Maybank House Limited

Maybank House

Inspection report

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Tel: 01619986566

Date of inspection visit:
16 May 2018
17 May 2018

Date of publication:
15 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 16 and 17 May 2018 and the first day of inspection was unannounced.

At the last inspection undertaken in February 2017 we rated the service as 'requires improvement' in safe and effective and 'good' in the key areas of caring, responsive and well led. This meant that the home received an overall rating of 'requires improvement'. We identified no breaches of legal requirements at our previous inspection.

At this inspection we rated Maybank House 'requires improvement' overall and this is the third inspection where the service has been judged as 'requires improvement.' We identified three breaches of regulation in respect of safe care and treatment, the need for consent and good governance.

Maybank House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Maybank House accommodates up to 25 people in one adapted building. At the time of our inspection there were 13 people living at Maybank House. The home had recently had major refurbishment to the ground floor accommodation which had affected the number of bedrooms available in the home. The provider had started to accept new admissions into the home prior to this inspection.

There was a registered manager in post 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.

People had individual risk assessments. Identified risks were assessed and ways to reduce the likelihood of the person being harmed were recorded. People were supported safely and in line with their risk assessments.

The home had undergone major refurbishment to ground floor bedrooms due to water damage. Staffing levels had been flexed based on the low numbers of people in the home at the time of this inspection.

There was a medicines policy in place for the safe storage, administration and disposal of medicines. Staff were given relevant information about specific medicines. The temperature at which medicines were stored at was being monitored but was too high. No remedial action had been taken to check the medicines fridge was working properly.

An external contractor had carried out an assessment of the premises in relation to water safety in January 2017 but no action had been taken as a result of this assessment. There were no processes in place setting

out cleaning and disinfecting regimes to ensure the safety of the water systems.

There was a pre-admission assessment in place. Following an initial enquiry, arrangements were then made with individuals to carry out a more detailed assessment prior to admission.

There was a CCTV system in communal areas and outside spaces of the home, although people were not informed of this is in the home's statement of purpose. Inside the home we saw the use of stair alarms, floor and door alarm sensors and a nurse call system in order to minimise the risks posed to people.

Records saw showed regular, planned supervisions with staff and annual appraisals were provided. Induction training was provided to staff so they had the skills and knowledge for their role. New staff spent time shadowing more experienced staff to help them understand their role.

We checked whether the provider was working within the principles of the Mental Capacity Act and whether any conditions on authorisations to deprive a person of their liberty were being met. We were satisfied the DoLS legislation was being used in the way it was intended, for example to protect people's rights. However, where it was considered that people lacked capacity to consent, we did not see decisions made in people's best interests, or consent forms signed by appropriate representatives in relation to receiving care and treatment or medicines. The only consent we saw in care plans was that for having photographs taken.

There was information in the kitchen relating to people's diets. Nutritional screening plans indicated people's preferences. Menus were flexed and the chef shaped the menus based on people's preferences and choices.

The provider had carried out a programme of major refurbishment to the ground floor bedroom areas. We noted improvements in the décor of these rooms and new fixtures and fittings contained within them.

People continued to be supported to access medical and healthcare professionals as required, which included GP's, district nurses, speech and language therapy (SaLT) and podiatry. Care plans contained information about people's health so that staff could provide appropriate support.

The staff team at the home was small and consistent and relatives told us there was no use of agency staff. We could see that staff had developed an obvious rapport with people, who felt comfortable in staff's presence. People looked clean, well-groomed and appropriately dressed.

People we spoke with confirmed they were treated with dignity and respect. Staff understood the importance of promoting people's independence and encouraged people to do as much for themselves as possible.

The provider was aware of the importance of ensuring equality, diversity and people's human rights were upheld and incorporated this aspect into an element of staff training. Staff took appropriate action to maintain confidentiality when dealing with personal and sensitive information relating to individuals.

Care plan profiles were personalised around individuals and documented their capabilities. Care files contained information about people's backgrounds, likes and dislikes, social and medical needs.

