undertook to add this to the assessment form.
• Other risks to people were managed appropriately. Checks of the water quality were conducted regularly and we found appropriate action had been taken when the results identified concerns. The temperature of the hot water was monitored periodically, including during the inspection, which confirmed it was within safety limits at all outlets.
• Lifting equipment, such as hoists, were maintained according to a strict schedule. In addition, gas and electrical appliances were checked and serviced regularly.

Using medicines safely:
• Arrangements were in place for managing medicines and staff had been trained and assessed as competent to do so safely; however, we found best practice guidance was not always followed.
• Medicines that had not been used and were awaiting return to the pharmacy were stored in a secure cupboard. A record was made of these medicines in the 'returns book', but not until they were about to be returned. This meant the medicines in the cupboard were not accounted for, for up to four weeks; this posed a risk that managers would not be aware if any went missing during this period.
• In addition, a medicine that should be taken before food was being given to the person at or after breakfast, which meant it might not have been fully effective; another person had not received their prescribed medicines as staff had incorrectly believed they should only be given on an 'as required' basis; and the topical cream charts for a further person showed their creams had not been applied as often as

needed. We raised these issues with senior staff who took immediate action to address the concerns.

Preventing and controlling infection:
• Staff had been trained in infection control techniques and usually followed safe operating procedures to reduce the risk of infection; for example, they used personal protective equipment, including disposable gloves and aprons, when delivering personal care to people. However, during an activity session we observed a staff member who was not wearing gloves applying hand cream to two people from the same tub. This posed a risk of cross contamination. We raised this with the home manager, who assured us they would address the issue without delay.
• The home was clean and staff completed regular cleaning in accordance with set schedules. The laundry had been refurbished since the last inspection. It was well organised to reduce the risk of cross contamination.
• The kitchen had also been refurbished since the last inspection and had consistently maintained a rating of five stars (the maximum) for food hygiene.
• Regular audits and monitoring of the cleanliness of the home and infection control procedures were undertaken.

Staffing levels:
• People told us there were enough staff to support them and to meet their needs in a timely way. One person told us, "There are enough staff and they're pretty good at answering my bell."
• The home manager told us staffing levels were based on people's needs; however, they did not use a recognised tool to support a systematic approach to setting staffing levels. The provider's regional manager told us an appropriate tool was used in the provider's other homes and would be introduced to Little Hayes in the near future.
• The provider had clear recruitment procedures in place. Records confirmed these were followed and had helped ensure that only suitable staff were employed.

Systems and processes to protect people from the risk of abuse:
• People said they felt "safe" and "comfortable" at the home. One person told us, "I feel safe, there's nothing to worry about here. I feel comfortable with all the staff."
• Appropriate systems were in place to protect people from the risk of abuse. Staff had received safeguarding training and knew how to prevent, identify and report allegations of abuse.
• Safeguarding incidents had been reported and investigated thoroughly, in liaison with the local safeguarding team.

Learning lessons when things go wrong:
• Incidents and accidents were monitored closely and reviewed to identify any learning which may help prevent a reoccurrence. For example, following one fall, a person had been given a raised toilet seat with handles to reduce the risk of another fall.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Ensuring consent to care and treatment in line with law and guidance:
People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
• We checked whether the service was working within the principles of the MCA and identified some concerns. Two DoLS authorisations had been made and one was awaiting assessment by the local authority. However, the managers acknowledged this was a low number of authorisations, given that most people were living with a cognitive impairment and were not free to come and go as they wished, as the doors were kept locked. This meant some people might have been deprived of their liberty unlawfully. The home manager undertook to review the DoLS status of everyone living at Little Hayes and submit further DoLS applications as necessary.
• Staff protected people's other human rights by following the Mental Health 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 made on their behalf must be in their best interests and as least restrictive as possible.
• Where people did not have capacity to make decisions, best interests decisions had been made in consultation with family members and other relevant people. We heard staff seeking verbal consent from people in an appropriate way before providing support. For example, a staff member said, "Ready steady" before helping someone up and the person replied, smiling, "Go".

