Mayfair residential care home Limited

Mayfair Residential Care Home Ltd

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Mayfair Residential Care Home Ltd is a care home providing personal care to up to 20 older people, some of whom may be living with dementia. At the time of this inspection, 13 people were living at the service.

People's experience of using this service and what we found
The service was not safe. Risks to people had not been assessed or recorded. Checks of equipment, maintenance checks and servicing had not been completed at required intervals. Where shortfalls had been found in relation to the health and safety of the service, action had not been taken to address this.

Medicines had not been administered or managed in a safe way. Safeguarding concerns had not been appropriately reported and thorough recruitment checks had not been completed prior to new staff commencing employment.

Staffing levels were not always sufficient which impacted on the quality of care provided. Staff had not been provided with sufficient support or training to ensure they had the skills and knowledge to carry out their roles.

Action had not always been taken to seek professional's advice and support when people had lost weight or suffered a high number of falls. People's care plans had not been updated to reflect people's current needs, and end of life care plans only contained basic information. We have made a recommendation about end of life care planning.

There was a lack of activities and stimulation within the service. We have made a recommendation about activities. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice

There was a significant lack of provider oversight and leadership within the service. Quality assurance processes were either not in place or had not been completed for a considerable amount of time. The provider had failed to take action to ensure they were meeting regulatory requirements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 8 April 2020) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected

The inspection was prompted in part due to concerns received about the lack of management oversight within the service. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

The provider acknowledged the significant shortfalls found during this inspection. They took action following the inspection to begin to address some of the shortfalls found. They produced an action plan and began to work with the local authority to make improvements.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Mayfair Residential Care Home Ltd on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to health and safety, assessing and managing risks, infection control, medicine management, recruitment processes, safeguarding people, nutritional needs, staff support and governance at this inspection.

You can see what enforcement action we took at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Mayfair Residential Care Home Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was undertaken by one inspector.

Service and service type
Mayfair Residential Care Home Ltd is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Mayfair Residential Care Home Ltd is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. An interim agency manager had been employed on a short-term contract and they were present throughout the inspection. They are referred to as 'the manager' throughout this report.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and other professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with five people who used the service and two relatives about their experience of the care provided. We spoke with five members of staff including the interim agency manager, senior carers, care assistants and the chef. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We conducted a tour of the service and looked at a wide variety of records. These included multiple care and medicine records, monitoring documentation, staff files and audits used to monitor the service.

Following the inspection site visit we contacted the nominated individual to request additional information. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At the last inspection the provider had failed to ensure risks relating to people's safety, health and well-being were appropriately managed which placed them at increased risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Risks to people in relation to their medical conditions, as well as the environment had not been assessed and recorded. For example, where people had a diagnosis of diabetes, appropriate risk assessments were not in place. Where risk assessments have been developed, these had not been updated when people's needs changed.
- The provider had failed to ensure equipment, servicing and maintenance checks were completed at the required intervals. Where shortfalls had been found following a service, action had not been taken to address this. For example, the provider had failed to improve fire safety following shortfalls found by a fire authority visit in April 2022.
- Unsuitable mattresses were in use. These did not fit the bedframe appropriately which resulted in an overhang and therefore, presented a falls risk.

Failure to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any such risks was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not administered safely or as prescribed, and risks posed by some medicines had not been considered. For example, the risk posed by the use of flammable creams.
- People had not always received their prescribed medicines as staff were not appropriately trained and competent.
- Where people were prescribed a variable dose of medicines, records had not been completed appropriately so it was not clear how much medication had been administered.

Failure to ensure the proper and safe management of medicines was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Infection, prevention and control was not sufficiently managed. Areas of the service, such as taps contain limescales and mildew.
● Appropriate Personal Protective Equipment (PPE) was not always worn by staff when entering the kitchen area. The flooring in the sluice room was heavily stained and the sink unit was heavily damaged which would prevent effective cleaning.
● There were a number of items of furniture that were damage and could not be cleaned sufficiently. This included chairs in communal areas.

Failure to ensure manage the risk associated with infection, prevention and control was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Lessons had not been learnt when accidents and incidents occurred. The provider had failed to take action to reduce risks of accident reoccurring.
● Shortfalls found at this inspection had been highlighted to the provider at previous inspections. They had failed to learn lessons and implement the required improvements to ensure they were providing a good quality service.