We looked to see how the service met people's social needs. Care workers tried to encourage people to participate in activities or group discussions. Reminiscence sessions and themed discussions were recorded. People were able to carry on doing the things they had previously enjoyed before moving to Maybank

House. People were encouraged to maintain relationships that were important to them.

There were no documented supervisions with the registered manager or action notes from meetings and discussions with the provider. We saw there were a variety of audits and monitoring systems in place to monitor the quality and effectiveness of the service but these audits were not robust enough and not fit for purpose. The lack of action in relation to safety checks of water systems had not been identified.

People's opinions of the service were sampled at regular intervals. Relatives had been consulted about the service in October 2017 and all responses were positive. Staff performance was monitored by way of spot checks. Staff were informed about any bad practices and supported to improve.

The home had a suite of policies and procedures available for staff stored in the office. The suite of policies contained detailed templates and paperwork not currently being used by the home, for example around recruitment and audits. The home was not using the quality compliance system to its full advantage.

With regards to the breaches in regulation identified at this inspection you can see what action we asked the provider to take at the back 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

Identified risks were assessed and ways to minimise risks were recorded. People were supported safely and in line with their risk assessments.

There were enough staff to care for people's needs. Staffing levels were flexed based on the number of people living at the home.

There were no processes in place setting out cleaning and disinfecting regimes to ensure the safety of the water systems.

Is the service effective?

Requires Improvement

The service had not gained consent from people or their representatives in relation to receiving care and treatment or medicines.

The home used technology to good advantage although the statement of purpose did not contain details about the use of CCTV in communal areas

Nutritional screening plans indicated people's preferences in relation to meals, for example portion sizes and favourite foods.

Is the service caring?

Good

Staff's knowledge and understanding of each person living at the home helped ensure they could both listen to and communicate effectively with people.

Staff understood the importance of promoting people's independence and encouraged people to do as much for themselves.

Staff at the home took action to maintain confidentiality when dealing with personal and sensitive information relating to individuals.

Is the service responsive?

Requires Improvement

It was not obvious from care plans to what extent people had

been involved. Not all care plans were signed by the person or their representative.

Care workers tried to encourage people to participate in activities or group discussions. Reminiscence sessions and themed discussions were recorded.

People we spoke with knew how to complain and told us if they had any issues they would be happy speaking to management or a member of staff.

Is the service well-led?

Requires Improvement

Audits and systems in place to monitor the quality and effectiveness of the service were not robust.

People's opinions of the service were sampled at regular intervals. Relatives had been consulted about the service in October 2017 and all responses were positive.

The home had a suite of policies and procedures which contained detailed templates and paperwork not currently being used by the home. The home was not using the quality compliance system to its full advantage.

Maybank 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.

This inspection took place on 16 and 17 May 2018 and the first day of inspection was unannounced which meant no one at the service knew beforehand that we would be visiting. The inspection team consisted of one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience in older people's care services.

Before our inspection, we reviewed the information we held about the home. This included correspondence we had received and notifications submitted by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example where a person who uses the service dies or experiences a serious injury.

The service had completed a provider information return (PIR) for this inspection. A PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted Manchester local authority and Healthwatch, an independent consumer champion that gathers and represents the views of the public about health and social care services in England We received feedback from the local authority and no concerns were raised about this service.

During our inspection we spoke with ten people living at the home and five relatives to obtain their views of the support provided. We spoke with eight members of staff, which included the registered manager, three care staff, the registered provider and ancillary staff such as maintenance, catering and domestic staff.

Throughout our inspection we spent time observing daily life in the communal areas of the home and how staff interacted with people and supported them. We looked at records, which included five care records,

four staff records and other records relating to the maintenance and management of the home, such as training, quality assurance audits and maintenance checks.

Requires Improvement

Is the service safe?

Our findings

People we spoke with said they did feel safe living at Maybank Care Home and received the help they needed. The relatives we spoke with told us that that they were happy with the care provided and considered their family members were kept safe. When asked if people were safe relatives told us, "Safe? Yes definitely; [person's name] is happy and relaxed here" and "[person's name] is safe and happy here; just not safe at home."