Adapting service, design, decoration to meet people's needs:
• Some adaptations had been made to the home to meet the needs of older people with reduced mobility. For example, a passenger lift gave access to the first floor and bathroom doors were painted in bright colours to make them easier for people to find.
• However, we identified there was a lack of handrails along corridors that were used regularly by people. This could put people at increased risk of falls or might dissuade them from mobilising independently. We discussed this with the home manager, who told us they planned to complete a comprehensive review of the home environment, using a nationally recognised tool, to help ensure it was fully supportive of people living at the home.
• Should they wish to, people could have their own furniture, personal fixtures and fittings in their bedrooms to make their rooms feel more homely.
• People had level access to a flat, enclosed garden area which we were told people enjoyed using in warmer weather.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• Comprehensive assessments of people's needs were completed before people moved to the home. These identified people's needs and the choices they had made about the care and support they received. If people were admitted to hospital, fresh assessments were completed before they returned to check that staff would still be able to meet their needs.
• Staff followed best practice guidance. For example, they used nationally recognised tools for assessing the risk of skin breakdown and the risk of malnutrition. They then acted to achieve positive outcomes for people identified as at risk.
• Staff made appropriate use of technology to support people. An electronic call bell system allowed people to call for assistance when needed and pressure-activated alarms, linked to the call bell system, were used to alert staff when people moved to unsafe positions.

Staff skills, knowledge and experience:
• People and family members told us staff were competent. For example, one person said, "Most of the staff know what they're doing and do it well."
• Staff completed a range of training to meet their needs, most of which was refreshed and updated regularly. Although some training was slightly overdue, this was planned for the weeks following the inspection.
• New staff completed an induction programme before being allowed to work on their own. This included a period of shadowing a more experienced member of staff.
• Staff told us they felt well supported in their roles by the home manager. Comments from staff included: "I get 100% support. For example, I get called to the office and told how well I'm doing" and "[The manager] picks people up [if they do something wrong], but in a supportive way. It makes me feel valued".
• Staff received regular one-to-one sessions of supervision. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. Yearly appraisals had not been completed, to assess the performance of staff, but the home manager told us they planned to introduce these during the coming year.

Supporting people to eat and drink enough with choice in a balanced diet:
• People's dietary needs were assessed and met consistently. People were offered regular meals, including regular snacks. A large, picture-based menu board was used to help people choose their meals and alternatives were suggested if people did not want any of the menu options for the day.
• There was a positive atmosphere at lunchtime, during which staff were attentive to people. People sat in small groups and clearly enjoyed mealtimes as a social occasion.
• Staff monitored the amount people ate and acted if people started to lose weight. For example, they referred people to GPs or specialists for advice and offered meals fortified with extra calories. We observed a person living with dementia who had eaten very little of their meal being skilfully tempted with a wide range of desserts; the staff member described each one in turn, giving the person time to respond, before moving on to the next option. The person eventually chose some ice cream and ate it all.
• Several people commented on the extra care taken with their meals if they were unwell. For example, one person said, "They [staff] know if you're unwell and they get you soup or a sandwich that you could eat."
• A choice of drinks was available and accessible to people throughout the day and we heard staff encouraging people to drink often.

Staff providing consistent, effective, timely care:
• People told us they received all the support they needed at the time they needed it. One person said of the staff, "They help me a lot. They help me walk to keep me mobile. I was frightened, but they've helped me overcome my fear."
• We observed people being supported in a safe way when staff supported them to move. When talking to

people living with dementia, staff faced people, used short simple questions and gave them time to respond.
• People were supported to access healthcare services when needed. Care records confirmed people were regularly seen by doctors, specialist nurses and chiropodists. A community nurse told us, "Staff are switched on, I've got no concerns. There's a nice atmosphere and staff are attentive to people."
• When people were admitted to hospital, staff provided essential information about the person to the medical team, to help ensure the person's needs were known and understood.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were supported and treated with dignity and respect; and were involved as partners in their care.

Ensuring people are well treated and supported:
• People told us they liked living at Little Hayes and were treated with consideration. Comments from people included: "We've got a chef who's always got a smile on his face. If I'm not feeling well, he'll give me something different, I don't know how he knows" and "It's a good place to be, they [staff] give you the opportunity to have a good life". A family member said of the staff, "They've been lovely here, very friendly."
• We observed people were treated with kindness and compassion. Staff spoke respectfully to people and supported them in a patient, good-humoured way. There was banter and laughter between staff and people. Staff used touch appropriately, including hugs and kisses for people who responded positively to a tactile approach.
• People were supported in a caring way; for example, when a person went into the garden to smoke, a staff member immediately asked if they wanted "a jumper or a coat" as it was a cold day. When a staff member gave positive and genuine praise for a piece of art a person had produced, we saw the person had tears of happiness and smiled.
• When we spoke with staff, they showed a good awareness of people's individual needs, preferences, backgrounds and interests.

