Mayfield Rest Home Limited

Mayfield House Care Home

Inspection report

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11 May 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Mayfield House Residential Care Home on 10 and 11 May 2016.

Mayfield House Care Home is a residential care home providing accommodation and support for up to twelve people with learning disabilities situated on a main road in Liphook in Hampshire. At the time of our inspection five people were living at the home. The home is a two storey building with communal areas located on the ground floor and with outside space in the form of a secure garden.

The home had 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service is required by a condition of its registration to have a registered manager.

During our inspection we found the provider had not followed safe recruitment procedures to ensure staff were suitable for their roles. The required pre-employment information relating to staff employed at the service had not always been obtained when staff were recruited.

Care and support plans and risk assessments contained information which was personalised to the individual. Risks associated with people's care and support needs had been identified and guidance was provided to help staff protect people from harm. People's care records and risk assessments were regularly reviewed by the registered manager, however any changes were not always recorded. This meant that staff who were new to the service may not necessarily have all the up to date information they would need in order to quickly understand the risks to people's health and welfare and provide people with care which met their needs.

People's safety was not always assured as the provider had no environmental risk assessment in place. There were no personal evacuation plans and business continuity plan to ensure people's safety in the event of an emergency. Although the manager was able to explain how an emergency situation would be managed, as none of this was documented it was not clear that staff would know what to do in the registered manager's absence.

New staff starting on their induction undertook the Care Certificate. The Care Certificate sets out learning outcomes, competencies and standards of care that care workers are nationally expected to achieve. Staff received training to support them to effectively meet the individual needs of people, although it wasn't clear that all staff had undergone all mandatory training or that this was regularly refreshed to keep people's knowledge and skills up to date. The provider had not always sought evidence that staff had undergone relevant training at previous employment, so in some circumstances if was not clear, for example, that staff administering medicines had been effectively trained to do so. Staff told us that they felt supported to carry

out their roles and told us that they received regular supervision (one to one meetings with their manager). However, we could not always see that this was the case from the records we viewed. We have made a recommendation to support the provider to improve staff training, support and supervision.

People can be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA) 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). During this inspection we found where people lacked the capacity to agree to the restrictions placed on them to keep them safe, the provider made sure people would have the protection of a legal authorisation and had made the appropriate DoLS applications to the local authority. However, we could not be assured that opportunities and appropriate support had been provided to ensure that people's rights under the Mental Capacity Act 2005 had been upheld. The registered manager had not carried out a mental capacity assessment for people prior to applying to deprive them of their liberty, and was not able to show how decisions had been taken in people's best interests. There was a risk that people's rights might not be upheld and restrictions might be placed on people unlawfully.

Effective governance and record keeping systems to monitor the quality of the service and identify the risks to the health and safety of people were not in place. Some audit checks were used but these were not robust enough to identify issues or concerns so that action could be taken to improve the quality of care people experienced and to ensure their safety.

We found that records were often not available for view, for example we were not able to see all the minutes of staff meetings we asked for. In some cases we found that records were not in place at all, for example medicines competency checks or documents to provide oversight of falls, accidents or incidents occurring in the home. A lack of effective record keeping meant that the registered manager was not always in a position to ensure the quality and safety of the services they were providing to people and to actively identify and mitigate any risks to people.

Mayfield House Care Home provided person-centred care. This meant that staff understood the needs of each individual and provided care accordingly. People, relatives and staff views about the management of the service were positive. People and staff spoke positively about the registered manager. They told us that the registered manager was approachable and listened to them. Opportunities were available for people, their relatives and professionals to provide feedback about the service. People's views and comments were listened to and acted on, and relatives had input into people's care.

People were spoken to with kindness and patience, and were offered choice in their day to day lives. People were encouraged to maintain their independence by helping out with daily tasks if they wished, such as gardening and helping in the kitchen. Staff knew and understood the personalities, behaviours and needs of each person well. They also understood how to promote people's dignity and respect.

People had prompt access to healthcare services when they needed them and the registered manager was quick to respond to changes in people's health. People liked the food provided at the home and received the support they needed to eat and drink enough.

The registered manager took action to notify safeguarding concerns appropriately. People were safeguarded from the risk of abuse, because staff understood how to identify and report concerns.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we

told the provider to take at the back of the full version of this 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.

The provider's recruitment procedures were not sufficiently robust to demonstrate that staff were suitable for their roles.

Risks to individuals were effectively identified but risk assessment documents, although regularly reviewed, were not kept sufficiently updated. This meant that staff might not always have current information relating to risks for people in order to protect them from harm.

