Oakray Care (Little Hayes) Ltd

Little Hayes

Inspection report

Church Hill
Totland Bay
Isle Of Wight
PO39 0EX

Tel: 01983752378

Date of inspection visit:
18 January 2018
19 January 2018

Date of publication:
27 February 2018

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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

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.

The home accommodates up to 34 people and at the time of our inspection 27 people were living at the home. The home was based on two floors connected by two passenger lifts. There was a good choice of communal spaces where people were able to socialise and all bedrooms had en-suite facilities.

This inspection took place on 18 and 19 January 2018 and was unannounced. It was prompted by concerns identified at another service operated by the directors of the provider's company where systematic failings were found.

There was a registered manager in post at the service. 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 and associated Regulations about how the service is run.

We found the governance arrangements were not effective in ensuring the provider met their legal obligations and the service made necessary improvements in a timely way. Recommendations made by professionals from the Clinical Commissioning Group (CCG) had not been implemented.

An action plan to make improvements to the premises did not include all of the work that was required. A structural defect identified a year ago had not been repaired. Audits completed by managers had not always led to improvements and there was no process in place to audit people's care plans.

We found some individual and environmental risks to people were not managed effectively. Risk assessments relating to the use of bed rails and for a person at risk of choking had not been completed. We also found two fire doors were wedged open which would have posed a risk in the event of a fire. However, people were protected from the risk of falling and developing pressure injuries.

Infection control procedures in the laundry were not effective, although staff used personal protective equipment to reduce the risk of cross contamination when supporting people with personal care.

Appropriate recruitment procedures were in place, although these were not always followed.

Staff received training to help ensure they could meet the needs of the people they cared for. Some refresher training was overdue, but this had been scheduled. Staff said they felt supported in their work by the management.

Staff followed the principles of legislation designed to protect people's rights. However, the views of family members involved in decision making were not always recorded and managers were not clear about the criteria for applications to deprive people of their liberty.

Staff demonstrated an in-depth knowledge of people and their needs. However, people's care plans did not support staff in the delivery of personalised care as information in them was not always accurate or up to date.

People were supported at the end of their lives to have a comfortable, dignified and pain-free death, although people's wishes and preferences were not always recorded. This posed a risk their wishes might not be followed.

Effective systems and processes were in place to protect people at risk of abuse and staff understood their safeguarding responsibilities. There were enough staff deployed to meet people's needs. Medicines were managed safely and people were supported to take their medicines as prescribed.

People were usually supported to access healthcare services when needed, although referrals were not always made to speech and language therapists when needed. There were clear procedures in place to help ensure people received consistent support when they moved between services.

Adaptations had been made to the home to make it supportive of the people who lived there. People were complimentary about the food. They were supported to eat and drink enough. Staff monitored people's weight and took action if they experienced unplanned weight loss.

People were treated well, by kind and compassionate staff with whom they had built positive relationships. Staff promoted people's independence and involved them in decisions about their care. They protected people's privacy respected their dignity at all times.

There was a complaints policy in place and people felt able to raise concerns. People had access to a range of activities designed to meet their individual interests.

Staff enjoyed working at the home and felt valued by management. They communicated effectively between themselves and expressed a shared commitment to providing high quality care to people.

There was an open and transparent culture. Visitors were welcomed and the provider sought and acted on feedback from people.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

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.

Individual and environmental risks to people were not always managed effectively.

There were systems in place to protect people from the risk of infection; however, working practices in the laundry posed a risk of cross infection.

People who used the service said they felt safe and staff understood their safeguarding responsibilities, although two staff members had not completed safeguarding training.

Appropriate recruitment procedures were in place, but these were not always followed.

There were enough staff deployed to meet people's needs. Medicines were managed safely and people were supported to take the medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were met by skilled staff who were supported appropriately in their roles, although some staff refresher training in essential subjects was overdue.

Staff followed legislation designed to protect people's rights. However, managers were not clear about the criteria for applications to deprive people of their liberty.

The environment was supportive of the people who lived there. People were supported to eat and drink enough to maintain a balanced diet.

People were usually supported to access healthcare services. There were clear procedures to help ensure people received consistent support when they moved between services.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They developed positive relationships with people and created a homely atmosphere.
Staff supported people to maintain their independence and promoted choice.

