Mr Khurshid Ayoub

Mayfield House

Inspection report

43 Langtry Grove
Nottingham
Nottinghamshire
NG7 7AX

Tel: 01158375426
Website: www.milestonescare.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We conducted an unannounced inspection at Mayfield House on 18 June 2018. Mayfield House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Mayfield House accommodates up to four people in one building. On the day of our inspection, three people were living at the home; all of these were people with support needs related to mental health conditions.

This was the first time we had inspected the service since they registered with us in May 2017 and it was the first time the service has been rated as Requires Improvement.

There was a registered manager in post at the time of our inspection, however they were absent at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found that the service provided at Mayfield House was not consistently safe. Medicines were not stored or managed safely. Medicines records were not completed to demonstrate people had been offered their medicines as prescribed and, medicines were not always recorded on medicines records. Staff did not always have access to accurate information about how to administer medicines safely. All of these issues increase the risk of medicines error, or abuse of medicines. Environmental risks were not safely managed, sufficient action had not been taken to protect people from the risk of fire or legionella. The provider told us they would address this as a matter of urgency.

Systems to ensure the quality and safety of the service were not comprehensive or effective. This had resulted in areas of concern not being identified prior to our inspection and placed people at risk of harm. Timely action was not always taken in response to known issues. The provider had failed to ensure records relating to the running of the home were accurate and up to date. People and staff were given the opportunity to provide feedback and make suggestions about the running of the home.

Risks associated with people's support were identified and assessed, and measures were put in place to ensure people's safety whilst also promoting their independence. People told us they felt safe and there were systems and processes to minimise the risk of abuse. There were enough staff to meet people's needs and ensure their safety. Safe recruitment practices were followed to reduce the risk of people being supported by unsuitable staff. Overall, the environment was clean and hygienic.

People were supported to have maximum choice and control of their lives; the policies and systems in the service supported this practice. People had access to healthcare and their health needs were monitored and responded to. People had enough to eat and drink, they chose what they ate and were supported to plan

and prepare meals. There were systems in place to ensure information was shared across services when people moved between them. The design and decoration of the building accommodated people's diverse needs.

Staff told us they felt supported and said they had enough training to enable them to meet people's individual needs. However, the provider was not able to locate records of this, which meant they were not able to provide evidence of staff training or details of staff supervisions.

People told us staff were kind and caring. Staff respected people's privacy and treated them with dignity. People were involved in day-to-day decisions about their care and support and had access to advocacy services if they required this to help them express themselves.

People received responsive support which was based upon their individual needs and preferences. Staff had a good knowledge of people's support needs, and people's diverse needs were recognised and accommodated. People spent their time doing things that they enjoyed and which were based on their individual interests and goals. There were systems in place to respond to concerns and complaints. However, the provider was unable to locate records of complaints, which meant we were unable to assess how previous complaints had been handled.

During this inspection, we found two breaches of the Health and Social Care Act 2008 regulations. You can see what action we told the provider to take 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 consistently safe.

There was a risk people may not receive their medicines as prescribed.

Environmental risks were not safely managed.

People were protected from risks associated with their care and support.

There were enough staff to meet people's needs and ensure their safety. Safe recruitment practices were followed.

There were systems and processes to minimise the risk of abuse.

Overall, the environment was clean and hygienic.

Is the service effective?

Good

The service was effective.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Care and support was effectively planned and coordinated when people moved between different services.

People were supported to attend health appointments and staff were knowledgeable about people's specific health conditions. People were supported to have enough to eat and drink.

Staff told us they had enough training and felt supported. However, we were not provided with evidence of staff training or supervision.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring. Staff respected people's privacy and treated them with dignity.

People were involved in day-to-day decisions about their care and support and had access to advocacy services if they required this.

Is the service responsive?

Good

The service was responsive.

People received the support they required from staff who had a good knowledge of their needs, wishes and preferences.

People were offered a wide range of opportunities for meaningful activity. People were supported to maintain relationships with those who were important to them.

There were systems in place to respond to concerns and complaints. However, the provider was unable to locate records of complaints so we could not make a judgement in this area.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems to ensure the quality and safety of the service were not comprehensive or effective. Timely action was not always taken in response to known issues.

Several records relating to the running of the home were not available to us at the time of our inspection.

People and staff were given the opportunity to provide feedback and make suggestions about the running of the home.

Mayfield House

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.