Some practices at the home however, did not always keep people safe. The temperature at which medicines were stored at was being monitored. We saw that staff were documenting the temperature of the medicines fridge, which from 31 March to 9 May 2018 was constantly over the acceptable level of 8 degrees, and recording that these temperatures were at acceptable levels. Medicines can become ineffective or unsafe to use when stored at too high a temperature. No remedial action had been taken to check the medicines fridge was working properly or if the thermometer was faulty and we brought this to the registered manager's attention.

The provider had commissioned the services of a company to carry out an assessment of the premises in relation to water safety. We saw paperwork relating to legionella checks and an initial assessment was completed by an external company in January 2017 however, no other work had been completed. The provider had not nominated a Responsible Person to deal with the checks associated with water safety, for example the sanitisation of showerheads and the flushing of infrequent outlets. We were later sent a copy of some records relating to this but these were over a year old. There were no processes in place setting out cleaning and disinfecting regimes to ensure the safety of the water systems. We will check with the provider what action has been taken and if this has not been addressed, refer on to environmental health.

Due to the lack of action to address the medicine fridge temperatures and no nominated 'Responsible Person' to deal with the checks associated with water safety we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to safe care and treatment.

We saw that people had individual risk assessments for such things as moving and handling and bed safety. All identified risks were assessed and ways to reduce the likelihood of the person being harmed were considered. Any actions agreed were recorded and reviewed regularly. We saw people were supported safely and in line with their risk assessments. During the inspection we saw staff had the skills to support people safely, for example when people needed equipment to help them mobilise.

We saw the home used assistive technology to help ensure the safety of residents. One person liked to spend time in their bedroom and was mobile with the use of equipment. The registered manager had deemed that a floor sensor mat would be too much of a risk, as it would pose a trip hazard to the individual, so had fitted a door alarm sensor. Staff were alerted if the person chose to leave their room and then went to assist to reduce the likelihood of an accident or a fall. This meant that people were kept safe whilst being able to remain independent.

Records showed staff had received training in safeguarding vulnerable adults and whistleblowing. Whistleblowing is one way in which a worker can report concerns, by telling their manager or someone they trust. Staff we spoke with were confident they would be protected should they ever feel it necessary to raise such concerns.

Safeguarding and whistleblowing policies and procedures were available for staff to refer to and on display in the general office at the home. Staff we spoke with were aware of their responsibilities in reporting any safeguarding concerns they had to the registered manager or deputy manager at the home. There was a system operating for relatives or visitors to leave money when visiting family members at the weekend. This meant people were protected from financial abuse and their money was kept safe dealt with by members of management.

At the time of this inspection there were 13 people living in the home. The home had just finished a period of refurbishment work and was looking to progress admissions to the home into the new rooms. People we spoke with told us that they felt there was enough staff to care for their needs. People said they understood the demands on staff and accepted that at times they had to wait for assistance but this did not happen often.

We saw that people living at Maybank House did not required full support but preferred to be supervised, for example when mobilising around the home. During our observations we saw people were comfortable in the presence of the staff and when people showed they needed assistance this was provided. Staff knew the capabilities and needs of each person so that they could keep them safe and from harm.

During the day, we saw at least one member of staff remained in the main lounge area or in view of people in case they needed assistance. Due to the layout of the home senior staff based in the office and those in the kitchen could see people sat in the smaller lounge area near to the dining area and were able to summon assistance for people if this was necessary.

On the day of the inspection there was the registered manager and three care staff, including the deputy and the assistant manager who both provided care and support. There was also one domestic, catering and maintenance member of staff working at the home. Staff told us there were always either two care staff plus a senior member of care staff on duty during the day. Staffing levels had been flexed based on the low numbers of people currently staying in the home at the time of this inspection. Staff we spoke with said enough staff were provided to support people's needs and people we spoke with agreed.

