Care Quality Commission

Chartbeech Ltd

Hay House Nursing Home

Inspection report

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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

Overall summary

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 and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

Hay House Nursing Home is registered to provide accommodation and nursing care for up to 35 older people. It provides a service for people with dementia as well as other mental health conditions. On the day of our inspection 30 people were living at the home. The home has a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act, and associated regulations, about how the service is run.

On the day of our inspection there was a very calm, friendly and homely atmosphere. People appeared

Summary of findings

relaxed and happy. People, their relatives and health care professionals all spoke highly about the care and support Hay House Nursing Home provided. One person living with dementia who had been dozing in a chair after breakfast was relaxed and smiling and said “I like it here." Another person told us; “It’s nice here. I’ve always liked it. The people are nice.”

The environment encouraged people to be independent if able. The décor of the building had been carefully thought out and took account of people’s needs. For example, people living with dementia were enabled to access bathrooms using pictorial signs and plain flooring to facilitate independent mobility. People who were able, moved feely around the building and its grounds as they chose. Staff actively supported people in meaningful activities and to access the grounds. People were involved in decisions about proposed changes, to further enhance their day to day lives.

Information we requested was supplied promptly. Care records were comprehensive. We discussed the format with the registered manager, as there was a lot of unnecessary information making it more difficult to find details about how to provide care. The provider had already noted this and they were discussing adding summaries and simplifying the format to make it more person centred. However, plans contained detailed person centred information about how individuals wished to be supported. People’s preferred method of communication was taken into account and respected. People’s risks were well managed, monitored and regularly reviewed to help keep people safe. People had choice and control over their lives and were supported to take part in a varied range of activities both inside the home and outside in the community. Activities were meaningful and reflected people’s interests and hobbies.

Staff put people at the heart of their work, they exhibited a kind and compassionate attitude towards people. Strong relationships had been developed and practice was person focused and not task led. The home’s philosophy was about providing care for people with dementia which was person centred and individualised. Staff told us that focussing on this philosophy had really “opened their eyes” and changed their understanding of people and the way they worked with them. They said the home had become “more homely and relaxed” and there was less of a routine.

The service had an open door policy, relatives and friends were always welcomed and people were supported to maintain relationships with those who matter to them. During the inspection people frequently came in to join the responsible manager and provider in their office. They were welcomed in, sat in an armchair and made themselves at home.

Staff were well supported through induction and ongoing training. Staff were encouraged to enhance their skills and professional development was promoted. Staff felt that the general training they received equipped them for the job. They could ask for specific training as the need arose, for example related to pressure area care and tissue viability. They emphasised that much of the care they provided was very individual according to the needs and preferences of the person, so the knowledge they needed was very specific.

Staff understood their role with regards the Mental Capacity Act (2005) (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Applications were made and advice was sought to help safeguard people and respect their human rights. All staff had undertaken training on safeguarding adults from abuse, they displayed good knowledge on how to report any concerns and described what action they would take to protect people against harm. Staff told us they felt confident any incidents or allegations would be fully investigated. People told us they felt safe.

People knew how to raise concerns and make complaints. People told us concerns raised had been dealt with promptly and satisfactorily. Any complaints made were thoroughly investigated and recorded in line with Hay House’s own policy. Learning from incidents had occurred and been used to drive improvements.

The service had a very open and transparent culture. Staff described the management as very supportive and approachable. Staff talked positively about their jobs. Staff told us that they had a “lot of confidence in the registered manager.” They described her as “very supportive”, a “good listener” and said they could go to her with any issues. She was caring towards the staff and understood they needed to be well supported in order to care effectively for people at the home. One member of staff told us, “The home is like my family. I want to put all my energy into it.” Staff were encouraged to come up with innovative ways to improve the quality of care people

Summary of findings

received. Staff felt listened to and empowered to communicate ways they felt the service could raise its standards and were confident to challenge practice when they felt more appropriate methods could be used to drive quality.

People's opinions were sought and there were effective quality assurance systems in place that monitored people's satisfaction with the service. Timely audits were carried out and investigations following incidents and accidents were used to help make improvements and ensure positive progress was made in the delivery of care and support provided by the home.

Summary of findings

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. There were sufficient numbers of skilled and experienced staff to meet people's needs.

Staff had received appropriate training in the MCA and the associated DoLS. Staff displayed understanding of the requirements of the act, which had been followed in practice.

Risk had been identified and managed appropriately. Assessments had been carried out in line with individual need to support and protect people.

Medicines were well managed and administered.