Failure to take action to mitigate risks relating to the health and safety of people was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse.
● We found a number of examples were suspected abuse had occurred, but appropriate referrals had not been made to the local authority or CQC.
● Staff had not been provided with safeguarding training. They did not have the skills and knowledge required in relation to safeguarding to identify when a concern should be raised.

Failure to safeguard service users from abuse is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Safe recruitment processes were not followed.
● We found examples where new staff had commenced employment prior to their Disclosure and Barring Service checks and references being received. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Failure to implement and follow safe recruitment processes was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A sufficient number of staff were not always on duty. The provider did not use a dependency tool to evidence safe staffing levels. One staff member said, "We are short staffed today. There is only two staff on duty this afternoon and we have to make meals, give medication and support 13 people with their care needs. Two is not enough."
● We found examples when suitably medicine trained staff were not on duty at night. This had resulted in one person not receiving their prescribed medication.

Failure to ensure a suitable number of qualified, competent staff were on duty was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
Visits to Mayfair Residential Home Ltd were in line with government guidelines. No restrictions were in place and visits took place during the inspection process.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- Pre-admissions assessments had not always been completed to ensure the service could meet people's needs prior to moving to the service.
- Poor record keeping meant that people's needs, and choices were not always recorded.
- The lack of management within the service meant care and support was not always delivered in line with standards and regulations.

Failure to ensure people's care and support was provided in a safe way, in line with regulations was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- Staff had not been provided with consistent and appropriate support. Regular one to one supervision had not been completed consistently, with some staff not being provided with any supervision in 2022.
- Staff had not been provided with sufficient training. For example, a number of staff had not completed training in mental capacity, safeguarding, stoma care or dementia.
- Staff told us they did not always feel supported. Comments included, "There has been so many changes in management. The last manager just walked out. We are just left to deal with it."

Failure to provide staff with effective and sufficient supervision and training to enable them to carry out their roles was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
- People were not supported to maintain a balanced diet. Staff failed to recognise the impact eating high sugar snacks would have on people with diabetes.
- People's weights were not consistently recorded. Where weight loss had occurred, it was not clear appropriate action had been taken.
- Records had not been updated to reflect people's current needs. For example, one person was observe drinking a supplement drink but there were no details in the person's care plan to state why supplements had been prescribed.

Failure to meet people's nutritional and hydration needs was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Staff did not always contact other professionals when required. For example, one person had suffered an increased number of falls. No action had been taken to report this concern to the appropriate professional.

● Where professionals had been contacted and follow up actions were required; these had not always been completed in a timely manner. For example, there had been delays obtaining urine samples when suspected infections had been identified.

Failure to actively work with other professionals to ensure timely care and treatment is provided was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite some delays, professionals spoke positively of the service. They stated staff worked in partnership with them and had a kind and caring approach.

Ensuring consent to care and treatment in line with law and guidance

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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Consent had been signed by people who did not have the legal authority to do so.

● Where people lacked capacity to make decisions, appropriate best interest decision were not recorded.

● Due to poor record keeping we could not be assured people were lawfully deprived of their liberty.

Failure to maintain securely accurate, complete and contemporaneous records is a breach continued of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Adapting service, design, decoration to meet people's needs

● Risks to people in relation to some areas of the service had not been considered. People had access to high risk areas such as staircases.

● Some areas of the service needed addressing as they were old and worn and presented a health and safety and infection control risk.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
- The lack of effective communication methods between the staff team staff meant not all staff were up to date with people's care and support needs. This had, at times, resulted in delays with treatment.
- Communication between people and staff was positive overall. However, we did observe a lack of respectful communication at busy periods of the day when staffing levels were low.
- People and relatives told us they were treated well, and staff were kind and caring. Comments included, "I feel the care provided by staff is from the heart" and "Staff will help me in any way they can".

Supporting people to express their views and be involved in making decisions about their care
- People told us they were able to express their views. Comments included, "I can chat to staff about anything and they do listen."
- People and realties told us they were involved in making decisions about their care. However, there was no recorded evidence that people or relatives had been included in reviews of people's care and support.

