Beaconsfield Care Limited

Mayfield House Residential Home

Inspection report

29 Mayfield Road
Hersham
Walton On Thames
Surrey
KT12 5PL

Tel: 01932229390

Date of inspection visit:
01 September 2020

Date of publication:
15 October 2020

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service:
Mayfield House provides care and accommodation for up to 34 people, some have physical needs and some people are living with dementia. On the day of our inspection 25 people were living at the service.

People's experience of using this service:
Where risks associated with people's care were identified there was not always appropriate guidance in place in relation to this. Incidents of behaviour were not always recorded appropriately in order for the registered manager to investigate and analyse. The service was not cleaned effectively, and appropriate infection control measures were not always being undertaken.

There were audits taking place, however these were not always robust particularly around the monitoring of infection control.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection:
The last rating for this service was requires improvement (published 15 August 2019) and there were multiple breaches of regulation. At that inspection we identified continued breaches in relation to the safety of people's care, and the lack of robust quality assurances at the service.

Why we inspected:
We undertook a targeted inspection due to concerns we received that related to incidents where people were put at risk, and to review the progress made by the service to become compliant with the multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This report only covers findings in relation to risk associated with people's care and quality assurance. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

CQC have introduced targeted inspections to follow up on a Warning Notice or other specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Enforcement:
We have identified continued breaches in relation to the safety of care provided and the quality assurance of the service. 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 discharge our regulatory enforcement functions required to keep people safe and to

hold providers to account where it is necessary for us to do so

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up:
We will continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information we may inspect sooner. We will continue to work with the local authority to monitor progress.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? Inspected but not rated. Details are in our Safe findings below.	**Inspected but not rated**
Is the service well-led? Inspected but not rated. Details are in our Well-Led findings below.	**Inspected but not rated**

Mayfield House Residential Home

Detailed findings

Background to this inspection

The inspection:
This was a targeted inspection to check a specific concern relating to the safe care and treatment people were receiving.

Inspection team:
Our inspection was completed by two inspectors.

Service and service type:
Mayfield House Residential Home a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection:
We gave a short notice period of the inspection to ensure safety of all involved and assess risks around Covid-19.

What we did before inspection
Our inspection was informed by information we already held about the service including notifications that the service sent us. We checked records held by Companies House.

We asked the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We received feedback from the local authority. We used all of this

information to plan our inspection

During the inspection
We spoke with one person who used the service and one relative about their experience of the care provided. We spoke with seven members of staff including the provider, the registered manager, and care staff.

We reviewed a range of records. This included five people's care records including risk assessments. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and quality assurance records. We spoke with three relatives.

Inspected but not rated

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question, we have specific concerns about.

We will assess all of the key questions at the next comprehensive inspection of the service.

The purpose of this inspection was to follow up on concerns that related to the risks associated with people's care not being managed in a safe way and to review the progress the service was making to become compliant with the breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified in relation to the management of risks associated with people's care.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Preventing and controlling infection

At our last inspection of the service, we found the provider had failed to robustly assess and manage the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) 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.

● Although staff we spoke with were knowledgeable around people's care needs, care plans did not always accurately demonstrate the risks to people or provide appropriate guidance for staff. For example, the provider and staff told us about the behaviour of one person that put themselves and others at risk. However, their risk assessment did not detail how these behaviours presented or how staff should intervene when they saw the person's behaviour escalating. We identified this person had been recently assaulted by another person as a result of behaviours displayed, demonstrating that the impact of his behaviour was not always well managed.
● Another person had a stoma (an opening on the abdomen that can be connected to either your digestive or urinary system to allow waste to be diverted out of your body). The provider told us the stoma would leak fluids and needed to be carefully managed. However, there was no risk assessment in the person's care plan around this detailing how the stoma should be cleaned or mentioning the risk of infection if not appropriately managed. Without clear guidance in place, there was a risk of inconsistent monitoring and support with the person's stoma care.
● People were at risk because the provider, the registered manager and staff had not adhered to infection control processes and COVID-19 guidance for care homes. When we and other visitors arrived at the service, the provider did not always undertake safety checks, for example asking visitors if they felt unwell or taking temperatures. This was despite there being a risk assessment in place detailing that this should be done. The provider, the registered manager and some staff were not wearing face masks while in the communal areas. Guidance from Public Health England (PHE) states that face masks should be worn when people are, "Within 2 metres of a resident but not delivering personal care."

● When visitors were meeting with their loved ones in the garden at the service, they were not encouraged to maintain social distancing. Whilst the provider was present, we saw one relative not maintaining social distancing and this was not challenged. This is despite PHE guidance that states, "Visitors should have no contact with other residents and minimal contact with care home staff (less than 15 minutes / 2 metres)." We spoke with the registered manager about the lack of social distancing and wearing of face masks and they told us they thought the guidance had changed around this and that this was no longer required if not providing personal care.
● Steps were not taken to protect people from the virus when new people were admitted to the service. A member of staff told us when new people were admitted they were not isolated to their room, however they were provided with a confirmed negative test. They explained that a person moved into the service the previous week and from the first day was sitting with people in the lounge. PHE guidance states, "For individuals with a confirmed COVID-19 negative status, from a test taken less than 2 days prior to admission, a 14-day period of isolation is still recommended, particularly in care homes for older residents." We found that this was not taking place and no information in records at the service relating to why this guidance was not being followed.
● The service was not appropriately cleaned or well maintained. For example, the toilet seats in the communal bathroom and in one person's room were dirty. One person's headboard on their bed had a large dark fluid stain and in another room a person's cleansing wipes had a faeces stain on the packet which was being stored in the cabinet by their sink. A member of staff told us, "There are not enough cleaners here."
● Staff told us one person frequently displayed behaviours that challenged, however staff were not always recording this behaviour on a chart as incidents to analyse any trends or triggers to these behaviours. We saw from daily notes that at times the person was said to become, "aggressive", however there was no detail on the incident or what led up to the behaviour or how future incidents could be prevented to keep the person and others safe.