Is the service effective?

Good

The service was effective .People received good care and support that met their needs.

Staff received on-going training to make sure they had the knowledge and the skills to carry out their role effectively. The service worked in partnership with other organisations and health professionals to make sure staff were trained to follow best practice.

Strong emphasis was placed on eating and drinking well. People were supported to maintain a healthy diet to improve their well-being.

Is the service caring?

Good

The service was caring. People were supported by staff that promoted independence, respected their dignity and maintained their privacy.

Positive caring relationships had been formed between people and supportive staff who were motivated to provide good quality, person-centred care.

People were informed and actively involved in decisions about their care and support. The service was creative and supportive in the way it involved people and their families and respected diverse needs.

Is the service responsive?

Good

The service was responsive. Care records were personalised and met people's individual needs. Staff had an excellent understanding of how individual people wanted to be supported.

Activities were meaningful and were planned in line with people's interests.

Is the service well-led?

Good

The service was well-led. There was a sustained open culture. Management were approachable and defined by a clear structure.

Quality assurance systems drove improvements and raised standards of care. Innovative systems were promoted and implemented regularly to provide high quality care.

The service had a clear vision to achieve a good quality service and sought out and consistently worked towards implementing best practice knowledge.

Hay House Nursing Home

Detailed findings

Background to this inspection

This inspection was unannounced, which meant the provider and staff did not know we would be visiting. At the last inspection on 13 November 2013, we did not identify any breaches of legal requirements and all the inspected standards were met.

The inspection was undertaken by two inspectors for adult social care. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service, previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with 12 people who used the service, two relatives, the provider and another director, the registered manager and eight members of staff. We also spoke with a visiting GP.

Some people we spent time with were unable to directly comment on their experiences due to living with dementia. We therefore looked around the premises and observed how staff interacted with people throughout the day. We also looked at seven records related to people's individual care needs, three staff recruitment files, and records associated with the management of the service, including training and quality audits.

Good

Is the service safe?

Our findings

People consistently told us they felt safe and were relaxed and looked content throughout the day. One person told us; "What more could you ask for, I can even ask for a fry up if I want." Another person said, "I can go where I want. I like this seat where I can look out the door at the trees with the cat." A relative said; "It's a lovely place, I don't have to worry."

People were supported to take everyday risks. We observed people who were able to, move freely around the home and its secure gardens. People made their own choices about how and where they spent their time. Staff were always visible around the home and were vigilant when people showed they required assistance or were unable to verbalise their need due to living with dementia. One person was trying to open the patio doors and immediately staff assisted them, ensuring they had their stick, and walked with them outside. Where possible, people were encouraged to go out independently into the local community. To facilitate this the provider was devising booklets to share with the local community and shops. This would explain about how dementia affected people and how to help people be more independent within the wider community, when using the shops or post office for example. Staff had actively advocated on behalf of one person living with dementia with neighbours. This enabled the person to walk in safe areas independently around the grounds, and to continue doing a hobby they loved. A risk assessment recorded concerns raised by the neighbours and noted actions to address the risk and allow the person to maintain independence. This respected the person's right to freedom and helped keep them safe.

Staff received training in how to recognise and report abuse and told us that the home had a clear policy on this. This was part of the induction training and reinforced in one to one and group supervision. They had a clear understanding of what may constitute abuse and how to report it, and told us this was the responsibility of every member of staff, regardless of their role at the home. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. Staff knew who to contact externally should they feel their concerns had not been dealt with appropriately. The registered manager gave us examples of where they regularly contacted the local safeguarding team for advice. One member of staff was trained as a trainer in safeguarding so staff could directly access them for advice also.

There were enough skilled and competent staff to help ensure the safety of people. Staff told us there were always enough staff on duty to support people. The staff rota showed there were two registered nurses, six care workers, an activities co-ordinator, a cook and kitchen assistant, two domestics (three on two days a week), the provider, the registered manager and an administrator/receptionist available each day. Management cover was less at weekends covered by an on call system but the care staffing levels remained the same. The provider had just recruited a registered nurse specialising in mental health care.