Prior to our inspection, we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events, which the provider is required to send us by law, such as, allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give key information about the service, what the service does well and improvements they plan to make.

The inspection was undertaken by two inspectors. During our inspection visit, we spoke with one person who lived at the home. We also spoke with two members of care staff, the team leader, the business development manager and the provider.

To help us assess how people's care needs were being met we reviewed all, or part of, three people's care records and other information, for example their risk assessments. We also looked at the medicines records of all three people, three staff recruitment files and a range of other records relating to the running of the service. We were unable to conduct observations of care and support as people living at Mayfield House were out in the community for much of our inspection visit.

During our inspection visit, we asked the provider to send us information about training, staff supervision, accidents and incidents and audits. However, we did not receive these prior to writing this report.

Requires Improvement

Is the service safe?

Our findings

Medicines were not stored or managed safely. During our inspection we found several concerns about the storage and management of medicines. Medicines records were not completed to document people had been offered their medicines as prescribed. One person's medicines records between 12 and 18 June 2018 were blank and did not evidence they had been offered any of their routine medicines. A member of staff told us this was because the person had chosen not to take their medicines. However, their refusal of medicines had not been appropriately recorded. This meant the provider was not able to assure us that the person had been offered their medicines as prescribed.

Medicines were not always documented on the medicines records. We found six medicines in stock which were not recorded on medicines records. This meant that there was no current record of some medicines in the service or instructions for staff of how and when to administer the medicines. Discontinued medicines had not been disposed of in a timely manner. We found three discontinued medicines stored with medicines in use. This was not in line with current NHS guidance on the safe administration of medicines. It was confusing, unsafe and increased the risk of error or abuse. This was of particular concern, as there had been two incidents in 2017 when medicines had gone missing from the home.

Staff did not always have access to directions about how to administer medicines. We found a medicine where the pharmacy label had worn away. This meant it was not possible to determine how the medicine should be administered. Furthermore, there was not information about the medicine in the medicines records. We also found the medicines records of a person who had recently moved in to the home had not been completed to the same standard as others. There was no photograph, no details of their allergies and no details about how they preferred to take medicines. This posed a risk that medicines may not be administered as required.

There were discrepancies between the pharmacy instructions for medicines administration and directions on medicines records. For example, the pharmacy label for one medicine directed one or two should be taken as required. However, the medicines record stated two to be taken every six hours. We discussed this with a member of staff who told us they thought the medicine record was correct as it had been changed by the pharmacy, however, there was no record or evidence of this in the medicines records. This meant the provider could not assure us people were given their medicines as prescribed. All the above issues placed people at risk of not receiving their medicines as prescribed.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above, we found people were encouraged and supported by staff to play a role in managing their own medicines. No one was managing their own medicines at the time of our inspection. However, a member of staff told us one person had expressed a desire to become more independent in this area and staff were able to describe how they planned to support them to achieve their goal.

Risks arising from the environment were not consistently managed safely. Although there was an up to date fire risk assessment, routine fire safety checks had not been completed at regular intervals. There were no records of checks on areas such as, fire doors, emergency lighting or extinguisher equipment since March 2018. Furthermore, there were no records of recent fire drills. This meant the provider was unable to assure us adequate action had been taken to protect people from the risk of fire. The risks of people contracting Legionnaires disease had also not been effectively managed. We have reported on this in the well led section of this report. We discussed this with the provider who told us immediate action would be taken to address our concerns.

People were supported to take risks and staff ensured this was done in the safest way possible without unnecessarily restricting people. People's support plans described the support they needed to stay safe and measures had been put in place which also respected and promoted people's independence. One person described how staff kept in touch with them when they were out in the community, they told us they felt reassured in the knowledge that staff were looking out for them.

Some people living at Mayfield House sometimes behaved in a way that placed them and others at risk. Overall, we found the risks associated with people's behaviours had been assessed and mitigated. For instances, sharp objects and potentially harmful chemicals were stored securely to reduce the risk of harm. We found one person's support plan required further information about the risk of the person attempting to cause harm to themselves. The provider told us they had already identified this and were in the process of developing further information for staff.

We were unable to make a judgement on how learning from accidents and incidents was used to improve the safety and quality of support provided at Mayfield House. During our inspection the provider was unable to locate incident records or behaviour charts and was unable to evidence how these were analysed and learnt from.