People were protected from the risk of abuse, because staff understood and followed the correct procedures to identify and report safeguarding concerns.

Procedures were in place to ensure that people were supported to receive their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

It was not always evident that decisions about people's care were made in accordance with the legal requirements of the Mental Capacity Act. Mental Capacity Assessments and Best Interest decision making processes had not been completed for people.

It was not always evident that people's needs were being met by staff who had received appropriate training to carry out their roles effectively.

People were supported to eat and drink enough and staff were aware of nutritional or hydration risks to individuals and how to manage these.

Effective liaison with health professionals ensured people's health needs were addressed promptly.

Is the service caring?

Good

The service was caring.

People and their relatives told us, and we saw during the inspection, that staff were caring and attentive to people's needs.

People and their relatives were listened to, and their views informed the care people experienced.

Staff were able to explain how to uphold people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

We found that people received person-centred care from staff who knew them well, and which was responsive to their needs. Daily logs of people's activities and behaviours provided staff with information to help them deliver care that supported each person's individual needs.

The home sought feedback from people, relatives and health professionals and responded to concerns or feedback provided.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Effective systems and processes were not in place to monitor the quality and safety of the home and to meet the requirements of the regulations.

People's records were not always accurate and complete. Any new staff solely reliant on this documentation may not have sufficient information to be able to provide support that met people's needs and ensured their safety.

The provider promoted a culture that was person-centred and encouraged open communication between people living at the home, their relatives and staff.

The registered manager was liked by people, staff and relatives and was visible in the day to day running of the home.

Mayfield House Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 10th and 11th May and was unannounced. The inspection was completed by one inspector.

Before the inspection we reviewed the information we held about the home. This included previous inspection reports and any statutory notifications. A notification is information about important events which providers are required to notify to us by law.

We did not request a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We gathered this information during our inspection.

We spoke with four people who lived at the home, two relatives, the registered manager, three members of care staff, a training manager, who also assisted the registered manager, and four health and social care professionals. We reviewed care records and medicine administration records (MAR) for four people living at the home. We also reviewed personnel files for five staff and other records relevant to the management of the service such as health and safety checks, accident and incident records, complaints and quality assurance audits and systems. During the inspection we spent time observing staff interacting with people, including during mealtimes. This helped us see how caring staff were when they were engaging with and supporting people.

The last inspection of this home was completed on 21 August 2014 where no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

We found the provider had not completed all the required pre-employment checks. None of the records we viewed documented applicants' full employment history. The provider did not have all the information they needed to judge whether an applicant's employment history might indicate concerns about their previous work conduct or character that might put people at risk. Three of the records we viewed did not contain any proof of identify or current photo. This meant that the provider could not tell from the information they held whether the applicant was who they said they were. There was a risk that staff being employed by the provider may not be suitable for the care roles they held.

With the exception of one person working at the home whose record was not available to us to view, records showed that relevant checks had been made with the Disclosure and Barring Service (DBS). The DBS is a criminal records check to help ensure that people are suitable to work with vulnerable adults. However in one case, we could not see the full date of the DBS, which meant that we could not assure ourselves that the DBS was in place before the person started to work with people. Although the person had been working at the home for some time and their conduct had been of no concern, this might have put people at risk. The registered manager could also not explain how they had taken the information disclosed on one staff member's criminal record check into account prior to making the decision that they would be suitable for employment. Although again, this staff member's conduct had been of no concern since they started working in the home, we could not be assured that the provider would scrutinise criminal check information and put plans in place to reduce the possible risks to people of employing staff with known concerns.

We found that the provider's recruitment procedure did not ensure that staff employed were of good character. This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three members of staff had recently left the home and the registered manager told us they were recruiting to fill two full time staff vacancies. The registered manager confirmed that two members of staff were always on duty when all five people were at home, and one member of staff was on duty if most people were out for the day. The registered manager was present at the home on most days and therefore provided additional support. We saw from the staff rota that the vacancies were being covered by the home's current staff team and the registered manager. During our inspection we saw that people's needs were being safely met. The staff rotas we viewed suggested that staffing at weekends was sometimes a problem, but we saw that the manager stepped in to cover any staff shortages. Staff told us that the impact of staff shortages had been minimised due to the support of the registered manager.