Staff protected people's privacy and respected their dignity.

People and family members where appropriate, were involved in discussing and making decisions about the care and support people received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Information in people's care plans was not always up to date or reflective of their current needs. However, staff knew people well and demonstrated an in-depth knowledge of their individual needs.

People were supported at the end of their lives to have a comfortable, dignified and pain-free death, although people's wishes and preferences were not always recorded.

There was a complaints procedure in place and people felt able to raise concerns.

People were supported to access a range of activities and were encouraged to socialise.

Is the service well-led?

Requires Improvement

The service was not always well led.

The governance systems were not effective at ensuring the provider met their legal obligations and the service made any necessary improvements.

An action plan had been developed to make improvements to the premises, but this did not include all the work that was needed.

Audits conducted by managers were not always effective in identifying and making improvements to the service in a timely way.

Staff communicated effectively with one another, enjoyed working at the home and felt valued by management. There was an open and transparent culture and the provider sought and acted on feedback from people.	

Little Hayes

Detailed findings

Background to this inspection

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

The inspection was prompted by concerns identified at another service operated by the directors of the provider's company where systematic failings were found.

This inspection took place on 18 and 19 January 2018 and was unannounced. It was completed by three 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.

Before the inspection we reviewed all information we had received about the service, including notifications. Notifications are information about specific important events the service is legally required to send to us. We also reviewed information we held about other services operated by the provider.

We spoke with nine people who use the service and two family members. We spent time observing the way staff interacted with people who use the service. We also spoke with the registered manager, the deputy manager, eight care staff, an activities coordinator, a maintenance worker, a chef and a housekeeper. We received feedback from three health or social care professionals who had contact with the service.

We looked at care plans and associated records for seven people and records relating to the management of the service, including: duty rosters, staff recruitment files, records of complaints, accident and incident records, maintenance records and quality assurance records. Following the inspection we reviewed additional material sent to us by the provider, including an action plan for improvements to the premises.

We last inspected the service in June 2017 when no breaches of regulation were identified.

Requires Improvement

Is the service safe?

Our findings

Individual risks to people were not always managed effectively. For example, bed rails were being used for some people to prevent them falling out of bed. However, an assessment of the risks posed by bed rails had not been completed for one person, so staff were unable to confirm that they were safe to use. The bed rails on another person's bed only covered two thirds of its length. Staff told us the person had a habit of "wriggling down the bed" and falling off beyond the end of the bed rails. Although a risk assessment had been completed four months earlier, it had not identified this concern, either at that time or during the monthly reviews of the risk assessments by senior staff. Care staff had implemented their own solution, by wedging a large chair between the end of the bed and the end of the rails. While this was a practical short-term solution, it was not an appropriate or dignified long-term solution. We discussed this with the registered manager, who agreed to obtain full length bed rails for the person and to update the person's risk assessment.

Staff told us a further person was at risk of choking as their swallowing was compromised. However, a risk assessment had not been completed to inform staff of the extent of the risk and the measures they needed to take to reduce the risk. The person had been prescribed a thickening agent to add to their drinks, but there was no information about how and when to use this in their care plan. The staff we spoke with knew how to thicken the person's drinks to the correct consistency, but the absence of any written guidance posed a risk that this would not be done in a consistent way by all staff.

Environmental risks were also not always managed effectively. The provider had engaged a fire safety consultant to complete a fire safety risk assessment of the home. This had identified the need to improve the fire alarm system, which the provider had agreed to complete by April 2018. It also identified action that needed to be taken 'immediately', including: 'to ensure corridor doors are kept shut until the new fire system is installed'. On the first day of the inspection, we saw a fire door in a corridor was being held open by a large box. In addition, the dining room door was wedged open on both days of the inspection until the batteries that operated the door closure device had been replaced. This put people at risk as fires in these areas would not have been contained.

Before placing people in baths, staff checked the temperature of the water using a thermometer to prevent people being scalded. However, we found the temperature of hot water outlets at the sinks in 12 people's rooms was not regulated to prevent people being scalded. Records showed the hot water temperature in these rooms varied between 52 and 54 degrees Celsius; this was significantly above the recommended safe temperature of 44 degrees Celsius. The maintenance worker told us they were in the process of fitting temperature control valves, but the work had been on-going for several months and was still in progress.

