Beaconsfield Care Limited

Mayfield House Residential Home

Inspection report

29 Mayfield Road
Hersham
Walton On Thames
Surrey
KT12 5PL

Tel: 01932229390

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Mayfield House Residential Home is a care home which provides accommodation and personal care for up to 34 people. At the time of our visit there were 25 people living at the home most of who are living with dementia. The accommodation is provided over two floors that are accessible by stairs and a lift.

The inspection of Mayfield House took place on 22 August 2016 and was unannounced. This inspection was to follow up on actions we had asked the provider to take to improve the service people received.

The provider was covering the registered manager's role at Mayfield House. 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. We were informed following the inspection that the deputy manager had commenced the application process to be registered as manager with the CQC.

At our previous inspection on 13 August and 1 September 2015 we found breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action in relation to infection control, risk management, obtaining consent in accordance with the requirements of the Mental Capacity Act 2005 and assessing and monitoring the quality of the service provided. Where the regulations were not being met, the provider sent us an action plan and provided timescales by which time the regulations would be met.

During this inspection we found that some improvements had been made. However, they were not sufficient enough to meet the requirements of the regulations.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

People were not always safe because there were a number of inconsistencies in the systems and arrangements in place to protect people from harm. Robust and up to date risk assessments were not in place to identify, assess and manage risk safely to minimise the risk of harm to people.

People did not live in a safe well maintained environment. There were a number of concerns in regard to the environment that put people at risk of harm. People were at risk because there were inadequate systems and arrangements to protect people from the spread of infection. Appropriate standards of cleanliness were not being maintained. Infection control policies and procedures were in place; however it was clear staff had not followed these. We raised concerns about the conditions of chairs, commodes and toilet seats. We also raised concerns with the registered provider about the conditions of some of the bathrooms and toilets. All of these concerns placed people at risk of infection and harm.

Although there was a system to manage and report incidents, accidents and safeguarding concerns to

monitor people's safety, we could not access information about any accident or incidents that happened after April 2016. The management team did not monitor trends or identify patterns in regard to accidents or incidents.

People were not always protected from being cared for by unsuitable staff because although recruitment processes in place, they were not always followed. There were insufficient numbers of staff deployed who had the necessary skills and knowledge to meet people's needs. The deployment of staff had an impact on the care people received.

Staff did not have a clear understanding of their responsibilities regarding the Mental Capacity Act or Deprivation of Liberty Safeguards. Where people lacked capacity they were not fully protected and best practices were not being followed.

There were inconsistencies in the care that people received; this included how staff respected people's privacy and dignity. During our observations, we saw examples of good and poor care; staff were very busy which had an impact on the support provided. Care was not always based on individual needs, care and treatment.

People were not receiving responsive care in accordance with their needs. Where people had specific health care needs these had not been taken into account when planning the care or identifying what support they needed. There were inconsistencies in the monitoring of people's health and support needs.

The environment was not conducive for people living with dementia, as the décor was dark, or the same colour and there was no distinction between areas of the home. This meant people may find it difficult to find their way around the home.

People had access to activities, however there were mixed feelings about the activities provided. People were not always protected from social isolation. The range of activities available was not always appropriate or stimulating for people.

The management and leadership of the home were ineffective. We were concerned about the lack of understanding or knowledge of people living at the home by the management team. This lack of knowledge meant the manager in day to day control would be unable to ensure that staff were delivering safe, effective and responsive care.

There were quality assurance systems in place to review and monitor the quality of service provided, however they were not robust or effective at identifying and correcting poor care or practices. We noted that not all relevant notifications had been received by the Care Quality Commission in a timely manner.

Medicines were managed, stored and disposed of safely. The medicines administration records (MARs) were accurate and contained no gaps or errors. However no one who had topical creams had charts completed to show that this had been administered and where. We made a recommendation that the provider ensures that body charts are completed in line with current guidelines in regard to the administration of topical creams.

People told us that they felt safe at Mayfield House. People told us, "Yes I am safe here." Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place. Fire safety arrangements were in place to help keep people safe, except in the area people used to smoke. The service had a business contingency plan that identified how the home would function in the

event of an emergency such as fire, adverse weather conditions, flooding or power cuts.