We looked at four staff files. Each contained two references, proof of identity and a Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have. This helped to ensure people employed were of good character and had been assessed as suitable to work at the home. All of the staff spoken with confirmed they had provided references, attended interview and had a DBS check completed prior to employment. This showed recruitment procedures in the home helped to keep people safe.

There was a medicines policy in place for the safe storage, administration and disposal of medicines. As part of our inspection we looked at how medicines were administered, stored and disposed of to ensure the service was managing this safely. We looked at the Medication Administration Records (MARS), observed staff administering medicines and checked the stock of medicines held for four people. We identified missing photographs from MAR records for a number of residents and made the deputy manager aware of this.

There were no controlled drugs on site at the time of our inspection. Medicines supplied by the pharmacy were in colour coded blister packs. The service highlighted the MAR to match so that it was clear to staff administering medicines what was due and when. Any medicines which had been dispensed then refused or dropped on the floor, were put in a sealed packet which was signed, dated and put in the returns box to be disposed of.

No one was in receipt of covert meds and PRN protocols were kept with the MARs. We saw information recorded with people's MAR charts about the side effects of medicines, for example a medicine to help control diabetes. This meant staff were given relevant information about specific medicines. The medicines policy in place indicated signatures from two members of staff were required for any medicines hand written on a MAR chart and we saw that this was being followed. Two members of staff checking and signing hand written entries means the likelihood of errors are reduced.

Regular checks of the building were carried out to keep people safe and the home well maintained. These had been carried out by the registered manager in the absence of maintenance personnel. Firefighting equipment and gas safety were all checked on a regular basis by qualified contractors. We saw that wardrobes were secured to the wall, including those in newly refurbished bedrooms.

We found policy and procedures were in place for infection control. Training records we saw showed staff were provided with training in infection control and were aware of their responsibilities in relation to helping prevent the spread of infection. One care worker we spoke with told us the importance of good hand hygiene to help with this. They also told us there was full access to personal protective equipment, such as gloves and aprons, when carrying out personal care tasks.

A nominated infection control champion was waiting to attend training organised by public health. There was a red bag system in place for soiled laundry and access to yellow bags for clinical waste. We did not see any audits of the home in relation to infection control although the home was clean with no unpleasant malodours observed and staff were taking appropriate measures to ensure the risk of the spread of infection was minimal.

Requires Improvement

Is the service effective?

Our findings

People spoke positively about living at Maybank House care home and the support they received. People we spoke with said they felt well cared for by staff 'who know what they are doing.' One relative we spoke with considered that staff were 'skilled' and the care to be 'excellent'. Another relative told us, "They [staff] are professional and know when to refer if things go wrong."

There was a pre-admission assessment in place. People or their relatives made an initial enquiry to the home. At this point the service gathered personal details and some basic personal information about the person, for example support needs and a brief medical history. Arrangements were then made with individuals to carry out a more detailed assessment prior to admission so the home could judge whether they were able to meet the person's care and support needs.

We saw at this assessment that people were given the option to self-medicate following their admission to the home. It was documented in the assessment why people chose not to self-medicate, when they had the capacity to do this. One person was frightened they might forget to take their medicines and preferred the home to administer these. We saw medicine records relating to the person and noted that staff took responsibility for this aspect of care.

The home used technology to good advantage. There was a close circuit television (CCTV) system with monitoring of communal areas and outside spaces of the home. Inside the home we saw the use of stair alarms, floor and door alarm sensors and a nurse call system in order to minimise the risks posed to people. We noted the statement of purpose did not contain details about the use of CCTV in communal areas and we informed the provider and registered manager about this. They said they would review the statement of purpose and include this and we will check this has been done at our next inspection.

We recommend that the home's Statement of Purpose reflects the usage of close circuit television in communal areas and outside spaces of the home.

We saw a policy on staff supervision and appraisal was in place for guidance and information. Records we saw showed regular, planned supervision and an annual appraisal were provided to staff. Staff spoken with confirmed they were provided with regular supervision meetings and an annual appraisal was held with the registered manager. The appraisal for employees detailed the job requirements and objectives of role.