The provider sent us a certificate which showed the electrical equipment in the home had been checked, serviced and was safe to use, as were two of the three boilers in the home. Remedial work was needed on the third boiler and this was scheduled to be completed within the following two months as part of refurbishment works in the kitchen.

There were systems in place to protect people from the risk of infection; however, these were not always effective. One person told us, "Everywhere is very clean. Our clothes are laundered and we get clean towels every day." Staff had attended infection control training and had access to personal protective equipment (PPE), which we saw they wore when needed. They described how they processed soiled linen, using special red bags that could be put straight into the washing machine. However, we found working practices in the laundry room created a risk of cross infection. There was not a laundry bin for the red bags to be kept in while waiting to be washed and staff told us they placed these bags on the floor of the laundry or on top of other clothes waiting to be washed. We also found clean clothing had been hung up to dry directly above the bins containing dirty laundry. In addition, although there were cleaning schedules and records in place for most areas of the home, these were not in place for the laundry room and the registered manager was unable to confirm when and how often the laundry was cleaned. This posed a further risk of cross infection. We discussed these concerns with the registered manager, who took action to obtain a new laundry bin and introduce a cleaning schedule for the laundry.

We also noted that the domestic waste bin and the clinical waste bin on the front driveway of the home were overflowing with rubbish bags, some of which had been left next to the bins rather than in them. This could encourage vermin and posed a potential risk to people. The registered manager told us they would arrange for the bins to be emptied more often, to prevent them from overflowing in the future.

The failure to assess and mitigate risks to people in a safe and consistent way was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments had been completed for other individual risks, together with action staff needed to take to reduce the risks. For example, two people were at risk of developing pressure injuries and records showed staff supported them to re-position in bed every two hours. In addition, special pressure-relieving mattresses had been provided and staff followed a clear system to check they remained at the right setting according to the person's weight. Where people were at particular risk of infection, for example due to having a catheter, infection control risk assessments had been completed. Where staff needed to use slide sheets to support people to reposition in bed, these were available and allocated individually to prevent any cross contamination.

People were protected from the risk of falling. One person told us, "I find walking difficult, so I use a [walking] frame. They [staff] got it for me." We saw staff made sure walking aids were accessible to people and prompted them to use them correctly. Where people had experienced more than one fall, staff completed multi-factorial risk assessments. These looked at a wide range of factors that might put the person at increased risk of falling and helped identify appropriate safety measures.

The registered manager reviewed all falls and adverse incidents in the home on a monthly basis to identify any patterns, trends or learning. Following one fall, where a staff member had not followed recommended procedures, we saw all staff had been reminded about the head injury protocol that should be followed. Later records confirmed that staff were following this protocol and had completed 24 hour monitoring of a person who had fallen, in line with best practice guidance. This demonstrated that staff learned from incidents.

People told us they felt "happy & safe" at Little Hayes. One person said, "I feel very safe. Nothing worries me, I never feel anxious." Another person said, "I go to bed at night feeling safe, knowing that the home is all locked up and there is always someone around if I need help."

The provider had effective systems and processes in place to protect people at risk of abuse and staff

understood their safeguarding responsibilities. Most staff had received safeguarding training and knew how to report incidents of abuse. However, we identified that two ancillary staff, who had regular contact with people, who had not completed this training and were not familiar with reporting arrangements. The registered manager immediately arranged for them to attend this training in the week following the inspection.

Staff told us they would report suspected abuse to one of the managers and were confident they would listen to them and act on their concerns. Staff were also aware of the option to take concerns to external agencies if they felt they were not being dealt with appropriately. One staff member told us, "If I had any concerns I would talk to the person first. If I needed to, I would go directly to the [local authority] safeguarding team. We have to protect the residents; it's their home and we need to make sure they are safe." We saw staff completed body maps of any bruises they found on people and these were reviewed by one of the managers to identify how they occurred. Records showed the managers had worked effectively with the local safeguarding team to undertake investigations and appropriate action to protect people from the risk of abuse.