Respecting and promoting people's privacy, dignity and independence
- People were not always supported in accordance with their care and support needs which compromised their dignity. For example, we observed one person who was not appropriately supported with their continence needs.
- The environment within the service did not always provide privacy. One communal bathroom had no window covering, and curtains in people's bedrooms did not fit the windows appropriately.
- Where possible, people's independence was promoted but risks associated with this had not been considered.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans had not always been updated when changes had occurred. For example, where people's mobility or skin integrity had deteriorated, care plans had not been updated to reflect this.
- There were times when the number of staff was not sufficient. This resulted in people's needs not always being met in a timely manner or in line with their preferences.
- Staff communication records showed tasks were often handed over to staff on duty the next day, which resulted in delays.

Failure to maintain securely accurate, complete and contemporaneous records is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not always supported to follow their interests or take part in activities. We observed a lack of stimulation throughout the inspection.

We recommend the provider seeks advice from a reputable source in relation to stimulation and activities and take action to update their practice accordingly.

- People and relatives, we spoke with told us they were happy with the activities on offer. Comments included, "We have music mornings and I enjoy the visit from the hairdresser". Another person said, "There is a list of activities on the wall I think." This list was not observed during the inspection.

End of life care and support

- People had end of life care plans in place, but these contained only basic information.
- Staff had not been provided with training in end of life care.

We recommend the provider considers current guidance in relation to end of life care and take action to update their practice accordingly.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get

information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were detailed in their care plans.

● Records showed staff had taken action to seek replacements when communication aids, such as hearing aids, had been misplaced.

● Information was not always present in a way people could understand. For example, picture menus were not used to aid decision regarding meal choices.

Improving care quality in response to complaints or concerns

● The manager was new to the service and was unable to locate any information relating to complaints.

● People and relatives told us they had no concerns or reasons to complain. Comments included, "I have never had to raise a complaint" and "I have never had a reason (to raise a complaint). They stated they knew who to speak to should they need to raise any concerns.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At the last inspection the provider failed to implement effective system to assess the quality and safety of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider has been in breach of Regulation 17 since 2017. They have failed to take action to address the shortfall found on numerous occasions.
- The provider had produced improvements plans following inspections in 2017, 2019 and 2020 to state what they would do, by when to ensure people received a good level of service. These had not been implemented or followed, and poor standards of care remained.
- Audits used to monitor the quality and safety of the service were either not completed or failed to identify the significant shortfalls within the service.
- There was insufficient provider oversight. The nominated individual had been appointed in January 2022 but had failed to visit the service. The provider had no systems in place to enable them to monitor the quality and safety of the service.

Failure to implement effective system to assess the quality and safety of the service was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- There had been no recent engagement with people or their relatives to seek their views on the service provided. One person said, "I completed a questionnaire once, but that was a long time ago now."
- There had been significant changes to the company directors. There had been no engagement with people or relatives in relation to this.

Failure to seek and act on feedback to continuously improve the service was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they did not always feel listened to and valued. However, they spoke highly of the new manager and changes they were trying to implement.
● Professionals spoke highly of the staff team and the support they provided. However, we found examples when timely action had not been taken to consult with relevant professionals.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● A positive culture had not been promoted. The number of changes in the management structure had impacted on the culture of the home.
● The staff team were committed to their roles, but the lack of appropriate training and support meant they were not clear on their roles and responsibilities. One staff member said, "We are rushed, and everything feels unorganised which does impact on the level of care we provide."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider was not clear on their legal responsibilities under the duty of candour. Their knowledge with regards to health and social care and associated regulations was lacking.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to asses the risks to the health and safety of people and do all that is reasonably practicable to mitigate any such risks. The provider failed to ensure medicine and risk associated with infection prevention and control were managed safely. 12(1)(2)(a)(b)(d)(e)(g)(h)

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider Failed to safeguard service users from abuse 13(1)(2)

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to meet people's nutritional and hydration needs 14(1)(4)(b)

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate effective systems and process to ensure compliance with regulations. The provider failed to assess, monitor and improve the quality and safety of the service provided. The provider failed to mitigate risks relating to the health, safety and welfare of people and they failed to maintain accurate, complete and contemporaneous records. The provider failed to seek and act on feedback provided. 17(1)(2)(a)(b)(c)(e)(3)(a)

The enforcement action we took:

Cancellation of registration

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 failed to implement and follow safe recruitment processes 19(2)

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to provide staff with effective and sufficient supervision and training to enable them to carry out their roles 18(1)(2)(a)

The enforcement action we took:

Cancellation of registration