People told us they felt safe and processes were in place to minimise the risk of people experiencing avoidable harm or abuse. One person told us, "I feel totally safe." Staff told us they had regular training in safeguarding adults and they were knowledgeable about indicators of abuse and knew how to respond should they have any concerns. Staff felt confident that any issues they reported would be acted on appropriately. The registered manager had taken action to make referrals to the local authority safeguarding adults team when required and, records showed action had been taken to reduce immediate risks to people.

There were usually enough staff available to meet people's needs and ensure their safety. People living at the home told us there were enough staff and this view was also shared by most staff. Staff told us unplanned absences could sometimes result in their not being enough staff and when we arrived at the home there was only one member of staff on shift, instead of the planned two. The provider told us staff were deployed from their other local services to cover short notice absence when needed and this was the case on the day of our inspection. We reviewed rotas and found that, overall, there were enough staff on shift. Two staff were on day shifts to ensure people received their one to one support. There was one member of staff on at night and they were supported by an on-call manager who could be contacted in the event of an emergency.

Safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal record checks were undertaken through the Disclosure and Barring Service. These checks are used to assist employers to make safer recruitment decisions.

Adequate hygiene practices were followed and overall the environment was clean and hygienic. Some areas of the home required deep cleaning to ensure their cleanliness and reduce the risk of infection. We discussed this with the provider who told us they would take immediate action to rectify this. The home had the maximum food hygiene rating of five, we observed the kitchen to be clean and food was stored safely.

Good

Is the service effective?

Our findings

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

People living at Mayfield House had capacity to consent and told us staff respected their choices. Staff had knowledge of the MCA and knew what to do should someone's decision making ability change. This meant people's rights under the MCA were upheld.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS were not required for anyone who was living at the home at the time of our inspection.

Care and support was planned and coordinated when people moved between different services. Before people moved into Mayfield House their needs were assessed to ensure the staff team could support them. This information was then used to develop support plans. During our inspection, we reviewed the support plan for one person who had recently moved in to the home. Their pre-assessment was detailed and this had resulted in the development of a clear and comprehensive support plan. In addition, 'hospital passports' had been developed for each person living at the home. Hospital passports are designed to share information between care homes and hospitals, to ensure care is person centred.

People received effective support with their day-to-day health needs. We saw records of contact with health professionals in people's support plans, which showed they were supported to access the GP and other health professionals, such as dentists and opticians as necessary. People told us if they needed to see health professionals this was arranged for them. Staff made referrals to physical and mental health specialist teams when advice and support was needed and we saw the advice received was included in people's support plans. Staff sought advice from external professionals when people's health and support needs changed. People had their health needs detailed in their support plan and people had been supported to maintain their sexual health where necessary. Support plans also contained information about people's mental health needs and guided staff in how to support them. We found that staff had a good understanding of how to respond should a person become unwell.

People told us they felt staff knew what they were doing. Staff said they had enough training to enable them to provide safe and effective support to the people living at Mayfield House. Staff also told us they received a thorough induction when starting work at the home. One member of staff explained this had consisted of training, shadowing more experienced staff and reading people's support plans. However, the provider was unable to locate training records during our inspection, this meant they were not able to evidence what

training staff had undertaken. Staff told us they had regular supervision and said they felt supported. Again, the provider was not able to locate records of staff supervision during our inspection which meant they were not able to provide assurances about the frequency of staff supervisions.

People had enough to eat and drink. People told us they could choose and prepare their own food. One person said, "I get to choose what I eat." Staff supported and encouraged people to eat a healthy diet. One member of staff told us, "We support people to make healthy choices." Another member of staff described how they supported people to make healthy choices about food by offering alternative options to people whilst doing the food shopping. One person living at the home had expressed a desire to improve their fitness. There was information in their support plan relating to this and a member of staff told us that they were supported to exercise frequently.

The home was adapted to meet people's needs. Mayfield House is situated in a large residential property, which has been adapted to accommodate the service. There were three bedrooms and an office upstairs and a fourth bedroom, lounge and communal kitchen downstairs. People also had access to a large well-maintained garden. During our inspection, work was underway to extend the home to create additional communal living space.

Good

Is the service caring?

Our findings

People were supported by staff who were kind and caring in their approach. Our observations of care and support were limited as people were out in the community for most of our visit. However, the interactions we did observe were friendly, kind and respectful. People appeared to be comfortable and relaxed when they were with staff. One person told us, "The staff are respectful and kind."