People's preferences, likes and dislikes had been taken into consideration. People's relatives and friends were able to visit.

People had enough to eat and drink throughout the day. Where people needed support with eating, they were supported by a member of staff.

People were supported to have access to healthcare services and healthcare professionals to support their wellbeing. The service worked effectively with health care professionals and referred people for treatment when necessary.

People told us if they had any issues they would speak to the manager. People were encouraged to voice their concerns or complaints about the service.

We found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made one recommendation to the provider. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people were not managed safely and in accordance with their needs.

People were at risk because procedures to prevent and control the spread of infection were not being followed correctly.

Safe recruitment practices and relevant checks were not always followed before staff commenced work.

There were insufficient numbers of suitable staff deployed to keep people safe and to respond to their needs.

Medicines were administered, stored and disposed of safely. Although documentation recording the administration of topical cream were not completed.

There were safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not have a clear understanding of the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS) or their responsibilities in respect of this.

People were not receiving effective care in accordance with their needs. People had enough to eat and drink.

The environment was not conducive to people living with dementia.

Staff had not always received appropriate support that promoted their professional development or reviewed their performance.

People were supported to access healthcare services and

professionals were involved in the regular monitoring of their health.

Is the service caring?

Requires Improvement 

The service was not always caring.

There were inconsistencies in the care that people received; this included how staff respected people's privacy and dignity. During our observations, we saw examples of good and poor care; staff were very busy which had an impact on the support provided.

People's likes and dislikes had been taken into consideration. People's relatives and friends were able to visit.

Is the service responsive?

Requires Improvement 

The service was not always responsive.

There was inconsistencies to the response to people's care needs. Where people required their health needs to be monitored, this was not always put into practice.

People were supported to participate in a range of activities; however there was a lack of individualised stimulation.

People and their relatives were not always involved in developing care plans, changes to people's needs were not always reflected and acted on by staff.

People were able to express their views and were given information how to raise their concerns or make a complaint.

Is the service well-led?

Inadequate 

The service was not well- led.

There were inconsistencies about how effective the management and leadership was.

Quality assurance systems in place failed to identify and manage risks to the home and people living there.

The provider actively sought, encouraged and supported people's involvement in the improvement of the service.

People told us the staff were friendly, supportive and management were always visible and approachable.

Mayfield House Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

We carried out an unannounced inspection to the home on 22 August 2016. The inspection was conducted by two inspectors.

Before the inspection we reviewed the provider's action plan which they had supplied to tell us how they were meeting or intended to meet their legal requirements in relation to the breaches of regulations we found at our last inspection.

Prior to the inspection we reviewed the previous inspection report. We gathered information about the home by contacting the local authority safeguarding and quality assurance teams. We also reviewed records held by the Care Quality Commission which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

The provider had already completed a Provider Information Return (PIR) for our inspection in August 2015. This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We did not ask for another PIR to be completed as we were following up on action taken in regard with the concerns found at the last inspection.

During the inspection we spoke to five people, one visitor, six staff, the deputy manager and the registered providers. We observed care and support in communal areas; looked at six bedrooms with the agreement from the relevant people. We looked at four care records, risk assessments, medicines records, accident and

incident records, minutes of meetings, three staff records, complaints records, policies and procedures and external and internal audits.

We last inspected this home on 13 August and 1 September 2015 when we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Our findings

People told us they felt safe and secure at the home and with the staff who provided care and support. A person told us, "I feel safe, staff are here when I need them, when I use the call bell they usually come pretty quickly." Another person told us, "I don't have to think about my safety." Although people felt safe we found that improvements were still needed to ensure people were always protected from harm and risk.

At our last inspection on 13 August and 1 September 2015, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk of harm due to concerns with the environment of the home. Risks associated with building work carried out around the home were not always managed well. People had access to areas that had a number of trip hazards. Staff were not familiar with how to open the front door which was operated by a coded keypad. Staff did not have information on how to support individual people in the event of an evacuation. During this inspection, although we found that improvements had been made, we found new risks to people, this demonstrated that the systems in place were not robust enough to protect people from harm.