Care and support was given in a timely manner. For example, staff were assisting people to move from the dining room to the lounge following breakfast. Breakfast was available when people wanted it so staff responded when people wished to move. Staff were quick to come together as pairs to use mobility hoists for people. They clearly described what they were doing in a caring way, ensuring people were not anxious. They left people with a call bell if appropriate, and with the things they needed. One person who was nursed in their room was constantly being checked to ensure they had enough drinks and were comfortable. This regular checking was part of their risk assessment. The registered manager said the staff rota allocated staff to named people around the two floors of the home each day, divided into three areas. Staff allocation changed each day. This meant that all staff were aware of each person as an individual and knew about their needs

Staff were knowledgeable about people who could display behaviour that may challenge others. Care records, where appropriate, documented behaviour which might have been challenging for staff. Forms were used to record events before, during and after an incident where a person had become distressed. The information was reviewed to identify any common triggers, and the action taken to defuse the situation noted, to allow learning to take place. The incident was then logged in the persons care record and discussed with staff during daily handovers. This had helped staff to keep people safe, for example, one person had been given a room near the front door due to some

Good

Is the service safe?

agoraphobia and now appeared settled. Another person could become distressed and aggressive if they required the bathroom. Staff offered assistance regularly to minimise this. Another person could be at risk of self-neglect and isolation. Staff ensured they interacted with them and brought them snacks and finger food to encourage eating. The registered manager gave us other examples where recording had ceased as the actions they had taken had stopped the distressing behaviour.

Staff recruitment records showed appropriate checks were undertaken before staff began work. Disclosure and Barring Service checks (DBS) had been requested and were present in all records. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service. Staff files contained evidence to show where necessary, staff belonged to the relevant professional body. The registered manager had a system that flagged when professional registration had expired so checks could be carried out to ensure it had been renewed. This showed the provider checked with the relevant professional body that the staff member had the skills and qualifications necessary to perform and carry out safe practice under the title they used. One staff member's DBS check came back showing a previous conviction. The file showed the registered manager had discussed and completed a risk assessment with the employee. The responsible manager had then amended the service's application forms so that applicants were clearly asked to declare and provide detail about any previous convictions. This helped to minimise any risk to people from unsuitable staff.

Medicines were managed, stored, given to people as prescribed and disposed of safely. Staff were appropriately trained and confirmed they understood the importance of safe administration and management of medicines. We looked at eight medicines administration records (MAR). All had been correctly completed. Medicines were locked away as appropriate and where refrigeration was required temperatures had been logged as well as opening and expiry dates. Staff were knowledgeable with regards to people's individual's needs related to medicines. For example, staff administered medicines individually from the treatment room, locking the door between each visit. They looked at the person to see if the medication was appropriate. For example, records showed where medicines were omitted correctly because the person was asleep. This was then followed up and discussed with the GP to prescribe an earlier time.

The home has a local pharmacy and dispensary service. This meant they could access weekly rolling prescriptions rather than sending them in. Medicines were generally delivered using the Nomad system. The home's relationship with the pharmacy meant they had quick access via the GP and dispensary to enable them to receive new medication promptly. For example, if staff thought a person had developed a urinary infection they could have antibiotics within the hour. Staff told us examples of how they regularly discussed changes in need relating to medication with the GP. For example, one person receiving respite care was on a certain medication queried by staff because of their symptoms. They then did not require this and felt better.

The treatment room was well organised. There was information about current medication issues on the walls such as national medicines alerts and homely remedies. An alert recommending a separate form to give details of blood sugars results had been actioned. There were details about people who had a medicine patch changed on certain days. We discussed recording of "as required" medication with the registered manager as some records within the MARs did not clearly show staff when to give the medication or if other actions needed to be tried first. For example, "as required" medication for agitation or anxiety or to state where the pain was.

The home was generally clean and staff used appropriate personal protection equipment (PPE). On the morning of the inspection there was an odour around an area on the ground floor. The registered manager and provider told us they were working to address the issue of odour at the home. Staff told us a focussed cleaning programme had been introduced. A recent summer newsletter for people and families acknowledged this odour and reassured people the home were dealing with it. When we visited on the second day there was no odour present. It had also been proposed that staff no longer had their own toilet, but that everyone at the home used the same facilities. Staff felt that not only was this important in terms of any 'us' and 'them' mentality, but that everyone would take

Good

Is the service safe?

responsibility for keeping things clean. The laundry was organised and clean with clear 'dirty to clean' areas. Care was taken with people's clothes, and individuals requiring mobility slings had named items to prevent cross infection.

Staff had a good understanding of the policy and procedures related to accident and incident reporting. It was the responsibility of the member of staff who found the accident/incident to involve the trained nurse and complete the accident/incident form. It was then the nurses responsibility to follow up. Records were clear and showed appropriate actions had been taken.

Good

Is the service effective?