Supporting people to express their views and be involved in making decisions about their care:
• People's protected characteristics under the Equalities Act 2010 were identified as part of their needs assessments before they moved to the home.
• Any identified needs were detailed in people's care plans. This included people's needs in relation to their culture, religion and diet. Most staff had not completed any equality and diversity training, so we could not be assured that people's needs would be met consistently in practice. However, the home manager told us they would explore ways of delivering this training to staff in the near future.
• Records confirmed that people were involved in meetings to discuss their views and make decisions about the care provided. This included their choice of activities, food and how they wished to be supported.
• Family members were kept up to date with any changes to their relative's health needs.

Respecting and promoting people's privacy, dignity and independence:
• People were encouraged to do as much as they could for themselves. For example, staff described how some people could brush their hair if handed a brush and their teeth if the toothbrush was prepared for them.
• A staff member told us, "I get people to do as much as they can as I don't want to take their independence away, even if it's just picking their own clothes."
• Some people were offered support to eat at lunchtime. If this was declined, staff gave people the opportunity to attempt their lunch before help was offered again. Other people had been given plate guards

to make it easier for them to eat independently and one person was offered a spoon in exchange for their knife and fork, which they were struggling to use.
• Some people told us they preferred to have a staff member of a particular gender to support them with personal care and said this was respected.
• Staff described how they protected people's privacy and dignity. This included listening to people, respecting their choices and closing doors and curtains when providing personal care.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were met through good organisation and delivery.

Personalised care:
• People told us their needs were met in a personalised way. Some told us the approach of staff had changed with the appointment of the new home manager. This encouraged staff to put people at the heart of the service and to be led by them. One person said, "It used to be very regimented, but it's more relaxed now. I can have a lie-in in the morning if I want. They just say, 'Ring when you want to get up'."
• People were empowered to make their own decisions and choices. They could choose when they got up and went to bed, where they took their meals and how they spent their day. One person told us, "I can go to bed when I like and I can stay up late if I want to watch a film." A staff member confirmed this and said, "The changes have been brilliant. We no longer get people up early just for breakfast. They get up as and when they want to. It's 24/7 care here, so there's no rush."
• Care plans had been developed for each person. These provided sufficient information to enable staff to provide support in a personalised way. People's daily care records confirmed that care and support had been delivered in line with people's care plans.
• Staff responded promptly to changes in people's needs. For example, special arrangements had been made for one person who wanted company at mealtimes but couldn't cope with the busier dining area. If people experienced head injuries during a fall, staff monitored them for at least 24 hours to check for signs of neurological injury.
• People's communication needs were met. For example, most information was available in accessible, picture based formats with large print. The breakfast cereals in the dining room were stored in glass jars on a trolley that staff took round to people. We were told this helped people make informed decisions about their breakfast choices.
• A staff member described how they supported a person living with dementia to make choices; they said, "[The person] can't verbalise, but they can take me and show me what they want or will point. You just have to take your time and not rush them."
• People had access to a wide range of activities. These included regular trips to the local shops, craft work, cooking, singing, quizzes, interactions with animals and sessions of reminiscence. To help prevent social isolation, staff had started a novel project supporting people to develop pen pals in another of the provider's homes. The initiative was still in the early stages, but demonstrated an innovative approach to activities support.

End of life care and support:
• Most staff had experience of delivering end of life care. Some had received relevant training and further training was planned for the coming year. Staff expressed a commitment to supporting people to have a comfortable, dignified and pain-free death.
• Letters from the families of people who had recently died at the home commended staff for the compassion and care they had shown. For example, one thanked staff for "all your love and kindness to [my

relative]".
• However, people's end of life wishes and preferences were not recorded in their care plans and an end of life care plan had not been in place for a person who had died recently. Therefore, we could not be assured that people's wishes and preferences would be known and met. We discussed this with the managers, who told us of plans to work with local healthcare professionals to develop end of life care plans for people where needed.

Improving care quality in response to complaints or concerns:
• There was an accessible complaints procedure in place and people told us they felt happy speaking with management if they had any concerns.
• The complaints policy was advertised on the home's notice board and was available in a large-print and picture based formats.
• The home manager described how they would use learning from any complaints to help drive improvement within the service and gave examples of when they had done so, for example by changing the menu.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

• At our previous inspection in January 2018 we found the provider had failed to operate effective systems to assess, monitor and improve the service. This was a breach of regulations. At this inspection we found action had been taken, but further improvement was required.