People may not be protected from the risk of harm as they were living in an environment that may not be safe. We found there were no recordings of water testing or water temperatures carried out. These checks are important as they allow staff to monitor that water is at its optimum temperature to kill legionella bacteria. The checks also ensure that staff are monitoring the temperature of the water to protect people from scolding when having a bath or shower. There were no window restrictors to prevent people from falling or entering through a window. One person's window (whose room was on the first floor) was kept open by a blanket and two of the bedroom doors were propped open, one with a bin and the other with the person's bed. This could become a trip hazard. Items of clothing were found in the electrical fuse box and radiator covers were loose and coming away from the wall.

Risks to people were not recognised, assessed or managed safely and in accordance with their needs. Where people had a history of substance misuse, there was no assessment in place to identify possible risks. Although we did find that risks and any healthcare issues that arose were discussed with the involvement of social or health care professionals such as the GP or speech and language therapist, these were not included in an assessment to guide staff in how best to prevent risks occurring. There were no arrangements in place to reduce fire risks for people who smoked. People were not offered a protective garment whilst smoking. The provider had not provided a safe smoking area, there was no fire safety equipment in place and the paving stones where the smoking area was situated were uneven which could cause a trip hazard. The facilities such as table and chairs in the smoking area were dirty. The provider told us they had not considered a smoking risk assessment was needed for people and they were not aware of any recent deaths in care homes where people had been smoking despite the local authority writing to all care homes advising them of this.

Although there was a system to manage and report incidents, accidents and safeguarding concerns we could not access information about any accident or incidents that happened after April 2016. The manager confirmed there had been accidents since that time but could not provide us this information. We read

incidents and safeguarding concerns had been raised and dealt with, incidents were reviewed but had not been monitored to identify patterns or trends, which would enable staff to take action to minimise or prevent further incidents occurring in the future. Each accident had an accident form completed, which included clear outcomes and actions taken. One member of staff said, "If someone has a fall, I would first check that they were alright, call an ambulance if needed and complete the accident report."

People and staff were not adequately protected from the risk of infection because appropriate guidance and practices had not been followed. There was an odour coming from some of the chair cushions which spread to parts but not the entire lounge. We saw a soiled pad was placed on a person's carpet instead of immediately put into a clinical bag. Items of clothing that had been soiled with bodily fluids such as faeces were found amongst dirty clothing and linen, rather than in a separate bag. One member of staff told us, "Girls (staff) sometimes don't have time to sort the soiled washing." Staff informed us that they did not follow best practices in infection control. One member of staff told us that people's commode buckets were cleaned in a bath with a cleaning solution although they were aware that there was a system for cleaning them in the shed outside. There were a number of toilets that had raised toilet seats, it was clear that they had not been removed when cleaning the toilet as they were still dirty with bodily fluids. There were commodes in people's rooms that had dried faeces on them and the wheels on the commodes were rusted and in need of cleaning.

There was a cleaning schedule for the home and domestic staff had daily lists of cleaning tasks. These detailed the different tasks that needed to be carried out and checked. Staff signed when tasks had been completed however there were no signatures for July and August for cleaning chairs and cushions. There was no monitoring of the work carried out and therefore no regular checking systems in place.

Failure to have systems and arrangements in place to protect people from the risk of harm and failing to assess the risk, prevent, detect and control the spread of infection are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Fire safety arrangements were in place to keep people safe apart from in the smoking area. Each person had a personalised emergency evacuation plan and staff carried out regular fire drills and evacuations so they knew what to do in the event of a fire. There was a contingency plan in place should an emergency have an impact on the delivery of care. Staff had a clear understanding of what to do in the event of an emergency such as fire, adverse weather conditions, power cuts or flooding. The provider had identified alternative locations which would be used if the home was unliveable. This would minimise the impact to people's care if emergencies occurred.

The communal areas and corridors were free from obstacles which enabled people to move freely around the home. Handrails were placed throughout the home to support and aid people's mobility. Fire, electrical, and safety equipment was inspected on a regular basis. Specialist equipment such as wheelchairs were checked on a weekly or monthly basis to ensure they were safe and in working order.