Our findings

People felt supported by knowledgeable, skilled staff who effectively met their needs. One person living with dementia, who had been dozing in a chair after breakfast, was relaxed and smiling and said, "I like it here." A relative had recently written to the staff saying, " You should all be proud of the wonderful, homely atmosphere you have created. Your understanding of each resident as an individual has been a privilege to witness. We are lucky to have found you." A GP said, "I have no concerns, the staff all seem to know what they are doing."

Staff received an induction programme and ongoing training support. This gave them the skills to carry out their duties and responsibilities. During the first week of their induction staff covered key subjects like health and safety, manual handling, dementia care and fire safety. This training was done partly by the registered manager, who had done a train the trainer course, using taught group sessions, DVD's and one to one supervision. The second week for new staff was spent shadowing more experienced staff. Following this they had to be 'signed off' as competent in specific areas before they could work on their own. Even then, the registered manager ensured that new staff were always with a senior member of staff who explained everything as they worked together.

Staff files contained individual supervision records. Staff told us this was sometimes done in small groups, or one to one with the registered manager, and covered areas such as dignity, safeguarding, nutrition and the Equality Act 2010. Staff told us that the registered manager had also introduced a system of "self-appraisal". This provided an opportunity for staff to tell the registered manager how well they thought they were doing, and was a starting point for agreeing strengths and areas for improvement. Staff who worked in the kitchen and did the cleaning were also appraised in this way, as they needed the skills and understanding to work effectively with people at the home. One staff member said "I love it here, there's no better."

Staff felt the general training they received equipped them for the job. They could ask for specific training as the need arose, for example related to pressure area care and tissue viability. An eye care specialist in dementia and ageing vision had given training to staff at the home, for example. Staff emphasised that much of the care they provided was very individual according to the needs and preferences of the person, so the knowledge they needed was very specific. Care plans were always up to date and accessible to staff. The registered manager talked through the care plans of new people with the whole staff group, including kitchen and cleaning staff. Any changes in people's needs were discussed at the daily staff handover and reinforced by the registered manager who ensured that all staff were made aware. Senior care workers also randomly chose care plans on a regular basis to talk through with staff. A Qualifications and Credit Framework (QCF) assessor was visiting some staff for assessment during our visit. The QCF is an accessible framework providing flexible routes to full qualifications. There were six staff doing the health and social care diploma level 2 and 3, one staff member was doing a business qualification. The registered manager told us how they valued staff qualifications from abroad and sought to provide staff with ways to validate learning in the UK. The home also used the nationally recognised Skills for Care resources and were registered to share their training information and progress using this resource.

Staff were enthusiastic about the training they were doing with "Dementia Care Matters" a national company specialising in dementia care provision, in order to become a "Butterfly Home". This philosophy was about providing care for people with dementia which is person centred and individualised. Staff told us it had really "opened their eyes" and changed their understanding of people and the way they worked with them. The home had become "more homely and relaxed", and there was less of a routine. For example, people could choose when and where they wanted to have breakfast and when they wanted to get up and go to bed . The training had highlighted the importance of the environment being colourful and full of interesting things that people could use and enjoy. There was a woodland mural covering one wall, lots of plants that people could touch, memory boxes and "rummage" areas full of clothes to try on and items such as a silver cross pram and an old type writer. The home were looking into setting up the rooms each day with a different theme, to make them more interesting for people, for example, a seaside day. Staff were more aware of the language they were using, for example, they now talked about having a coffee, rather than "going for a break", as this implied you needed a break from people. The staff on the course were keen to share their learning across the staff group and were looking at how to "bring their learning back home".

Good

Is the service effective?

Adaptations had been made to the interior of the building and signage and decoration had been added to meet people's needs and promote independence. Around the home were items to look at, use and touch that took into account people's needs and provided stimulation. Pictures were placed on walls to evoke memories. Other pictures were used to spark reminiscent thoughts as well as large, colourful walls showing different views. Clear signs aided people to find their way around independently and seating was laid out to provide natural walkways. People had easy access to the gardens. A new conservatory had been built two years ago and allowed access to rear gardens which were secluded and secure. There were several places for people to sit and spend time alone or with each other as they chose.