• Individual concerns raised at the previous inspection had each been addressed effectively; for example, the laundry had been refurbished, risk assessments had been completed where they were lacking and hot water temperatures had been monitored.

• The provider operated four other homes. They had developed standard policies and procedures which were being used in all their homes, including quality assurance processes. Although these had not been fully embedded at Little Hayes, work was in hand to achieve this. The provider had recently appointed a regional manager and a quality assurance manager who were working closely with the home manager to implement a series of improvements. These included actions to address each of the concerns we identified during the inspection.

• The quality assurance processes already in place included daily "floor walks". These had proved effective in identifying concerns and had brought about improvements. For example, they had identified areas that needed extra cleaning and the need to monitor the frequency of people's baths more closely.

• There was a management structure in place, consisting of the provider's quality assurance manager, the regional manager, the home manager, the deputy manager and senior care staff. The management team was new and needed time to become fully effective; for example, individual roles and responsibilities were still being developed and the home manager recognised they needed to delegate more tasks to other senior staff.

• To comply with the conditions of their registration, the provider is required to ensure that the home is managed by a registered manager; this is a manager registered with CQC with legal responsibility for how the service is run and for the quality and safety of the care provided. However, the home manager, who had been in post for three months, had not applied to register until we pointed this out during the inspection. They told us this was because they had been focused on other, more pressing priorities, including reviewing people's care plans and bringing about a more person-centred approach to care.

• The provider is required to notify CQC of all significant events. This helps us fulfil our monitoring and regulatory responsibilities. Whilst all routine notifications had been made, we found the provider had not notified CQC when the previous registered manager had left the service in November 2018. The provider's nominated individual acknowledged this was an oversight and assured us they would do this consistently in future.

Promoting person-centred care and support and a positive culture that is open, inclusive and empowering, which achieves good outcomes for people:
• People told us the service was run well and they would recommend it to others. One person said, "They've done a good job all the time I've been here." Another person described the home manager as "a little darling".
• Some people told us they had not always felt listened to in the past, but said the culture of the service had started to change following the appointment of the new home manager. One person said, "I see the new manager a lot, she's very good. She wants to make it a happy home and she seems very easy going." This was echoed by staff, one of whom told us, "[The home manager] has made a big difference. We used to be task orientated but there's a totally different atmosphere now; people are so much happier." Another staff member described the home manager as "the most caring person I've ever met".
• The home manager described their vision for the home, which was to put people at the heart of the service and create a "happy environment for people and staff". They added, "I tell people, 'It's your home, not ours'." From our observations, it was clear that staff understood and had a shared commitment to delivering that vision.
• The home manager demonstrated an open and transparent approach to their role. Where people had come to harm, relevant people were informed, in line with the duty of candour requirements and the previous CQC rating was displayed prominently.
• Friends and family members could visit at any time. They were made to feel welcome and were offered meals and drinks.

Engaging and involving people who use the service and staff:
• The provider consulted people in a range of ways. These included quality assurance surveys, residents' meetings and one-to-one discussions. The home manager had acted on people's comments; for example, people had asked for condiments on the tables and we saw these were in place; people asked for more trips to local attractions and these had been arranged. One person told us, "We're very lucky; our manager is always asking if we're okay and if anything can be improved."
• Staff told us they felt engaged in the way the service was run and enjoyed high levels of morale. Comments from staff included: "I love it here, I look forward to coming to work, everyone works well as a team", "We have a good team. We don't argue, we just crack on with the work" and "I'm very impressed with the new manager. If I go to her with an idea, she'll say, 'Yes, let's try and achieve that'. I feel listened to. The atmosphere has lifted; it's more relaxed and happier."
• Staff spoke positively about the home manager, describing them as "approachable" and "supportive". Comments from staff included: "The new manager is lovely, she comes out on the floor and puts residents first. Things are more relaxed and I'm allowed to get on with my job"; and "There's a common goal. Everyone wants to strive to improve, to raise standards and make sure everyone is happy and the care is as good as it can be".

Continuous learning and improvement:
• The provider analysed feedback from people, staff and audits. They used the findings to drive improvement, as evidenced in the action they had taken following the previous inspection.
• They had recognised the need for greater support for home managers and had enhanced the management team to achieve this and provide improved oversight.

Working in partnership with others:
• Staff had links to other resources in the community to support people's needs and preferences. These included links with local church communities and children who visited the home to interact with people.
• The providers and the registered manager had worked with social care professionals and the local authority to develop and improve the service.