Relatives told us that the home "seemed short staffed sometimes" and that "sometimes there hasn't been the right members of staff employed". However "the ones there at the moment know what they're doing". A health professional told us "There never seem to be many staff around". While we could not see the impact of the staff shortages during our inspection, there was a risk that if additional staff were needed at short notice, for example because of staff sickness or a person having a fall, then there might not be enough staff to meet everyone's needs. Although the manager did not like to use agency staff, she told us she would have

to consider it if something like this happened. The home had on-call arrangements in place to provide staff with emergency out-of-hours support and this was reflected in the staff rota we viewed.

Risk assessments were personalised to the individual. We could see that the risk assessments carried out reflected the risks to that person, and reflected information in their care plans. For one person, we saw risks assessments relating to weight gain, mobility and risk of falling which were particular to that person. Another contained specific risk assessments relating to constipation, diabetes and urinary tract infections. Another addressed aggressive behaviour, ritualistic habits and hand hygiene. We also saw that there were risk ratings and guidance to staff on actions they could take to reduce or prevent the risk.

People's risks assessments were, in most cases, subject to regular review, although we could not always see what changes had been made to people's care plans and risk assessments as a result of those reviews. This meant that any new staff who did not know people well could not always rely on people's care plans and risk assessments for up to date information on how to keep people safe if their needs and risks were to change. However, staff used the home's communications book to stay up to date with people's risks, and this information was shared at staff handover. The communications book included detailed information about recent events for each person, including messages from GPs and other health professionals, changes arising from care plan reviews, and the person's health and behaviours for each day.

Care plans included incident forms of when people had falls in the home, and included the completion of body maps to show where an injury had occurred. There was also an accident and incident book, with forms completed appropriately to detail who had had the accident, what had happened and any resulting injuries, along with any first aid or other treatment given. However the home did not have an effective means by which to maintain an overview of the numbers and types of accidents and falls that were occurring and their causes. This meant that the home was missing the opportunity to identify any trends and patterns in falls or incidents and take possible preventative actions to keep people safe.

Arrangements were in place to ensure people would be safe in the event of fire. There were fire extinguishers in the office, kitchen and dining room and a fire blanket in the kitchen, all of which had been subject to recent checks. The home carried out fire drills every six months. People were able to tell us what to do in the event of a fire. One person told us "I know what to do if the fire alarm goes off" and was able to explain what procedure they would follow, including which door they needed to exit by.

However, people did not have individual personal evacuation plans in their files. Staff might not be aware of how to evacuate each person safely from the home in the event of an emergency. There was no documented business continuity plan in place at the home to ensure the home could continue to run safely in the event of an emergency. The registered manager was able to explain to us what would happen in an emergency such as a fire or a flood, to ensure continuity of care for people, which included transferring people to another location. However, because it was not documented, the information was not readily available to the wider staff team, who might not immediately know what to do to keep people safe and ensure their care continued if an emergency was to occur.

The home promoted good food hygiene and infection control practices. The kitchen had posters displayed on safe hand-washing techniques, guidance on using different chopping boards for different foods to minimise the spread of bacteria and guidance on the dangers of raw poultry. Fridge and freezer temperatures were recorded and monitored daily to ensure that foods were being stored at the correct temperature. The registered manager advised that the home used a probe thermometer to check that foods were cooked to the right temperature. These measures meant that people were protected from eating food which might be harmful to them.

We saw that there had been an outbreak of impetigo, which is a contagious skin infection, in March 2014. Records contained an action plan in response to this, details of outcomes and a review. People were protected from the risk of infection as the home had responded appropriately to manage the outbreak and the risk of it spreading further and reviewed practices to protect against a reoccurrence.

Relatives told us that they felt their loved ones were safe in the home. On person living at the home said "I feel safe, staff are here to look after us, they help keep me safe". The home had safeguarding and whistleblowing policies and procedures in place, and the registered manager had submitted the required notifications to CQC and the safeguarding team. Staff told us that they were aware of the safeguarding policy, were able to describe different types of abuse, and knew what to do if they had any concerns. They described reporting their concerns to the registered manager or the Hampshire Safeguarding team, the CQC or police. Guidance on the procedure for reporting safeguarding concerns to Hampshire was attached to the communications book and staff had signed to say they had read this. People were protected from the risk of abuse, because staff understood and followed the required safeguarding processes.

However, while the registered manager had raised safeguarding concerns appropriately, she had not always followed through with appropriate actions such as, for example, completing an investigation and notifying Disclosure and Barring Service, until prompted to do so. It was not always clear that the registered manager was aware of how best to discharge her responsibilities in identifying and managing potential risks to ensure people's safety.