People when appropriate, were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). The MCA is a law about making decisions and what to do when people cannot make decisions for themselves. DoLS is for people who lack the capacity to make decisions for themselves and provides protection to make sure their safety is protected. The registered manager was up to date with the recent changes to the law regarding DoLS and had a good knowledge of their responsibilities under the legislation. Care records showed where DoLS applications had been made. Applications had been made appropriately for all residents to be assessed under the Deprivation of Liberty Safeguards. (DoLS) following the Supreme Court judgement on 19 March 2014, which widened and clarified the definition of deprivation of liberty. The service was therefore meeting its requirements. Three had been approved and all other people had had appropriate applications made. They evidenced the registered manager had followed the correct processes and recorded the views of all the professionals and family involved in the decision. The decision was clearly recorded to ensure staff adhered to the person's legal status and helped protect their rights. We noted where the person could not physically sign to acknowledge involvement, records could be clearer that they had been involved, but were unable to sign.

Staff had received training in the MCA 2005 and told us how they were using the principles of the act on a daily basis. All staff were committed to supporting people to make choices for themselves as far as they were able. They told us that people had a right to make an unwise decision if they had capacity to do so. They understood that any decisions made on behalf of people lacking capacity should be in their best interests and proportionate. For example, a person who was very unsteady on their feet wanted to walk. They did not have capacity to understand the risk of falling. Rather than encourage them to sit down in a safe chair the staff walked alongside them to keep them safe, as that was what they wanted. One person's care plan documented a considered best interest decision in relation to their risks from smoking. The cigarettes and lighter were kept in the office. The person was able to smoke outside when they wanted to, with staff supervision and a smoking blanket to protect them and their clothes. This was the least restrictive option which recognised the person's right to smoke if they wished.

We observed practice during the lunch time period. People were relaxed and told us the meals were nice, hot and of sufficient quantity. Comments included; "Very nice", and "The food is very good." People were given a choice of meals and asked where they would like to eat. Some people decided to eat their meal in their room whilst others preferred to sit in the dining area or in the lounge or lobby. People were not rushed, but supported to have enough to eat and drink. We noted some people had chosen a meal but did not wish to eat it. These people were gently spoken with and offered an alternative. Staff engaged with the people and supported them appropriately.

Meals were appropriately spaced throughout the day and flexible to meet people's needs. A snack area provided finger food and drinks for people to access when they wanted. Staff were able to take drinks with people and this was encouraged. The cook told us how they were able to spend time talking with people who had complex needs. They would discuss the menu, go through what they could and could not have due to their medical condition, and offer a choice. They said the provider was very open to what food could be provided to ensure people's choices were respected.

Care records highlighted where risks with eating and drinking had been identified. For example, one person's record evidenced when staff sought advice and liaised with a speech and language therapist (SALT). The kitchen had clear records of who had what diet, such as Stage 1 fluids for example. The cook knew what each diet was and what consistency was appropriate. Where someone had a vegetarian diet the staff reassured the person that the meal

Good

Is the service effective?

was indeed vegetarian. Their meals were like non-vegetarian meals, so people could eat similar meals. There was plenty of fresh fruit and vegetables and meat was sourced from a local butcher.

Care records showed health and social care professional advice had been obtained regarding specific guidance about delivery of certain aspects of care. For example, there was a regular GP round at the home where staff could share concerns.. Staff had escorted one person to have their eyes tested to reduce anxiety. A specialist consultant had also been asked to visit the home rather than the person travel, which enabled the consultant to see the person in a more natural environment and address realistic issues. One person had had a wound and this had been addressed with the support of the local tissue viability team. On review the wound had healed quickly and progress had been recorded, noting specific issues such as swollen ankles. Health professional advice was recorded in care plans and recommended actions taken.

Records showed staff had made referrals to relevant healthcare services quickly when changes to health or wellbeing had been identified. For example, one person had become unwell. They had received prompt treatment from the out of hours doctor and there had been a clearly recorded transition from one type of medication to another.

Good

Is the service caring?

Our findings

People were generally unable to tell us directly about their experiences due to living with dementia or other conditions. However, people looked calm and comfortable and responded to us in a positive way and made comments such as "I'm happy", "it's a lovely place" and "I'm ok". A relative had made a comment in a personal profile stating, "when I visited I felt a warmth at Hay House." A recent quality assurance survey for families included comments such as "If it ain't broke, don't fix it! The staff are fantastic and I love them for the love they have given my [relative]", "The [staff] treat [the person] as an individual and keep me informed of all aspects of care" and "The staff are excellent and my [relative] lives in a very high standard home." One relative wrote "A special thank you to staff when [my relative] was ill recently and the staff were so helpful and kind when I was upset."