Appropriate recruitment procedures were in place, although these were not always followed. The procedures included pre-employment reference checks and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these processes were followed before they started working at the home. However, we identified gaps in the employment histories of three staff members who had been recruited recently. The provider was unable to confirm what the staff members had been doing during these times and whether that impacted on their suitability for employment. The registered manager acknowledged this was an area for improvement. They agreed to investigate the gaps and assess the outcomes.

There were enough staff deployed to meet people's needs. One person told us, "Last night I felt awful, so I rang the bell and the carer came immediately." A family member said "[Staff] always have time for people." Analysis of call bell response times showed that most people were attended to within two minutes. The registered manager did not take a systematic approach to calculate the number of staff needed at different times of the day, but relied on her experience and feedback from people and staff. The home had seven vacancies and the registered manager was clear that they would not admit any more people until they had recruited more staff, which they were actively trying to do. Staff absence was covered by existing staff working additional hours, which meant people were cared for by staff who knew them well.

People told us they received their medicines safely. One person said, "[Staff] are very good with medicines. I didn't get on with an antibiotic they gave me, so they arranged for them to be changed." Medicines were administered by staff who had received appropriate training and had their competency to administer medicines assessed, to ensure their practice was safe. There were suitable systems in place to ensure the safe storage of medicines, the ordering of repeat prescriptions and the disposal of unwanted medicines.

Medicines administration records (MAR) confirmed that people had received their medicines as prescribed. People who were prescribed 'as required' (PRN) medicines, such as pain relief, told us these were provided when needed. One person said, "If I had a headache, they [staff] would get me something." Information was kept in people's care plans, housed in the managers' office, about when and how PRN medicines should be given and how people liked to take their medicines. The registered manager acknowledged that this information would be more accessible to staff if kept with people's MAR charts. This was also recommended during a recent visit by the Medicine Optimisation Team from the Clinical Commissioning Group, but had not yet been implemented.

Requires Improvement

Is the service effective?

Our findings

People's needs were met by staff who were skilled and competent. One person told us, "I have been very happy here with great support from staff." Another person said, "They [staff] are all well trained. They know what to do." A family member echoed these comments and said, "I am confident [my relative] is being looked after well."

New staff completed an effective induction into their role. This included time spent working alongside experienced staff until they felt confident they could meet people's needs. The registered manager told us that the length of the induction period was usually three months and said they or the deputy manager observed new staff providing support to people before they were allowed to work unsupervised. New staff were also supported to complete the Care Certificate if they did not already hold a care qualification. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. A new member of staff confirmed they were currently undertaking the Care Certificate.

The registered manager had a system to record the training that staff had completed and to identify when training needed to be updated. This included essential training, such as medicines management, moving and positioning, safeguarding adults and fire safety. However, on reviewing the training records we found that not all staff had updated their training within the required time frame. For example, only two staff members had up to date first aid training and none had up to date fire safety training. When we discussed this with the registered manager, they provided us with dates when all of this training would be completed during the following month.

Experienced staff were supported to gain additional vocational qualifications relevant to their role
A staff member told us, "The training is good and I have asked for extra training, which [the registered manager] provided."

Staff told us they felt supported in their roles. Comments from staff included, "We are always thanked (by managers); it makes me feel appreciated"; and "The manager and other staff are all really supportive". Staff had annual appraisals where they discussed their performance and development needs, together with one-to-one sessions of supervision with a manager to discuss their progress and any concerns they had. In addition, managers regularly observed staff delivering care and support to people to check their practice was up to standard. Staff spoke positively about the support they received from management on a day to day basis. One told us, "I feel that I can talk to the manager at any time." Another said, "We can discuss anything [during sessions of supervision] including best practice and any courses we want."

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

During the care planning process, managers had assessed people's capacity to make specific decisions, such as to receive medicines or personal care. Family members told us they had been involved in the process, although we found their views had not been recorded as part of the best interests process. For one person, we found their capacity to make a decision about the use of bed rails had not been assessed in line with the MCA. This meant the provider was unable to confirm that the decision staff had made to use bed rails was necessary or in the person's best interests. We discussed this with the registered manager, who assured us they would complete the necessary assessment and ensure the views of family members were recorded in future.