Induction training was provided to staff so they had the skills and knowledge for their role. New staff spent time shadowing more experienced staff to help them understand their role. We found people continued to receive effective care and support from a consistent staff team who received regular training to ensure their knowledge remained up to date. Staff were provided with a range of training which included infection control, safeguarding vulnerable adults, moving and handling, mental capacity act, fire prevention, health and safety, equality and diversity and person-centred care.

We spoke with one care worker who had just completed an external training course around the safe

handling and administration of medicines. They told us they were not yet administering medicines as they had not been observed by senior staff and deemed competent. This was company policy. We were assured that staff were receiving appropriate and relevant training for their respective roles.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw DoLS applications had been submitted for people deemed to lack capacity to consent to their care and treatment. The home had systems in place to monitor the expiry date of each person's DoLS along with dates when re-applications were required.

We saw that an independent assessor visited one person on 15 May 2018 as their DoLS had expired in March 2018 and the home was awaiting paperwork prior to notifying CQC of the authorisation. The registered manager made us aware of the current delays in receiving this and told us they were aware of their legal responsibilities of informing CQC once a DoLS authorisation was granted. We were satisfied the DoLS legislation was being used in the way it was intended, for example to protect people's rights.

It was recorded in the service when relatives or people's representatives had lasting power of attorney (LPA). LPA is a formal arrangement when one person can make some decisions on behalf of another. The service was aware of those family members holding LPA's for people, for example for finances, health and welfare or both. The registered manager was also aware of whom to approach if more than one family member was responsible for specific decisions and we saw this outlined in care plans.

Where it was considered that people lacked capacity to consent we did not see decisions made in people's best interests or consent forms signed by appropriate representatives in relation to receiving care and treatment or medicines. The only consent we saw in care plans was that for having photographs taken. The home was therefore not always gaining people's consent where required. We discussed this with the manager who advised they would review the consent aspect of people's care plans, obtain this from the person where possible, from relatives with a valid LPA and where necessary, complete a best interest decision.

We identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to the need for consent.

The chef was an integral member of the staff team at Maybank House and we noted that all ancillary staff, for example the chef, completed all the training associated with the caring role. We saw the chef had completed MCA DoLS, infection control and dementia refresher training as well as health and safety and food hygiene training.

Due to the rota pattern the chef worked split shifts during the week, taking two hours off during the day. The chef told us they would sometimes spend this time at the home talking with residents and from our observations and from the conversations we heard they were highly regarded by people living in the home.

There was information in the kitchen relating to people's diets. No one living at Maybank House required any thickeners to be added to food or fluids at the time of this inspection. Nutritional screening plans indicated people's preferences in relation to meals, for example portion sizes and favourite foods, as well as

foods they did not enjoy. One nutritional screening plan we saw listed the individual preferred wholemeal or brown bread and disliked too much cheese and eggs. The chef identified people who received a diabetic diet and those that preferred their food cut into smaller pieces so that they could eat independently.

We saw that menus were in place and these were altered if the chef thought it appropriate. For example, coq au vin was included on the menu but the chef told us this was substituted for an alternative chicken dish as residents had not enjoyed it. We were assured the chef was aware of people's dietary needs and shaped the menus based on people's preferences and choices.

The people we spoke with told us that they enjoyed the meals at Maybank care home. People told us, "The meals are enjoyable, oh yes", and "The meals are very good; cooked on the premises." We saw there was a choice of main meal offered at lunch time and the food served looked appetising. Everyone was able to eat independently and we heard one care worker encouraging people to eat. Two people were served smaller portions of food and staff told us this was because they had smaller appetites. If they wanted more food this would be given.

We identified at our last inspection remedial work was required to bedrooms on the ground floor due to water damage caused by a leak from pipework in the home. At this inspection we saw this work was nearly completed. The provider had carried out a programme of major refurbishment to the ground floor bedroom areas. We noted improvements in the décor of these rooms and new fixtures and fittings contained within them.