Friends and relatives were able to visit without restriction. There was an open door visiting policy and the environment offered a choice for people to meet in the company of others or in private, dependent on their choice. People told us they were supported by staff to have frequent contact with friends and relatives. During the inspection people living at the home frequently came in to join the registered manager and provider in their office. They were welcomed in, sat in an armchair and made themselves at home.

We observed staff interacting with people in a caring manner throughout the inspection. We saw that all staff, from care workers, to kitchen staff and management, treated people with dignity and respect. They asked permission before providing care, even if the person was not able to respond verbally. For example, one person was sitting with their feet on a foot stool. The care worker asked, "Shall I take your feet down?", and helped them to be more comfortable. People were spoken to and acknowledged as staff moved around the home. There were lots of offers of tea or toast or snacks in between meals if people wanted them, and staff were vigilant in identifying if someone was feeling anxious or becoming isolated. One person was waiting for their shower and staff were encouraging them to help with collecting breakfast bowls as they knew this reduced anxiety for them and they enjoyed being busy. Staff often repeated explanations for people before carrying out tasks to ensure people had understood. There was a sense of there being no hurry and the day was relaxed.

One member of staff told us they felt that not supporting people to make choices in their daily lives was neglectful. They emphasised the importance of communication, for example when people were not able to verbalise their wishes, and watching for body language and expression such as when offering a choice of clothes or food. One letter from a consultant mentioned how staff accompanying the person to the appointment had clearly been able to interpret what the person was saying and understood them. Staff also recognised when people's likes and dislikes changed over time, and even though they might have loved roast potatoes, for example, before they had dementia, staff wouldn't assume they still did.

When new people came to the home, staff spent time sitting and talking with the person and their family, in order to learn about their background and their preferences, and provide care in the way they would like. They also saw when families needed additional support and phoned people later when they had left their relative at the home. This was to relieve some anxiety and let families know how their relative was settling in. One person's care plan said that dogs had been invited to visit, as they were "significant others" in this person's world.

Staff showed concern for people's wellbeing in a meaningful way and responded to people's needs quickly. A person living with dementia was sitting in a wheelchair at a table after breakfast. Their blanket had fallen off and they had not wanted to put any trousers on. A care worker came in and got down on their level to speak with them, covering them up with the blanket and taking them to their room to get dressed, to maintain their dignity. The same applied to ensure people were clean after their meal.

Practice was not task focused but people led. Care plans identified how staff should respond to people's preferences, allowing people to live how they chose. For example, one person liked private time in their room. Staff were aware and tried not to disturb them if their door was shut. Their care plan recorded that this had been discussed with them. The registered manager also showed a caring response when asked to assess a possible new admission. They looked at how the person would fit in and considered the needs of current people living at the home. One

Good

Is the service caring?

person's relative had been distressed at the thought of using a care home they had seen on the hill from their home for many years. The registered manager told us how they had advocated for the relative with commissioners so they understood why Hay House may not be for this person. This showed understanding and care for people as individuals, rather than accepting each potential admission to fill beds.

One relative mentioned the staff did not wear name badges. The provider said they had a no uniform policy, which is common good practice especially for homes where people are living with dementia. However, they said they were compiling a staff photo board to improve staff identification. This had been discussed in the "Relatives and Friends Forum" meeting and recorded in the minutes for action. Other actions from this had included adding new staff details to subsequent newsletters stating their names and roles. This showed people and families were able to have input into the running of the home. Staff told us they could call a staff meeting if they had issues to discuss.

The home often cared for people at the end of their lives. The registered manager told us how they liaised with the local hospice and training was done in end of life care. The home had enrolled on a hospiscare education programme for developing and supporting the end of life care workforce. Staffing levels could be amended to ensure people had supportive care during the end of life. Each person at the home had a current decision about resuscitation wishes kept prominently in their care files. Staff said they attended funerals and often rang relatives to check how they were doing. Relatives and families were always welcome to visit at any time. There was provision for overnight stays and support. All staff were knowledgeable about each person including their families and friends and had good relationships with people. This was reflected in thank you comments received.

Good

Is the service responsive?

Our findings

Care records contained detailed information about people's health and social care needs. They reflected how each person wished to receive their care and support. Although records were organised and gave guidance to staff on how best to support people with person centred care, they were large files and could be difficult to extract information from about care needs. The provider had already identified this and was looking at simplifying records and adding a care summary and removing unnecessary information from working documents. Care plans were regularly reviewed to respond to changes in people's needs. Some reviews contained information not in the actual care plans and the registered manager was looking at improving this. A staff member said; "There is no hurry, we are able to sit with people and I feel I know them really well and their families." This was also encouraged in staff meetings and recorded in the minutes with examples of what staff could do with people especially when the activity co-ordinator was not working. The home employed volunteers and work experience students, who were also able to sit and chat with people. Families were involved in the care plan process and completed "This is Me" forms to enable staff to have a picture of each person's life as a whole. This information was used in the care plan. For example, one person loved to walk and another liked to sit outside and this was happening for them.