We viewed medicines administration records (MARs) for four people living at the home during the inspection dated from February to May 2016. People's MARs demonstrated that people received their prescribed medicines at the times required. People's medicines were checked against their MAR to ensure people were administered their required prescribed medicines. We saw that MAR sheets were signed when people had taken their medicines and that staff knew how people liked to take their medicines, for example using a spoon or cup, and supported people to take their medicines as they preferred.

A medicines audit was completed annually by a community pharmacist. The last one was dated June 2015 and no issues were identified. The home does not currently keep any controlled drugs. These are prescription medicines controlled under the Misuse of Drugs Act 1971 and have additional safety precautions and storage requirements. The home had kept controlled drugs in the past and therefore had suitable storage arrangements in place for them.

The registered manager explained the procedures used for the safe receipt, storage, administration and disposal of medicines. Medicines were checked in by the registered manager and another member of staff. In the medicines file, there was a list of staff authorised to administer medicines and specimens of their signature. Medicines were stored in a suitable cabinet and the temperature of the room in which they were kept was monitored daily to ensure they were being stored at the correct temperature to maintain their effectiveness. We viewed monthly medication checks that had been carried out from January 2015 to April 2016. These included people's names, the names of their medicines, dosage, quantity used, quantity remaining, quantity ordered and the quantity and date received. The check also listed any medications which had been returned to the pharmacy.

Each person's medicine file included a "pen picture" at the front of their current MAR, which also included information about, for example, how the person liked to take their medicine and when topical creams should be applied. Some medicines were taken out of the home if people were attending day centres, for example, and we saw carers' notes confirming whether medicines had been administered at the day centres, and details recorded on the back of the MAR sheets. This ensured that there was an accurate record

of what medicines the person had taken during the day.

Requires Improvement

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had made applications for all five people living at the home to have a DoLS authorisation. The local authority had granted two DoLS authorisations and the home was still awaiting the outcome of the other three applications. We saw that consent had been sought for some decisions about people's care, for example for medical procedures.

However, people's care records were not compliant with the MCA requirements. The provider had not carried out a mental capacity assessment for each person to assess whether they had capacity to make decisions or not, prior to applying for a DoLS. There were no records available to evidence that decisions about people's care, including the decision to apply for a DoLS, had always been taken in their best interests and that less restrictive options had been fully explored. In one case a person attended church regularly unaccompanied, so it was not clear why a DoLS had been applied for, as the person appeared to be free to independently leave the home when they chose.

Most staff had completed training in MCA and DoLS, but only one that we spoke to could describe effectively the requirements of the Mental Capacity Act and what it meant for people at the home. This meant that we could not be assured that staff understood their responsibilities in ensuring that they were providing care in accordance with the Mental Capacity Act 2005.

Where people were unable to give consent to their care and treatment because they lacked capacity to do so, the provider did not act in accordance with the MCA. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New members of staff received an induction when they started work at the home. Staff described this as being shown around the home, meeting the residents, spending two days shadowing more experienced member of staff and familiarising themselves with people's care plans and risk assessments. The registered manager told us that new members of staff, if they weren't already holding an NVQ qualification in Health and Social care, also completed the Care Certificate. This is the industry standard recommended for care workers which sets out the learning outcomes, competences and standards of care that care workers

nationally are expected to achieve. At the time of our inspection, one member of staff was completing the Care Certificate.

Staff training provided included infection control, manual handling and practice, medicines administration, epilepsy, safeguarding adults and dementia awareness. A member of staff described the training at the home as "very good" and "up together". One member of staff told us how the registered manager had supported them to do their NVQ3 in Health and Social Care.

Although the training record noted the dates when training was last completed by individual members of staff, it did not indicate the required regularity of the training, nor when it was next due. This meant that there was a risk that staff were not having their training refreshed regularly to ensure that they were competent to continue to deliver effective care and kept up to date with practice developments. We noticed that there were some gaps in the training record where not all staff had received training in some areas. For example, the record we viewed showed that not all staff had received training in medicines administration. The registered manager told us that some staff had been trained to administer medication in their previous role, and this had been established at interview, but they had not obtained evidence of this. The registered manager did not carry out formal medicines competency assessments for staff, but told us that they completed random checks on a regular basis and that they would always intervene if they saw that anything was wrong. However the registered manager did not record these checks.

We therefore could not be assured from records that all staff administering medicines had received appropriate training or were receiving effective competency assessments. However during our visit we saw that people received their medicines appropriately and that there had been no recorded medication errors.