Staff described how they sought verbal consent from people before providing care and support and said they were led by the person and acted in the person's best interests. Where people had capacity to consent to specific decisions, we saw they had signed 'consent forms' confirming their agreement to the care and support they were receiving.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found DoLS applications had been submitted for three people and these were awaiting assessment by the local authority. Staff were aware of which people the applications related to and the support people needed as a consequence. However, we identified one person who was subject to continuous supervision and control for whom a DoLS application had not been made. From our discussion with the registered manager and the deputy manager, it was clear they lacked a detailed understanding of the current criteria for making DoLS applications. They assured us they would research this, submit an application for the person we identified and review other people living at the home for whom DoLS applications might also be needed.

Adaptations had been made to the home to make it supportive of the people who lived there. For example handrails were provided along corridors and the bathroom doors had been painted bright yellow with large signs to make them easier for people to find. This showed the provider had taken account of people's communication needs. The lighting levels in a lounge used to run activities with people had recently been improved to make it more suitable for this purpose. People described the environment as "homely" and had decorated their bedrooms with personal possessions and memorabilia that were important to them. One person told us, "It's home from home here and nothing could be better." Following the inspection, the provider sent us a maintenance schedule of planned works to further enhance the home. This included the installation of a new kitchen, refurbishment of the carpets and chairs in the ground floor lounge and re-decoration of corridors.

People were complimentary about the food. One person told us, "The food is very good and I can get extra if I want anytime." Another said, "The meals are fine and they're served nicely; the presentation makes a lot of difference." Choices were offered for all meals and people were offered alternatives if they did not want anything on the menu. For example, one person accepted a ham sandwich having declined a roast dinner.

Staff were attentive to people at meal times and provided support when required. Two people were being cared for in bed and needed full assistance with all their meals. Staff described how they did this in a dignified way on a one-to-one basis. One person had requested a modified diet as a personal preference and we found this was provided consistently. Five people had asked for smaller portions and we saw staff accommodate this, using smaller plates so as not to overwhelm them.

Staff monitored people's weight and took prompt action if they experienced unplanned weight loss. For example, their meals were fortified with extra calories and they were offered additional snacks. In addition, when people were at risk of becoming malnourished, staff monitored and recorded how much they ate using food charts. Records showed one person had been gradually losing weight over a prolonged period. This had been identified by the monitoring process and we saw the person was receiving additional support to help maintain a healthy weight. A nurse consultant who had regular contact with the home told us staff always notified them of people who had lost weight, so they could discuss suitable interventions.

Three people were receiving a pureed diet. For one person, this was their preference. For the other two people, it was due to swallowing difficulties. However, staff were unable to confirm whether advice about this had been sought from a GP or a speech and language therapist. Whilst a pureed diet might have been appropriate as an emergency measure, an assessment by a specialist should have been considered to check if this was necessary or appropriate in the long-term. We discussed this with the registered manager, who said they would seek appropriate advice. A further person who was having difficulty eating had been referred to a speech and language therapist and was awaiting assessment.

We saw a range of well-known tools were used to monitor people's health and wellbeing in line with best practice guidance. For example, one person was unable to be weighed, so staff used the Malnutrition Universal Screening Tool (MUST) to help calculate the person's body mass index. Other nationally recognised tools were used to assess a person's risk of developing pressure injuries and to monitor their bowel movements. In addition, when night staff were recruited, the registered manager arranged for them to work day shifts initially, so they could get to know people and their needs while they were awake. This helped ensure people would not become anxious if they woke to find unfamiliar staff in attendance.

People were supported to access healthcare services when needed, with the exception of speech and language therapists as mentioned above. One person told us, "The doctor comes quickly; you don't have to wait like you do if you go to the surgery." Another person said, "I had a chest infection the other day and they [staff] got the doctor in immediately." Records confirmed that people were seen regularly by doctors, specialist nurses and chiropodists. For example, one person was seen daily by a community nurse for dressing changes to a wound. A nurse consultant who had regular contact with the home told us they were contacted promptly when needed and that staff followed their advice.

The home was piloting a 'Telehealth' scheme in partnership with a local doctor's surgery to help prioritise people's medical care. This allowed staff to monitor people's health using handheld computers and to electronically transfer the data directly to the surgery for analysis. The registered manager told us this had led to quicker diagnosis of conditions and earlier treatment for people.