As risks were not always being managed in a safe way this is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were aspects to the risks around care that were managed appropriately. We saw other risk assessments that related to moving and handling, skin integrity and people's food intolerances were in place. One relative told us, "I think they have a good understanding of the risks around (persons) care."
● Where people were at risk of leaving the service without the support from staff there were systems in place to ensure staff knew of their whereabouts at all times. For example, one person was being monitored every fifteen minutes. When the person went into the garden, staff monitored them by keeping at a safe distance.
● After the inspection the provider advised us they had taken steps to address the shortfalls identified. This included fixing the window restrictor in a person's room, updating the fire risk folder and they had rostered a member of staff to undertake cleaning at the weekends. They also provided photos to evidence some of this. We will follow this up at our next inspection.

Inspected but not rated

Is the service well-led?

Our findings

We have not changed the rating of this key question, as we have only looked at the part of the key question, we have specific concerns about.

The purpose of this inspection was to follow up on concerns that related to about the management of the service and the quality assurances processes and to review the progress the service was making to become compliant with the breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified in relation to the management of risks associated with people's care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection of the service the provider had failed to have robust oversight of the quality of care. This was a breach of regulation 17 (Good Governance) 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.

- Relatives and staff told us they felt supported by the registered manager. A relative said, "She is very approachable, and I can speak to her at any time." Another told us, "I'm impressed, she seems good." A member of staff said, "I am very happy with (registered manager). She is number one. She is helping us and supporting us." Another said, "We have a lovely manager, she does things good, very kind, she looks after people."
- Despite this positive feedback from staff we found there was a lack of robust oversight by the provider and the registered manager. For example, we raised concerns about the standard of cleanliness of the service and despite the provider advising us they were aware of this, they had not taken sufficient action to address it. The provider told us there were no cleaning staff at the weekend and that, "It's something we need to get on top of."
- Although there were some systems to assess the quality of the service provided, we found these were not always effective. We found concerns relating to lack of effective staff training and infection control. Audits the provider and the registered manager were undertaking were not identifying the shortfalls with the cleanliness or the maintenance of the service. An audit was undertaken at the service in May 2020 by two visiting nurses. One of the recommendations was that there should be infection control signage at reception for visitors to the service to be aware of expectations. The provider and the registered manager told us they had intended on putting this signage up but had not yet done so.
- Routine checks of safety had not highlighted out of date resident information for the fire service in the event of an emergency and had not picked up on a broken window restrictor on a first-floor bedroom. The provider informed us after the inspection that these concerns had been rectified, but they had not been proactively identified through regular auditing.
- The provider and registered had not ensured that staff had completed necessary training in relation to their role. The training matrix provided showed that out of 13 staff, five had not received health and safety training despite their safeguarding policy stating it was a requirement to have this training. Seven staff had

not received basic life support training.

● The cleaning checklists that were completed did not reflect what we found at the inspection. The records indicated that bedrooms, bathrooms, communal lounges had been cleaned. However, we found concerns with the cleanliness in bedrooms and bathrooms.

● The provider had not ensured that staff at the service were being tested for COVID-19 despite PHE guidance that states, "Staff will be tested for coronavirus weekly, while residents will receive a test every 28 days to prevent the spread of coronavirus in social care." There were mixed responses from staff about when or if they had been tested. One told us they had refused a test whilst others could not recall when their tests had been undertaken.

● We asked the provider to send us evidence of which staff had been tested and when. The provider told us, "(The providers) had our COVID-19 test on 7/06/2020. Some test kits were recalled, and we reordered at the end of June we received new kits towards the end of August, but some staff had testing done outside the home." The records they provided showed that out of 16 members only three had been tested the week prior to the inspection. For the remaining staff it had been several weeks since they were last tested.

● The provider and the registered manager were not always following their own policies. For example, the infection control policy stated in relation to cleaning audits, "Corrective action forms must be completed and checked that compliance has occurred." We found this was not taking place. The infection control policy had also not been updated to include measures that needed to be taken in relation to COVID-19. The provider was listed as the infection control lead at the service, however they gave incorrect information about the infection risk of a person that had a potential infectious health condition.

● There is a history of continued breaches of regulation and lack of action by the provider to improve quality and safety.

As systems and processes were not established and operated effectively this is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 had not ensured that risks were always being managed in a safe way.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not put appropriate systems and processes in place to ensure quality and safety of care.

The enforcement action we took:

We issued a warning notice.