There were also some areas of training which might have been relevant but not offered by the provider, for example, how to manage behaviour which challenges, as some people in the home required support to safely manage their anxiety.

We could not see from records that all staff had received the training they needed, when they needed it, in order to effectively support the people living at the home. However we did not see that this had an impact on people, who received their medicines safely as the manager had showed staff what to do. Staff were also confident in managing behaviours which challenged, as they knew people well and what they responded best to.

Although the provider's supervision records for 2013, 2014 and 2015 showed that staff supervisions took place every two to three months, we could not find corresponding supervision notes to confirm staff had received supervision this frequently. Staff told us they felt supported and that they could always go the registered manager for guidance on anything they weren't sure of. There was no annual appraisal process in place for staff at the home. This meant that the registered manager did not have an effective procedure to evaluate staff performance over the year and to identify and address any staff learning or developmental needs for the following year. This meant that people might not always be receiving care which was based on current best practice from staff who had received training and support to carry out their roles and responsibilities effectively.

We recommend that the provider seeks guidance from a reputable source on current best practice concerning the training, supervision and appraisal of staff, assessing their competence and encouraging professional development.

Food provided at the home was nutritious and people were offered a choice of meals. We saw people being

offered different sandwiches fillings for their lunch and choosing their favourites. People were supported to eat and drink enough to maintain a balanced diet. Staff freshly prepared the food themselves and meals looked and smelt appetising. People were involved in choosing menu options and people who weren't able to communicate verbally were able to use flashcards to help choose their meals. People ate well at the home and enjoyed their mealtimes. One person told us "All the food is lovely". We saw one evening meal was a relaxed occasion with people chatting and music playing. Records were kept of what people ate each day and their weight was regularly monitored.

People who were at risk of choking had been assessed by a speech and language therapist (SALT) and for one person we saw, further advice had been sought more recently when she was showing signs of swallowing difficulties. This person's care plan included "guidance at mealtimes" for staff to refer to, which included how to recognise signs of a problem, and how the person's positioning and environment could help manage the risk.

Some people at the home had been diagnosed with high cholesterol and staff made sure that people were offered healthy alternatives, even though they often preferred to choose the unhealthier options.

People told us that staff enabled them to see healthcare professionals when they needed to. One person said "If I'm not well, I let staff know and they take me to the Doctors. They rang for an ambulance once when I felt ever so ill". Staff ensured that people regularly attended hospital, clinic and GP appointments to review ongoing health issues. These practices enabled any issues to be addressed quickly, and for people to get the support they needed to keep in good health. All people had regular visits to the dentist, optician and chiropodist and had an annual GP review. The registered manager told us that the home had a good relationship with the GP and would always phone the GP if they had any concerns. The GP confirmed this by saying "If anything changed, they would make contact with me straight away. They are doing a really good job".

We saw evidence in people's files of engagement and recent appointments with the local hospital, including the neurology, x-ray and ophthalmology departments. Three people had incontinence issues at the home and had been seen by an incontinence assessor to determine the support they required. We noticed during our visit that one person was not managing their incontinence well at night. The registered manager made a referral to the continence assessment team for them during our visit.

We saw during our visit that the upstairs shower was currently broken and had been for about two months. However, the impact on people was minimised as they could still use the bath upstairs, or make use of the ensuite shower facilities in a vacant room upstairs, or use the downstairs shower.

Good

Is the service caring?

Our findings

People told us that they liked living at the home and relatives confirmed that they were happy with the care their loved ones received from staff. We observed kind, caring and compassionate interactions between people and staff throughout our visit. We saw people being supported and spoken to kindly at mealtimes, with staff using words of encouragement such as "That's good, well done". People were encouraged to take their time and not rush their food.

One person told us "I want to always live here if I can". We heard the person singing happily during our visit. Relatives told us that the "staff are caring" and that the registered manager is "very kind". They told us that the home was run "very much like your own home", with residents able to get involved in cooking, cleaning, laundry and shopping. Staff also confirmed this by describing Mayfield House as "a very homely house".

We noted that the registered manager was attuned to people's moods and behaviours and their interactions with each other and intervened where necessary, for example to encourage people to join in discussions. One health professional told us that the registered manager was "very devoted" to the people living at the home. They told us that they thought that the home "is a really happy place for them".

Staff told us that they loved working at the home and that the people living there, because there were so few of them, felt "like an extended family". They were able to tell us about each person in detail, such as who enjoyed helping to prepare meals every day, who liked to take part as well but needed more supervision and who sometimes just liked to come and watch.