There were clear procedures in place to help ensure that people received consistent support when they moved between services. A nurse consultant who had regular contact with the home gave examples of where this had happened. They said staff made sure there was "always a nice, smooth transition" when people moved into or out of Little Hayes.

Good

Is the service caring?

Our findings

People told us they were treated well by patient, kind and compassionate staff. Comments from people included: "All the staff are very nice"; "They [staff] treat me very well"; "I am happy and content being here, everyone is lovely"; and "I think the home is a lovely place to live and there is nothing more the staff could do to make it better."

Staff developed positive relationships with people and created a homely atmosphere. One person commented, "I am happy here, the staff are my friends", and another said, "They [staff] all know me so well and I am happy that they do." A staff member described Little Hayes as "like a family as I know everyone very well". Another staff member said, "I love working here. It's like having 30 Grandparents in one room." We observed a further staff member, who was on maternity leave, brought her new baby in for people to meet and interact with. It was clear from people's responses that they thoroughly enjoyed the experience. We were told that other staff sometimes brought their young children in to meet people, including at Christmas when they dressed up as Santas and elves to distribute presents to people.

All interactions we observed between people and staff were positive and supportive. Throughout the inspection, we heard good natured and friendly conversations between people and staff. Staff engaged well with people and showed concern for their well-being. After lunch we saw a person was supported back to the lounge having not eaten their lunch as they were feeling "giddy". Within the space of five minutes, the registered manager, the deputy manager, and three staff members all spoke to the person in close succession, offering support and advice. Although this seemed to confuse the person initially, it demonstrated staff's concern. After a further five minutes, the person visibly relaxed and accepted something to eat. When supporting people to move, staff were patient and encouraged people to take their time and go at their own pace.

The registered manager told us they explored people's cultural and diversity needs "by talking to them and their families and by getting to know them and their backgrounds." Most people living at Little Hayes were of one particular faith and a local minister was invited to conduct a service every month. Staff knew that one person was not of that faith and made a point of not inviting them to the service out of respect for the person's views.

Where people had specific communication needs, these were recorded in their care plans and known to staff. For example, one person's care plan instructed staff to "speak clearly and make eye contact" and we observed staff doing this when they interacted with the person

Staff supported people to maintain their independence by offering choices and encouraging them to do as much as possible for themselves. One person told us, "I like the staff who all help me to stay independent." Another person said, "The management let you get on with things, especially if you are with relatives or friends." A staff member described how they promoted independence when supporting people with personal care. They said, "I will give a person the flannel and see what they can manage for themselves. I would only help them if they need it."

We heard staff encouraging people to make choices, for example of where they wished to spend their day, what they wanted to eat and which activities they wanted to take part in. One person told us, "I can please myself and do anything I want. I've got complete freedom." Another person said, "I have all my meals in my room; it's my choice." Where people struggled to make choices, due to a cognitive impairment, staff supported them by making suggestions and giving them time to respond. A staff member told us, "We treat people as individuals and give them choices all the time; what they want to wear, where they want to sit, whether they want [support] to do their teeth before or after breakfast, whether they want a bath or a full body wash and so on."

Staff protected people's privacy and respected their dignity at all times. One person told us, "They [staff] treat you with respect. They always say 'please' and 'thank you'." Another person said, "All [the staff] know me and treat me with dignity and respect." We saw staff knocked before entering people's rooms and kept doors closed while delivering personal care. After lunch, staff noticed that two people had spilt food on their clothes, having declined clothes protectors, so supported them to their rooms to change. This showed respect for people's choices and helped maintain their dignity.

People and relatives told us they were involved in discussing and making decisions about the care and support they received. A family member told us, "I am consulted [about my relative's care] all the time. They [staff] always update me, they're very informative." Reviews of people's care plans were completed regularly. Although staff told us they consulted people and their relatives as part of the review, we found their views and comments were not recorded. The registered manager acknowledged this and took action to help ensure people's views were documented in future.

Requires Improvement

Is the service responsive?

Our findings

People told us they received personalised care and support that met their needs. One person said, "I am very happy with all staff and the support that they give me." Another person told us, "I get all the help I need."