There was some signage around the building to help people with dementia find their way around, for example there was a sign in the home that directed people to the garden area and signage to toilets and bathrooms. Bedrooms we visited had been personalised to people's tastes. We saw people had family photographs, personal furniture and ornaments to help the room feel homely. The rooms were clean and tidy.

People continued to be supported to access medical and healthcare professionals as required, which included GP's, district nurses, speech and language therapist (SaLT) and podiatrist. Care plans contained information about people's health so that staff could provide appropriate support.

Good

Is the service caring?

Our findings

All residents and relatives we spoke with were happy and contented with the care that was offered to them by staff and to their loved ones. People spoke positively about the care provided and about their relationship with staff members. Staff were described as 'patient' and 'caring'.
Relatives we spoke with also used positive words to describe staff, such as 'kind', 'compassionate' and 'professional'. One relative explained how staff had provided emotional as well as physical support to their family member.

Staff we spoke with told us about each person's needs, likes, dislikes and how they wanted to be supported. Staff's knowledge and understanding of each person living at the home helped ensure they could both listen to and communicate effectively with people. We observed care interactions that were kind, and sensitive.

We observed care support workers speaking kindly and sensitively with residents they were supporting to eat their meal in the dining room and during tea trolley time. The staff team at the home was small and consistent and relatives told us there was no use of agency staff. We could see that staff had developed an obvious rapport with people, who felt comfortable in staff's presence. People looked clean, well-groomed and appropriately dressed.

Staff were mindful of the importance of maintaining people's privacy and dignity. One said to us, "It's so important to preserve people's dignity." They went on to tell us ways they would help to do this, for example covering a person with a towel when providing personal care. People we spoke with confirmed they were treated with dignity and respect. One person we spoke with confirmed that staff would ask, wait for permission and then explain before providing personal care.

Staff understood the importance of promoting people's independence and encouraged people to do as much for themselves as possible. We observed appropriate moving and handling interactions when staff were assisting residents to move to the dining room and in the lounge area. We observed residents who wanted to mobilise independently, but slowly, being allowed to do so; people weren't rushed.

We observed staff dealing sensitively with a resident who was distressed and had spilled a cold drink. Staff held the person's hand whilst walking with the resident to get a change of clothing, reassuring and laughing with the person. We saw that menus were flexed for any celebrations. On the day of our inspection we saw that a celebration lunch was planned for the forthcoming royal wedding. People were looking forward to the event.

The provider was aware of the importance of ensuring equality, diversity and people's human rights were upheld and incorporated this aspect into an element of staff training. There were policies and procedures in place to assist in meeting this requirement. We saw and people told us that their faith was important to them. The home supported people to maintain their faith and we saw people who chose to took communion when representatives from the local church visited. This meant that religious needs were met if this aspect was important to people.

The home had signed up for a General Data Protection Regulation (GDPR) tool which included a new policy and procedure. The use of this tool designed for the care sector would strengthen data protection processes and help with compliance in this area. The registered manager also informed us that they had access to a secure method of sharing information and used this when communicating with social work professionals.

We saw a health professional visited the home on the second day of inspection. They attempted to update a senior member of staff about an individual's health in the dining area, in front of others. The senior member of staff realised this was not an appropriate place to discuss personal information and took the health professional to a more private area. This showed us that staff at the home maintained confidentiality when dealing with personal and sensitive information relating to individuals.

We spoke with a resident in the enclosed garden who liked to sit in there or walk round the garden for much of the day. We observed some residents relaxing or watching TV in their bedrooms as the patio doors and windows that opened onto the garden were in full view; there were no window coverings to ensure residents' privacy or dignity. We discussed this as part of our feedback to the provider and the registered manager who noted this and told us they would seek a solution. We will check on this at our next inspection.

Requires Improvement

Is the service responsive?