At our last inspection on 13 August and 1 September 2015, we identified a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although the provider had systems to ensure appropriate standards of cleanliness were maintained, not all of these were being followed, which had an effect on the standard of cleanliness throughout the home. During this inspection, we found the standard of cleanliness had not improved enough to meet the regulation.

We raised concerns with the registered provider about the conditions of some of the bathrooms and toilets. We saw that a bathroom sink was coming away from the wall and a bathroom floor had the remains of

faeces on it. The light pulls in the bathrooms and toilets were dirty and we found a cracked toilet basin and broken toilet seat. The provider stated that the matter would be reported to the maintenance person.

Failure to ensure the premises were clean and safe was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from being cared for by unsuitable staff because although recruitment processes were in place, they were not always followed. Records contained an application form which recorded employment and training history, provided proof of identification and contact details for references. However, the provider had not obtained any explanation for gaps in people's employment history. One file had no information or confirmation about UK criminal checks made through the disclosure and barring service (DBS). There was no risk assessment in place to identify the risks and action taken to protect people from unsuitable staff.

Failure to operate an effective recruitment system was a breach in Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff effectively deployed to meet people's needs. This was an issue that was identified during our previous inspection. People told us that there were not enough staff, their comments included, "Staff know themselves that there are not enough, I ring my bell and it goes on for a long while, they will come in and reset it and come back again", Staff don't have time to do anything with me, it would be nice to have conversations, there is a lack of contact."

The accommodation is provided over two floors with different annexes adjacent to the corridors. There were five care staff to care and support 25 people including people who remained in bed at all times. We reviewed the staffing rotas over a four week period; we found that on two occasions there was less than 5 staff on duty during the day. This meant that the staffing levels were below the minimum amount of staff required. There was a call bell system in place that enabled people who chose to stay in their rooms to call for assistance when needed. There was a delay in answering call bells, in particular there were a number of instances where the two people who were requesting help throughout the day had to wait between 5-10 minutes to be responded to by staff. Those who were in communal areas had their request for assistance answered promptly by staff. The provider told us, "I don't have a call bell log to look at how often call bells are being answered." They said they did not use a dependency tool to assess the needs of people who lived at the home but had discussions with staff. They told us, "I put my hands up, I don't have everything in place." Although we were told by the provider that regular meetings took place to discuss staffing levels there was no record to evidence this was the case. Therefore the provider was not able to evidence how they assessed people's needs and provided the correct staff to meet those needs. The deputy manager told us there needed to be more carers on in the morning at least. They said that the senior on duty should be supernumerary but they are not because they were helping care staff to provide care and support.

The deployment of staff had an impact on the care people received. According to the weighing records people had not been weighed since June 2016, despite several people being at risk of malnutrition, four of which were at high risk. A member of staff told us that people had not been weighed because staff did not have the time. Another member of staff said. "It's our fault that we have not weighed people."

Staff had not always received appropriate support that promoted their professional development. A member of staff told us, "I can't remember when I had my last one to one and I have never had an appraisal." Another member of staff said, "I have supervision with the manager, we discuss my role and any issues." The provider's records showed that only three members of staff had received supervision within the

last three months and 16 staff were awaiting supervision. There was no documentation to evidence that appraisals had been carried out. Management had observed staff in practice to review the quality of care delivered and any observations were discussed with staff.

Failure to ensure there were sufficient numbers of staff deployed to meet people's needs safely was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had their medicines on time and as prescribed. Only staff who had attended training in the safe management of medicines were authorised to give medicines. We saw staff administer medicines to one person; they explained the medicine and waited patiently until the person had taken it. Any changes to people's medicines were prescribed by the person's GP. All medicines coming into and out of the home were recorded and medicines were checked and recorded at each handover.

Arrangements were in place to record and store medicines. The medicines administration records (MARs) were accurate and contained no gaps or errors. A medicines profile had been completed for each person and any allergies to medicines recorded so that staff knew which medicines people could safely receive and which to avoid. A photograph of each person was present to ensure that staff were giving medicines to the correct person. There was guidance for staff to use when people were on PRN (as needed) medicines. PRN records included dosage details and the reason they may require them. However no one who had topical creams (medicines in cream form) had charts completed to show that this had been administered and where.