Each person had a care plan which contained individual information about their specific needs and how they wished them to be met. However, the information in some care plans was out of date and did not always support staff to deliver personalised care to people in a consistent way. For example, one care plan contained two summaries which included conflicting information. In one summary it said one staff member was needed to support the person and in the other it said two staff members were required. One summary said the person had an allergy to a particular medicine, but this was not mentioned in the other summary. Neither summary was dated, so staff would not have known which one was current. In another example, the person's care plan instructed staff to support the person to transfer from their bed to their chair each day, but the registered manager and other staff told us this was no longer possible as the person had become too frail. The care plan also stated that the person could eat independently, but staff told us the person now needed full support with all their meals.

The risks posed by inaccurate information in the care plans were mitigated by the relatively low turnover of staff and the fact that staff knew people well. When we spoke with staff they all demonstrated an extensive knowledge of people, including their current needs, wishes and preferences. A staff member told us, "Every person has their own needs and we do our best to meet them."

Staff kept records of the care and support they provided to people. These confirmed that people's needs had been met consistently. For example, they included 'turn charts' for people who needed support to reposition regularly and monitoring charts of the fluid input and output of people with catheters, to check they were working properly. During a handover meeting between shifts, we heard staff discussing people's needs and any additional support they might need. It was clear that staff were able to recognise changes in people as they occurred and were committed to delivering the best care possible. For example, they had recognised that one person was in a low mood and suggested ways to support them by undertaking activities they felt the person would enjoy.

People were supported at the end of their lives to have a comfortable, dignified and pain-free death. This was confirmed by a nurse consultant who had regular contact with the home, who told us staff provided "really good end of life care" to people. Recent written feedback to the registered manager from a family member stated, "Thank you for providing such compassionate and professional care to [my relative]. In addition to making the last years of her life comfortable and dignified, you provided great relief to her loved ones knowing that she was in such safe hands. The end of life care you gave her in the last days of her life was exemplary."

One person told us, "They [staff] have got all the information for my funeral arrangements and they know I want to stay [and be cared for] here." However, we found the end of life wishes and preferences for this

person and a person who was receiving end of life care had not been recorded. This posed a risk that their wishes might not be respected, particularly if they had to be transferred to hospital or another care service in their final days. We discussed this with the registered manager, who acknowledged this was an area for improvement. In response, they and the deputy manager immediately enrolled on an end of life training course to support them with this work.

People told us they felt able to raise concerns or complaints with the management, although they all said they had not had cause to complain. One person said, "I've never had to make a complaint, but if I had to I'd go straight to [the registered manager]." A complaints procedure was in place and was displayed on the home's notice board. This was only available in standard sized print, which some people would have struggled to read, but the registered manager told us they were planning to make it available in a more accessible format.

People were supported to access a range of activities. An activity coordinator had been appointed since our last inspection. They had spent time talking to people on a one-to-one basis about the activities they would like to take part in and had started to organise these. For example, people had taken part in, quizzes, reminiscence, exercise and poetry; they had also been supported to visit local shops and other attractions. Each activity was also used as an opportunity to promote conversation and discussion. For example, we observed a session of poetry where people discussed each line of a familiar poem and the memories they evoked. In addition, the activity coordinator was encouraging people with similar interests to join groups to encourage social interaction. These included cookery and flower arranging groups. People who did not wish to take part in group activities received one-to-one activities in their rooms. One person told us, "I don't go to the activities, but they [activity staff] come and talk to me and they have asked what I might like." A nurse consultant who had regular contact with the home told us the activity programme had had a positive impact. They said people were "more stimulated", which was beneficial to their well-being.

Requires Improvement

Is the service well-led?

Our findings

People told us they were happy living at Little Hayes and felt it was well-led. Comments included: "The home is well run and organised"; "The home is very well run. All the staff are happy and this make me feel happy here"; and "I am happy with everything about the home".

However, we found the governance arrangements were not effective in ensuring the provider met their legal obligations and the service made necessary improvements in a timely way. The registered manager told us that one of the directors of the provider's company visited regularly, but they did not always provide a report of their findings and any action they needed to take. Where improvement actions were recorded, these were not always completed. For example, we were shown an audit of "room checks" completed by the director a month before the inspection, on 17 December 2017. This had raised a number of actions, including: "We need to increase the distribution of PPE (personal protective equipment) across the home" and "Please arrange for a pedal bin to be purchased [for the laundry room]". These actions had not been completed. The registered manager told us they disagreed with the need to increase PPE distribution and a new pedal was not purchased until we raised the issue on the first day of the inspection.