Our findings

Care plan profiles were personalised around individuals and documented their capabilities in areas such as mobility, eating and drinking, standing and transferring, bathing and communication. Care files contained information about people's backgrounds, likes, dislikes, preferences, medical and social needs, along with what had been put in place to manage any risks. If preferences changed then care plans were updated and staff told us this information would be documented and shared during handovers. We saw one person on admission preferred to wear particular clothing but when this changed the care plan was updated.

The service had a system in place where each person had an individual A4 book where staff recorded daily notes on the person, including any professional visits such as district nurse or GP and recorded any weights taken. Care staff had access to care plans and the A4 books and told us they regularly referred to them.

We looked to see if care plans had been written with the involvement of people or their representatives, but it was not obvious from care plans to what extent people had been involved. We saw one care plan had been signed by the person and the plan contained details of personalised care, including what specific tasks they needed assistance with. This person did not like to take their meals at the dining room table but preferred to sit in a chair. The care plan outlined the medical reasons for this so that care workers were aware. However, not all care plans were signed either by the person or their representative. Relatives we spoke with differed in their views. Most knew about the care plan, one felt 'involved and informed' in changes and reviews but three other relatives told us that there was not much involvement of them in agreeing or reviewing the care plans of their loved ones.

We did not see photographs on every care plan we looked at. Photographs provide a reference for staff and contribute towards people receiving the right care. We brought this to the attention of the registered manager who assured us this would be addressed.

We looked to see how the service met people's social needs. There was no activity coordinator in the service however care workers tried to encourage people to participate in activities or group discussions. Reminiscence sessions and discussions were recorded and themes for these included allotments, favourite places to holiday, and motorbikes. In October 2017 staff had started a discussion about old and new money and it was documented that people had been shown the new bank notes that had been introduced at the time.

The service had invested in two games that encouraged discussion and stories. We saw a life histories board game which contained questions about life experiences, life events and things people had enjoyed doing when younger. This game had been played but was in the office at the time of this inspection and therefore not readily available for staff to use.

We observed a care support worker encouraged and involved three residents to dance. In the afternoon two care support workers organised a game of bingo in which five residents participated. Other residents were either sleeping in the lounge or resting in their bedrooms. We looked at feedback provided by people living

at Maybank House in the form of questionnaire responses. People had been asked what activities they enjoyed. One said they wanted more quizzes and we saw that care workers arranged quizzes for those that wanted to participate.

People were able to carry on doing the things they had previously enjoyed before moving to Maybank House. One person liked to spend time in the enclosed garden and we saw they were safe doing this. Another resident went into the quiet lounge and started to play the piano. Staff told us this was a regular activity for the person and one they enjoyed doing. Although no one was listening at the time, a care worker we spoke with told us two people had asked in the past who was playing and had requested to listen. Both liked classical music and had purchased cd's as a result of listening to the piano music. Someone new to the home enjoyed using technology, for example an ipad and mobile phone. This had been discussed prior to admission and on one day of this inspection we saw that the home had arranged for a contractor to fit additional plug sockets in the room and for access to wifi. This meant that the electrical facilities in the room were improved for the individual and they could continue maintaining relationships with family and friends using Skype and social media.

We saw records that indicated the home had a 'resident of the day' system, although it was not clear if this was currently operating. The nominated resident of the day received a consultation with the chef and a care plan review, along with room checks. Records we saw in relation to this were from 2017. The home planned to reintroduce this system once the refurbishment was completed and new people were admitted to the home.

We looked at how complaints were handled. The complaints procedure was displayed in the foyer of the home however no formal complaints had been received since the last inspection. People we spoke with knew how to complain and told us if they had any issues they would be happy speaking to a member of staff, who they felt would help them with this.

The home was able to care for people approaching the end of life if this was their wish and we saw that support was extended to family members. At the time of our inspection a person became unwell and the service was responsive in a quiet and dignified way. The registered manager contacted health professionals and relatives to agree that being cared for in the home was in the person's best interests. We were assured that the home was able to provide good care for people approaching the end of life.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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.