Staff were aware of what mattered to people and used this to inform their support. People told us they had good relationships with staff and staff spoke about people with compassion and insight. One member of staff told us, "We work as a team and create a bond with people." People's support plans recorded their preferences for how they wished to be supported as well as their history, likes, dislikes and what was important to them. Staff had a good knowledge of people's backgrounds and were understanding about the impact this had on their mental health. For example, one member of staff talked insightfully about one person's previous traumatic experiences and the impact on their wellbeing.

People were involved in choices and decisions about their support. People told us they felt involved in decisions and we saw that they were, as far as possible, involved in decision making. One person told us, "I have choices, staff consult with me about things, they listen and sort things out." Throughout our inspection staff routinely checked with people about their preferences. Staff we spoke with understood their role in ensuring that people had choice and control. People were offered the opportunity to get involved in the development and review of their support plans and this was clearly evidenced in support plans.

People had access to an advocate if they wished to use one. Advocates are trained professionals who support, enable and empower people to speak up. Information leaflets were available to people and this was also discussed with people on an individual basis. No one was using an advocate at the time of our visit.

People were supported to develop and maintain their independence. One person told us, "Staff help me work towards my goals, my independence. I am very happy here, it is my home." The provider explained that the service was focused on giving people the skills they needed to live more independently, they told us that in the short time that people had been at the service each person had grown in confidence and independence. Staff discussed people's goals with them and these were recorded in their support plans. One person had expressed a desire to get fit and improve their health and staff had supported them to find a local gym where they felt comfortable and included. Staff supported them to attend the gym and sometimes worked out with them. Another person had a goal to go to college. They told us, "Staff help me practice using the bus for when I go to college." In addition, people were encouraged to get involved in domestic tasks, such as cleaning and cooking. One member of staff told us how they had worked with a person to support and encourage them to clean their own room. Although people's goals were recorded in support plans there was not always clear detail of what support the person would be given to pursue their goals and there was no documentary evidence of progress. The provider informed us that formalising these plans was part of their ongoing improvement plan.

The business development manager told us community inclusion was an important aspect of the service provided at Mayfield House and, gave examples of how they achieved this. For example, by recruiting staff who were of a similar age to people living at the home and by staff not wearing a name badge or uniform when they supported people to go out in the community so as not to draw attention to them.

People's rights to privacy and dignity were respected. Staff had a good understanding of how to respect people's privacy, they respected that people's bedrooms were their private space and said they always knocked before entering. One member of staff told us, "We would never just walk into someone's room." People we spoke with confirmed this to be the case.

Good

Is the service responsive?

Our findings

People received responsive support which was based upon their individual needs and preferences. One person told us, "I get the support I need, I have a plan for each day so that I know what I am doing." Each person living at Mayfield House had an individual support plan. Support plans were clear, personalised and contained detailed information about people's preferences and how best to support them. Staff used people's plans to inform their support. One member of staff told us, "I have read the support plans for all the people here." Staff told us there were effective systems in place to share information about people's support and wellbeing. There were handovers between shifts where staff shared updates about each person who lived at the home. Staff told us this was a useful way of staying up to date. We found staff had a good knowledge of what mattered to people and how best to support them.

Although the service was not supporting anyone who was coming toward the end of their life at the time of our inspection, people had been offered the opportunity to discuss their wishes for the end of their lives and this was recorded in their support plans.

People's diverse needs were recognised and accommodated. When people moved into the home, they were given the opportunity to discuss their individual needs, relating to their culture, religion and sexuality. Staff told us people's individual needs were accommodated. For example, one person living at the home was frequently supported to attend their chosen place of worship. Another person spoke a different language and they were given the option to communicate in this language and discuss their cultural heritage. This meant people could be assured their diverse needs would be catered for.

People spent their time doing things that they enjoyed and which were based on their individual interests and goals. One person said, "Staff know what I like to do. They always offer the right things and I like to do them (the activities)." Each person had an individual activity planned and records showed people were supported to take part in the activities planned for them. Activities included a variety of day to day domestic tasks, social activities and trips out, such as going shopping or to the gym. One person enjoyed going for meals and watching films and they were supported to go for lunch and to the cinema on the day of our visit. Another person enjoyed spending time with their family and again, they were supported to do so. It was clear that staff saw social activity as part of their role and we saw that when staff had spare time they sat and socialised with people.