Social care professionals working for the Clinical Commissioning Group (CCG) had visited the service on 4 December 2017. They had recommended a number of improvements to people's care plans, for example in the recording of people's end of life wishes and preferences, and the documentation of mental capacity and DoLS assessments, but these had not been completed. A visit by a member of the CCG's medicines management team on the same day had recommended that information regarding people's 'as required' (PRN) medicines be kept with the medication administration records, but this also had not been done. The registered manager told us they had not made these improvements as they were waiting for written feedback from these visits, which only arrived on the first day of our inspection. However, we confirmed that they had received extensive verbal feedback at the end of the visits on 4 December 2017, which could have been actioned at that time.

The provider had created an action plan to make improvements to the premises, including the installation of a new fire alarm system and a new kitchen. However, the plan did not include all of the work that was required and had not ensured that work was completed in a timely way. For example, temperature control valves needed to be fitted to hot water outlets in people's rooms to prevent scalding, but this work was not scheduled. Staff told us valves that had been delivered had been taken away again, so new valves had to be ordered. A health and safety audit had identified the need for external lighting in case people had to be evacuated from the home at night, but this had not been installed and was not included on the provider's action plan. A ceiling above the first floor corridor had been damaged by water from a leaking roof a year before our inspection, but had not been repaired. Recent heavy rain had caused further damage and the ceiling was now at risk of falling down. Quotes had been obtained for the work, but it was not scheduled to start for a further two months.

The registered manager completed a range of audits including medicine management, infection control, staff training and support, and the environment. However, this had not ensured that staff remained up to

date with essential training or that some ancillary staff had not received safeguarding training.

Audits of people's care plans had not been completed, so neither the provider nor the registered manager had identified that some contained conflicting or inaccurate information. For example, some risk assessments relating to people's bed rails were out of date or had not been completed. This had not been picked up in the care plan reviews conducted by senior staff.

The failure to operate effective systems to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A director of the provider's company told us they were in the process of recruiting a regional manager to enhance the quality assurance processes and to promote the sharing of best practice between all the provider's homes.

Staff told us they enjoyed working at the home and felt valued by management. Comments included: "I love this place the management are good and the residents are all such good fun to work with"; "This is the best home I have every worked in. The manager is always happy to give us advice and her door is always open"; and "The [registered] manager is absolutely lovely. She listens to us and always asks if everyone is okay. She nips any [problems] in the bud, as does [the deputy manager]". During the inspection, we saw and heard the managers providing clear direction and support for staff. An 'on-call manager' system was also in place so staff could access advice and guidance out of hours.

Staff communicated effectively between themselves to ensure people's current needs were known and met. This was supported by daily handover meetings between shifts and regular staff meetings. One staff member told us, "We get a handover from nights and anything that hasn't been done just rolls over to the next shift. It works well." Another staff member said, "We all work well as a team and get on well." Staff expressed a shared commitment to providing high quality care to people. Comments included: "I like working here and love caring for the residents"; "I enjoy my job, I enjoy [spending time with] the residents"; and "If I had a relative that needed to move to a care home, I would like them to come here".

People and relatives described an open and transparent culture within the home where they had ready access to the management at all times. Recent written feedback to the registered manager from a family member stated, "You always know there will be a lovely welcome and a smile when you go to Little Hayes." The provider notified CQC of all significant events and the home's previous inspection rating was displayed prominently on the home's notice board. A duty of candour policy was in place; this required staff to act in an open and transparent way when accidents occurred. The registered manager showed us examples of where this had been followed and family members confirmed that they were always updated when their relative had an accident.

The provider sought and acted on feedback from people, including through the use of on-going questionnaire surveys. For example, feedback in the latest survey suggested some areas were in need of redecoration and we found this had been planned. The chef described how the menus had been influenced by people's comments and requests and the activity coordinator told us they were planning to hold 'residents' meetings' to provide further opportunities for feedback.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess and mitigate risks to people in a safe and consistent way. Regulation 12(1) and 12(2)(a)&(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems to assess, monitor and improve the service. Regulation 17(1) and 17(2)(a).