During our visit, we saw that people had the opportunity to be involved in expressing their views and making decisions, for example; one person decided that they didn't want to go to the day centre, and staff respected their decision. Staff had also looked into whether the person might be able to go to the day centre on different days of the week when they might feel happier to attend. People were also supported to make decisions about what clothes they wanted to wear. Staff understood the wishes of people who were not able to verbally communicate as they were able to interpret people's individual communication, such as their nodding or shaking their head, making noises or through other behaviours.

One member of staff described how they would help the residents make choices by asking them if they wanted to go out to do an activity rather than just assuming and taking them. In the communications book used by staff we saw that choices were regularly offered to people, for example; instructing staff to ask someone if they wanted an electric or wet shave. We also saw from residents' meetings that people were asked to bring forward ideas for new things to be added to the menu. The meeting minutes confirmed that suggested changes had been made.

People's independence was encouraged, according to their capabilities. We saw that some people were encouraged to pour their own cup of tea, and take their dirty dishes into the kitchen and seemed to enjoy the sense of achievement this provided. One person was encouraged to walk rather than use their wheelchair just for short distances when moving around the home to help with their mobility and sense of

independence. Other people liked to get involved with sowing seeds in the vegetable patch and growing vegetables. Relatives we spoke with agreed that Mayfield House promoted people's independence, describing how people were responsible for changing their own bed and doing their own laundry, but also that staff would provide help and support when needed.

Staff were able to describe how they would respect and promote people's privacy and dignity. We observed staff knocking on someone's door and waiting for a reply before entering. A staff member described how she would ensure that people wore their dressing gowns when moving between the bathroom and the bedroom after a shower and described the care provided as "the same as what we would want for ourselves". Another described how, when delivering personal care, they would keep the bedroom door closed, give people choices, and give them time. They also described encouraging people to be discreet when out in public and that they would always carry a change of clothes for the person in case they were needed.

The registered manager explained that some residents' rooms were close to each other, so they encouraged doors to be closed to avoid the temptation for people to peep into others' rooms. Staff were advised to encourage people to close the door when using the bathroom. We saw a poster displayed in the home called "Do not forget the person – respect choice and dignity".

Good

Is the service responsive?

Our findings

People's care and support plans were personalised to each individual. They included people's care and health needs, and contained personal information about each person, their likes and dislikes and daily routines, their behaviours and things that were important to them. People living at the home who experienced epilepsy had care plans which included an epilepsy profile and risk assessment. These detailed the characteristics of each person's epileptic seizure and guidance for staff on the management of that person's epilepsy. Staff were able to describe to us how they would know if someone was having a seizure and what to do. People who had diabetes also had diabetic support plans and profiles so that staff would know the signs to look out for and what to do if someone's blood sugar levels became too low or too high. One person had an additional care plan for when they were feeling unwell. This discussed the characteristics of their behaviours and instructed staff to record any untoward signs and report these to the registered manager.

Detailed activity sheets were completed for each person outlining what they had done for each day in both the mornings and afternoon and we also saw detailed daily logs in place for each person. These documents provided staff with information to help them deliver care that supported a person's individual needs, for example whether they had been very busy on a particular day and were likely to be tired. The daily logs contained information, for example, about the impact of stress on a person's medical condition and behaviours, which reflected what we had been told by staff and the registered manager. This information enabled staff to understand a person's mood or behaviours and respond accordingly in how they delivered their care for the person.

We saw that there was an annual review with social services for each person. This was attended by all the people involved in the care of the person, including staff, social services, managers at the day centres and people's relatives. These contained detailed information around the person's general health and medical information, as well has their routines, sleep patterns, social interactions, domestic skills and communication. They also contained areas of risk for each person, and a review against their goals. Relatives confirmed that they were involved in the review of care plans and attended the reviews with social services and day care staff. One relative told us "I am happy with the care, they always involve me in everything".

We found that the service responded to changes in people's needs, for example; one person was overly tired when they came back from a full day at the day care centre, and was often too tired to eat their evening meal. The registered manager was therefore reviewing options for reducing the length of time the person spent at the day care centre, and exploring the possibility of them attending for two shorter days as an alternative to one full day.