The service was meeting its duties under the Accessible Information Standard. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. At the time of our inspection, no one living at the home had any specific needs related to accessing information. However, a member of staff told us this would be accommodated if needed.

People were supported to maintain relationships with those who mattered to them. People's support plans included information about relationships that were important in their lives and we saw records to show that people were in regular contact with those who were important to them. There were no restrictions upon

visitors to the home. People also maintained friendships with people in the provider's other services. Staff had good knowledge of people's support networks, they worked together with them to avoid contact with individuals and groups who had previously had a negative impact on a people's lives.

There were systems and processes in place for people to provide feedback and to deal with, and address complaints. People told us they would feel comfortable telling the staff if they had any complaints or concerns. Staff knew how to respond to complaints if they arose and were aware of their responsibility to report concerns to their manager. Staff told us they were confident the management team would act upon complaints appropriately. There was a complaints procedure available to people which detailed how they could make a complaint. However, during our inspection the provider was unable to locate records of complaints. This meant we were unable to assess how any previous complaints had been handled.

Requires Improvement

Is the service well-led?

Our findings

Audits were not comprehensive which meant concerns about the safety of the service were not always identified and addressed. The provider told us they thought there was a medicines audit in place; however, they were not able to provide us with evidence of any medicines audits. During our inspection, we found multiple concerns about the management of medicines. The failure to ensure robust audits meant these issues had not been identified or addressed and this exposed people to the risk of harm.

Some audits had not been completed regularly or in full, consequently there had been a failure to some identify areas of concern. Weekly and monthly health and safety checks were in place but these had not been completed regularly. There had been no monthly checks since March 2018 and no weekly checks since the start of April 2018. Consequently, there had been a failure to identify that regular fire safety checks had not been completed. This placed people at risk of harm.

The provider had failed to ensure records relating to the running of the home were accurate and up to date. During our inspection the provider was unable to locate several important records, including; complaints, staff training, supervision, medicines audits and accidents and incidents. We also gave the provider further opportunity to provide additional information following our inspection visit; however, we did not receive anything prior to writing this report. This meant we were unable to make judgements about the safety and effectiveness of the service in these areas.

Where areas for improvements had been identified, the provider had not always taken action to ensure people's safety. A legionella risk assessment completed in 2017 had identified remedial actions required to reduce the risk of legionella developing; however, action had not been taken to address this. Recommendations were made to remove some parts of redundant pipe work to reduce the risk of bacteria developing stagnant water. However, we observed this pipework had not been removed. In addition, the risk assessment had advised regular maintenance tasks to reduce the risk of legionella developing, again these checks had not been implemented. The failure to take timely action meant people were placed at risk of harm for a prolonged period.

The above information was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked our records, which showed the provider, had notified us of events in the home. A notification is information about important events, which the provider is required to send us by law, such as serious injuries and allegations of abuse. This helps us monitor the service. However, as we were unable to view accident and incident reports during out inspection we were unable to fully review if there were any other notifications that should have been made.

There was a registered manager in post at the time of our inspection; however, they were absent during our inspection visit. The provider had recently employed a business development manager and an operations manager to support the team and to ensure the quality of the service. Records showed the provider worked

with partner organisations, such as health and social care professionals, to ensure people got the support they needed.

People living at the home had regular meetings with a named member of staff. This gave them the opportunity to discuss their support, raise any concerns and give feedback about the home. People told us that they trusted staff to act upon any concerns or suggestions they raised.

Staff told us they were given an opportunity to have a say in the running of the service. Regular meetings were held with the staff team. Records of these meetings showed they were used to provide updates, discuss training and address any areas of concern. Staff said they felt supported and understood their roles and responsibilities. They were aware of their duty to whistle blow on poor practice and felt confident in raising any concerns with the registered manager. Staff commented that recent changes at the home had had a positive impact. One member of staff said, "The place has been calmer and more organised."

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. As this was the homes first inspection since their registration they did not have a rating. However, we observed a rating for another of the provider's homes was displayed at Mayfield House. This could have been misleading and confusing for people living at the home and visitors.

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 Medicines were not stored or managed safely. Regulation 12 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to ensure the quality and safety of the service were not comprehensive or effective. Action was not taken in response to known issues. Records relating to the running of the home were not always accurate or complete. Regulation 17 (1) (2)