At this inspection however, the registered manager informed us of their intention to leave the service. The provider was aware of this decision and was seeking to recruit a new registered manager of the service so that a handover could take place and a smooth transition for one manager to the other could be achieved.

The staff we spoke with told us they enjoyed working at the home, which they said was well run and felt supported by the registered manager. We saw the registered manager supported the small team of care workers and on occasions, worked alongside staff providing care. One staff member we spoke with told us, "I can raise anything with my manager."

We noted that medicine competencies had been carried out on two members of staff in May 2018. One competency detailed how a care worker had been supervised by a senior member of staff administering lunch time medicines and had completed the round 'with confidence', following 'correct procedures'. However, we had previously spoken with the care worker who informed us that they did not yet administer medicines as they had not yet been observed doing this. We questioned the validity of the supervision document with the registered manager given that we had spoken with the care worker directly.

We asked the registered manager about support and supervision. There were no documented supervisions or action notes from their meetings and discussions with the provider. The home had operated without a maintenance role for some time and we saw occasions when identified repairs had not been addressed. Environment and building checks to ensure safety of the premises had been the responsibility of the registered manager. In one audit carried out on 21 April 2018 it was identified that a room required grab handles in an en-suite toilet. We checked on 17 May 2018 and found these were not yet fitted. The registered manager told us that this role had detracted from other management duties as there had been delays in the recruitment process. At the time of this inspection a maintenance person had been in post for two weeks.

We saw there were a variety of audits and systems in place to monitor the quality and effectiveness of the service. There was an accident log in place detailing any slips or trips in any one month. The registered manager analysed any accidents for general decline or trends. The format of the care plan audit paperwork did not allow for any comments or narrative and it was not clear which care plans had been audited. Audits we saw in this area just contained a series of ticks for every plan against each question and we judged that the audit was meaningless, as it did not provide any feedback for staff about how and whose care plans could be improved.

We judged that the audits of care plans and the environment were not robust enough and not fit for purpose. The lack of action in relation to safety checks of water systems had not been identified. We

questioned the validity of a medicines competency.

This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to good governance.

We asked about meetings for people and staff but were not provided with any evidence. The provider told us that people living in the home were reluctant to have formal meetings. Despite the lack of formal meetings people were asked their opinions of what the service could do to improve via questionnaires. We saw that people's opinions of the service were sampled at regular intervals and feedback had been provided by residents.

One person had been asked to move rooms because of the refurbishment work. In the April questionnaire they expressed a wish to return to their old room and we saw that at the time of this inspection they were back in their original room and happy with the improvements made. Relatives had been consulted about the service in October 2017 and all responses were positive.

Staff performance was monitored by way of spot checks. We saw when performance was not acceptable, for example poor standards of care delivery, then appropriate action with staff was taken. More regular spot checks were undertaken and support offered to staff until improvements were noted in employees' practice. This showed us that staff were informed about any bad practices and supported to improve.

Although staff meetings were not held formally the registered manager told us that due to having such a small team and all working alongside each other, ongoing communication was maintained, with conversations taking place at least weekly, but on a daily basis between members of the management team. A stakeholder pension scheme was made available to staff who were given the option to opt into this if they wished to do so.

The home had a suite of policies and procedures available for staff stored in the office. The provider had subscribed to an service with an external company, who tailored policies to the home and automatically sent through updates of any new or amended policies. This ensured the home always had the latest policies available. We saw that the suite of policies contained detailed templates and paperwork not currently being used by the home, for example around recruitment and audits. The home was not using the quality compliance system to its full advantage.

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 11 HSCA RA Regulations 2014 Need for consent The service had not gained consent from people or appropriate representatives in relation to receiving care and treatment or medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Temperatures at which medicines were stored at were too high. No remedial action had been taken by the home. There were no processes in place setting out cleaning and disinfecting regimes to ensure the safety of the water systems.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We judged that the audits of care plans and the environment were not robust enough and not fit for purpose. We questioned the validity of a medicines competency. There was a lack of formal engagement from management with people using the service.