People received personalised care that was responsive to their needs. For example, one person had times when they were more mobile. Staff were aware to make the most of these times and involve them in activities they enjoyed. When there were particular individual behaviours behavioural issues these were respected. For example, one person did not like to wear continence pads at night and this was respected with staff discreetly changing bedding. Another person was prone to plugging their call bell into the wrong place so staff had ensured the lead was removed so they only had to press the button. One person had been admitted to the home requiring nursing in bed. Over time staff had got to know them and slowly encouraged them to get up and play dominoes which they had previously enjoyed. This person had had a career outdoors so staff placed their bed by the window so they had a good view of the countryside. The registered manager said they had then been able to have a better quality of life than previously hoped. We saw a letter from the family praising the staff team.

Care files contained relevant information for staff about people's health conditions. One care plan seen stated, "staff are now using the hoist for all transfers as [the person's name] can no longer weight bear safely". Risk assessments and care plans were detailed, and reviewed and updated monthly, including falls risk and waterlow scores, a score to monitor pressure area risk. MUST (nutritional assessments) were done weekly for someone at high nutritional risk. Care plans were put in place to manage specific situations, for example the management of a wound. All wounds we saw documented had now healed. This meant that staff had access to current information to support them when providing care for people. The care files of people with capacity to make such decisions showed they had been consulted in relation to their care and treatment, for example, whether to have a flu vaccine or bed rails. Best interest decisions (under MCA 2005) for people without capacity were clearly documented, along with guidance for staff about how to minimise risk while promoting people's independence. Care files showed that the service had referred people to external health professionals appropriately, such as Speech and Language Therapists and GPs.

People were supported to follow their interests and take part in social activities. For example, one care record stated that a person, where possible, liked to join in with activities that matched their interests, such as art. Daily notes contained activity charts that showed this had been respected. During our inspection we saw that this person was encouraged to partake in meaningful activity that reflected their individual preference.. Beyond that their art had been included in a home exhibition and one picture auctioned with consent from them and their family as part of the recent fete. They had moved to a bigger room to further enable their hobby. Staff were able to tell us about a book the person had written which they took home to read, and how they used this to start conversation.

After breakfast people were sitting in the lounge. Many people there found it difficult to communicate verbally. The activities co-ordinator made a point of talking to them individually. "Did you have a good night's sleep? You're a bit sleepy this morning." "Where would you like to sit?

Good

Is the service responsive?

Would you like to look out of the window?" She had a good understanding of people's background and interests. For example, she talked to one person about the royal family and passed some pencils and paper to someone who enjoyed drawing. She spoke with somebody else about some visitors the day before. "I see you had some visitors yesterday. A gentleman from [previous workplace] came to visit you." She used her knowledge of this person's history to help them to engage and enjoy the conversation, even though it was difficult for them to tell her about it themselves. Staff told us that people enjoyed trips out in the home minibus, for example to a nearby national trust property for coffee, drives, trips to the Zoo and to ride on a steam train. Lots of activities took place within the home. They had recently got a "music box", which was a karaoke machine where the words came up on the screen so everybody could join in. They often used this before lunch as they found that people were then more awake and in good spirits, so enjoyed their lunch more.

People were encouraged and supported to maintain links with the community to help ensure they were not socially isolated or restricted due to their disabilities. People enjoyed drives out, drama therapy, pampering, external musicians, singalongs, and other activities such as art and crafts. A recent fete had been well attended and involved families and friends. Activities were recorded on a daily basis to ensure people were not isolated and were offered activities they enjoyed. There were one to one chats and time was spent with people who were unable to leave their rooms. A person was sitting alone in the hallway, listening to music and eating toast. A care worker noticed their potential isolation and asked them if they were ok. They then brought a small side table for them to put their plate on and spent time with them. Care workers also encouraged people who needed a lot of support, to use the outside space and enjoy the garden saying, "Maybe we could go outside in the garden this afternoon? Would you like that?" A person who used a wheelchair was sitting outside after breakfast. They were unable to communicate their needs easily, but care workers came and checked regularly to make sure they were warm enough and happy to remain outside. We did notice after breakfast several people were sitting in the main lounge. There was conflict between music in the dining room and the television in the lounge, which were both on, making it difficult for people to focus on one thing or the other. The registered manager said they would monitor this and ensure television subtitles were on if appropriate.