Although a relative commented that due to staff shortages, staff were not always able to do as many things with people as they might like, such as going out for walks, during our inspection we saw that people were supported and encouraged to take part in activities. Most people visited the local day centres several times a week. The registered manager told us that there was an activities co-ordinator that came to the home

once a week to do arts and crafts with people. Staff told us that one person goes to church every Sunday on his own. They told us "He loves to go, he has friends there". The home had books, games, a TV, DVDs, puzzles, colouring books for people to enjoy and access to the computer and a Wii console. During our visit we saw people watching the television, colouring, and helping out with the cooking. We also saw people enjoying a new game as a group which they had recently learnt to play with a member of staff. People were encouraged to keep up their hobbies, including baking cakes, French knitting and gardening. The home had held a barbeque the previous weekend. People enjoyed this and requested another, which the home was planning. Staff told us that people had been on a trip to the Hovercraft Museum near Portsmouth and had also enjoyed a trip to Gatwick for the day to watch the planes.

One relative told us that their loved one had done well at the home, and over the years they had lived there, had grown in confidence. They described that the home had "really brought her on".

We viewed the minutes of residents meetings held in October 2015, January 2016 and April 2016. Although there was repetition in some minutes, we saw that they included people being asked about whether they liked the current menu and whether they would like anything added. One person had asked for two new items to be added to the menu and the minutes confirmed that these had been included. Another person had asked for alternatives to toast for breakfast and during our inspection they told us that they had had cornflakes for their breakfast that morning. Family satisfaction surveys had been completed in July 2015. One relative had suggested some improvements to one person's wardrobe and we saw that staff had implemented this. This showed us that the home had made improvements in response to people's feedback.

The home had a complaints policy in place. People and relatives told us that they felt able to go to the registered manager with any concerns or complaints and had confidence that she would act on them. One relative told us that she knew her loved one would also be confident in approaching the registered manager if she wasn't happy about anything and the registered manager would in turn let her know as communication was good. We viewed five complaints that had been recorded during 2014 and 2015. Of these, only two complaints from a relative related to the service provided, the others were internal complaints between people living at the home. We saw that the manager had recorded, investigated and taken action in relation to the complaints received.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had not consistently followed the requirements of their registration to notify CQC of specific incidents relating to the service. We found some notifications had been sent to us as required, for example in the event of safeguarding incidents. However, we had not received notifications for the two known DoLS application outcomes as required by law to support us to monitor whether the service was meeting their requirements relating to DoLS. As we had not been made aware of the outcomes of the applications, we were not able to assure ourselves that where people were being deprived of their liberty that this was being done lawfully.

The provider had not notified CQC of the outcome of their applications to deprive people of their liberty. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The registered manager told us that they checked the quality of the service regularly as they were in day to day control of the service. However, systems were not in place, or for those in place, not effectively operated, to support the manager and staff to continuously evaluate the quality of the service being delivered.

The provider did not operate an effective safety incident management system to ensure all safety incidents would be responded to appropriately and the risk of harm to people mitigated, for example; during our inspection we did not see a record of how the provider monitored people's falls to see if there were any trends or patterns. This record has since been provided after the inspection. However the record was not complete and did not include, for example, three falls for one person who was a risk of falls. Records did not show what post-falls observations had been completed. People were therefore at risk of not receiving safe care as staff might not have identified any possible post fall complications that would require an urgent referral to a medical team. When the registered manager had become aware of these falls there was not a system in place to ensure that the incidents informed potential risks to the service. The provider's response to safety incidents was not always monitored to ensure that swift action could be taken to keep people safe.

The registered manager carried out some quality assurance checks of the service, such as for health and safety and infection control. The documents we viewed in relation to these did not highlight any concerns. However we were not assured of how regularly these checks were being carried out or how effective they were in identifying areas for improvement. We saw an annual quality assurance document dated April 2016 which included information relating to house maintenance, garden maintenance, improving people's activities and social skills, people's DoLS applications and staff training. However this document was more of a general update than a quality audit, and with the exception of some plans for cleaning and painting of some outside areas, did not serve to highlight areas for improvement, or related actions and when these would be achieved by. We could not see how quality assurance, audit and governance systems were effective and used to identify and drive improvement in the quality and safety of the services provided and improve people's experiences of living at the home.

We saw that the provider had policies and procedures in place on a variety of areas such as continence management, moving and handling, food and nutrition, infection control, falls management, accident and

incident reporting, health and safety, safeguarding, and DoLS and the Mental Capacity Act. However these were long and generic documents and were not tailored to suit the individual circumstances of the home. There was little evidence that the registered manager or staff were familiar with their contents. The manager had started to address this by introducing a system where they downloaded each policy and asked staff to read it and sign to say they had read it. So far, this had only happened for the medicines and safeguarding policies, and not all staff had signed to say that they had read those. If staff were unfamiliar with the provider's policies and procedures there was a risk that they were not delivering care in accordance with them, and that people may not be receiving care in line with current best practice.

People's care and support plans were reviewed regularly by the registered manager; however changes that arose as a result of those reviews had not been reflected in people's care plans. The registered manager explained that the key workers were responsible for updating the care plans following their review, but this did not always happen. This meant that we could not see what changes had arisen as a result of those reviews in their care plans, or be assured that people were receiving care that reflected their current needs. This impact of this was mitigated by the size of the service, as there were only five people for staff to get to know, and the use of the communications book which did include changes in people's care needs. However there was no record to provide assurance that all the entries in the communication book reflected the outcomes of the reviews carried out by the registered manager. We also saw that care and support plans contained a lot of old information and that some documentation was not dated at all. This meant it could be difficult for a new member of staff joining the team to find out what they needed to know quickly about a person and what information was or wasn't relevant to their care needs.

Two sets of notes of residents meetings, dated six months apart, discussed almost exactly the same issues and contained almost the same wording. This made it difficult to see how these meetings were being effectively used to improve the experiences of people living at the home.

A staff member told us that the regularity of staff meetings "was a bit hit and miss" but that they always felt able to raise issues with the registered manager in between times. We saw that staff meetings had been held on 29th April 2016, 10th February 2016, 9th October 2015 and 20th March 2015. However, records relating to these meetings, such as the agenda and minutes, were not always available. This meant that staff might not always be able to refer back to the minutes of staff meetings to ensure that they were delivering care in accordance with what was agreed at those meetings.

We found from this inspection that there was a lack of effective records, systems and processes in place to assess, monitor and improve the quality and safety of services and to mitigate risks associated with people's health, safety and welfare. The provider had not always maintained an accurate and complete record in respect of the care provided to each person. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we saw that the registered manager was a strong and visible presence. Staff told us that she was flexible and provided direction and support. We saw from the minutes of staff meetings that we did view that the registered manager provided clear direction on what she expected from staff working at the home.

People, relatives and staff spoke well of the registered manager. A staff member described the registered manager as being "open about staffing issues" and described the current staff team as having good communications and camaraderie amongst themselves and with the residents. A staff member told us that the registered manager was "very approachable, always listens and tries to put things right. Always has the people at the heart of everything she does". One person told us that she liked the registered manager very

much and that she was "so kind". A relative told us that she thought that the registered manager "ran the service very well" while another said that they thought that communication with the home on any significant issues was very good.

The provider had a statement of purpose dated March 2016 which included: "We place the rights of service users at the forefront of our philosophy of care. Our mission expresses our founding aspiration to provide opportunities for all…..we encourage our service users to exercise their rights in full". Staff described the home as having an open and inclusive culture and that the people living at the home were the staff's priority. A staff member told us "If I'm not happy about something I will say. I need to make sure they [the residents] are always looked after properly."

The registered manager was able to describe to us the home's links with the community, and talked to us about the residents' involvement with the local leisure centres, churches, bowling alleys and pubs. There was also good links with the local day centres, and during the inspection we heard a call from the day centre to advise the registered manager how a person that was with them that day had been a little tired and not quite themselves.

We received mixed views from health professionals in respect to how well the home was run. One health professional told us that the registered manager "held all the information about the people and was very much in control" of the running of the home. They spoke about the manager being proactive in raising any concerns. Another health professional told us that the registered manager "responded to and did everything we asked of her". However another had concerns that the home was reactive rather than proactive, and while they responded well when concerns were raised, they were not necessarily quick to identify things for themselves and take action unprompted, such as ensuring that staff got the training they needed.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified CQC of the outcome of their applications to deprive people of their liberty. This was a breach of Regulation 18(4B)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where there were concerns about people's capacity to consent to decisions about their care, the provider did not act in accordance with the Mental Capacity Act 2005. This was a breach of Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not implement effective quality assurance systems to assess, monitor and improve the quality and safety of the home, or to assess, monitor and mitigate the risks to the health safety and welfare of people living at the home. The provider had not always maintained an accurate, complete and contemporaneous record in respect of each person. This was a breach of Regulation 17(1)(2)(a)(b)(c)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The provider had failed to establish and operate effective recruitment procedures to ensure that persons employed were of good character. The provider had not protected people by ensuring that the information specified in Schedule 3 in relation to each person employed was available. This was a breach of Regulation 19(1)(a)(2)(a)(3)(a).