The provider had a policy and procedure in place for dealing with any complaints. This was made available to people, their friends and their families. The policy was placed in each individuals service user pack and clearly displayed in several areas around the home. People knew who to contact if they needed to raise a concern or make a complaint. People, who had raised concerns, confirmed the issues were dealt with to their satisfaction without delay. Complaint had been responded to in a timely manner and thoroughly investigated in line with Hay House's own policy. Appropriate action had been taken and the outcome had been recorded and fed back. The registered manager told us, they used monthly audits to monitor concerns and complaints. Appropriate action was then taken to improve their service and raise standards of care. For example, actions were recorded and completed following staff meetings such as improving communication, providing bum bags for staff to use instead of pockets, and nail care and individual toiletry packs for people living at the home. This showed staff were also able to be involved regularly to drive improvement.

Staff told us their views were listened to and changes had been made at the service as a result of their suggestions. For example, one person who struggled to use a knife and fork had their own personalised cutlery. They also had a heated bowl as they ate slowly and this stopped their food getting cold. Staff suggested that a pack was made up for them to keep this all together, to save the person having to wait while staff looked for it in the kitchen. Three days after the suggestion had been made, the pack was in place.

Good

Is the service well-led?

Our findings

There was a strong emphasis on improvement and innovation at Hay House. Staff told us that the provider was "eager to move things on and change things". The registered manager and provider talked to us about their commitment to providing high quality care for people with dementia. Resources were actively sought out in relevant subjects. They were using the resources of "Dementia Care Matters" a national company specialising in dementia care, to consider becoming a "Butterfly Home". This model shifts the focus of care for people with dementia from a task centred one, to one based on emotional connection. Six members of staff were in the process of completing a twelve month training course. The home was also using the "Eden Alternative", which focused on the relationship between staff and people. It is a philosophy enabling people to live their lives with dignity, and as much independence, choice and control of their lives as they could manage. These philosophies were reflected in the way staff worked and how they spoke to people and to us.

Quality assurance arrangements at the service were robust. Bi-annual quality surveys were sent out to people and their relatives, and analysed by the provider, who published the results in a newsletter. Results were positive with 53% rating care overall as excellent. The newsletter detailed people's comments in general such as "good staff manners, friendly, caring staff, clean and tidy, go the extra mile and keeping relatives informed." It then detailed things people would like to see changed and how the home was improving any areas highlighted. For example, details of maintenance projects and how the home were trying to address an on-going odour.

Staff told us they had a "lot of confidence in the responsible manager." They described her as "very supportive", a "good listener" and said they could go to her with any issues. She was caring towards the staff and understood they needed to be well supported in order to care effectively for people at the home. At the same time, she would address any issues with staff and be clear about how they should do things differently. Staff meetings were held regularly and staff could call one themselves if they felt it necessary. One member of staff told us, "The home is like my family. I want to put all my energy into it."

Relatives and families had regular opportunity to discuss any issues or chat generally with staff and the management team. People were coming and going during the inspection and able to pop in to the office at any time. The home holds "Relatives Get Togethers". This had developed from relatives' meetings and now the home brought in speakers to encourage family involvement and understanding. For example, a speaker from the Alzheimer's Society with Hospice care experience. This had been well attended and become a support group for people and their families. The home had held a sponsored walk and a recent fete had included stalls run by family members, a local fire engine and majorettes. This showed an inclusive way of managing the home. Community involvement was important to the provider and they told of different ways they were hoping to involve the local village, businesses and neighbours to promote a better understanding of dementia and how to be a "dementia friend".

There were clear lines of responsibility and accountability within the management structure. The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. Staff were up to date with training and supported well with one to one supervision, group supervision and appraisals. Staff were aware of their roles but also worked together as a team, working with all people living at the home. All staff were included in training and valued. One new staff member was in charge of doing the new admission assessments with the manager's support to help them get to know people and what was expected.

Audits were done regularly and analysed to ensure patterns could be picked up and improvement made. For example, related to falls, medication and care plans. The home was also part of a group of homes who visited each others' homes to look objectively, as a peer review. One review had raised the issue of low lighting levels at Hay House in some areas, which may make it more difficult for people, especially those living with dementia, to move independently and safely. The provider was already looking into different bulbs to improve this.