We recommend that records are completed in line with current guidelines with regard to the administration of topical creams.

Staff had access to a copy of the most recent local authority safeguarding policy and company policy on safeguarding adults at risk. This provided staff with up to date guidance including contact details about what to do in the event of suspected or actual abuse. Staff knew that the manager would contact the safeguarding team to report any concerns. Staff told us that they had received safeguarding adults training since our last visit and were aware of their role in reporting suspected abuse. We confirmed this when we looked at the staff training programme. A member of staff told us, "I would go to the senior or go to the manager."

Requires Improvement

Is the service effective?

Our findings

People spoke positively of the staff working at the home. A person told us, "I like living here. The staff know me and I know them." Despite people's comments we found that improvements were still needed to ensure people received safe and effective care.

At our last inspection on 13 August and 1 September 2015 we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's rights were not upheld in line with current guidelines. Mental capacity was not correctly assessed or considered and action taken when a person was found to lack capacity to consent. Despite having received training not all staff were able to demonstrate a clear understanding of the Mental Capacity Act 2005 (MCA) and Deprivations of Liberty Safeguards (DoLS). DoLS applications had not been completed for those people it affected.

During this inspection, we found MCA assessments had been completed but they were generic and not in regard to specific decisions. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Best interests were not always considered when decisions that affected people were made which meant the people's rights had been reduced or limited. A member of staff told us that one person had been refusing their medicines. They said this person did not have capacity to make this decision however there was no MCA assessment completed.

The provider and staff did not have a clear understanding of their responsibilities under the MCA and DoLS, although records viewed confirmed staff had received training. We asked staff if they would assume capacity and they said, "No, our senior would tell us."

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The provider had confirmed they had submitted DoLS applications to the local authority for everyone living at Mayfield House, this included people where DoLS was not applicable as they had the capacity to make decisions. People's freedom was restricted as people had bedrails in place and there were stairgates at the base of the staircases which reduced people's movements and no authorisation or consent had been sought.

Failure to gain appropriate consent in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to make their own decisions and their consent was sought before simple personal care was provided. Staff checked with people that they were happy with the support being provided on a

regular basis and attempted to gain people's consent. Staff waited for a response before acting on people's wishes. Staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them. Where people declined assistance or choices offered, staff respected these decisions.

There were inconsistencies in how staff used their training and put this into practice which put people at risk. We observed good and poor examples of how integrated their training into practice. Staff confirmed they had received training and that they had sufficient knowledge to enable them to carry out their role. Staff provided us with information about people's care and support needs and how they met these. During our observations, we saw staff assisted people to stand up from chairs using their walking frames and further observation of transfer techniques confirmed that staff had sufficient knowledge to enable them to carry out this task safely and effectively. However we also noted that staff were not following best practices in regard to infection control and MCA. Staff confirmed that an induction programme was in place and all new staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role. The provider's records confirmed that all staff had received mandatory training such as such as: administration of medicines, safeguarding, moving and handling, fire awareness, food hygiene, health and safety, infection control. Training was delivered in different formats such as online learning, training courses and certificated learning workbooks.

People told us about the food at the home. One person told us, "I get a choice of two meals, the food is fair, I get enough to eat." Another person said, "The food is reasonable, I don't eat much." A third person told us, "The food is pretty good." The cook prepared and cooked all of the meals in the home. There was a choice of nutritious food, snacks and drinks and alternative options were available if people did not like what was on offer.

Lunchtime was a quiet occasion; there were varying degrees of interactions between people and staff. People were able to choose who they sat with and some people enjoyed their lunch together in the designated dining room, or in their room. People sat in groups and engaged in conversation with each other and staff.

People had their dietary needs assessed and specific care records had been developed in relation to this. The cook told us that staff spoke with each person in the morning, explaining what options were available on the menu. The cook was able to explain to us the individual preferences of people and that people had access to fortified puddings or drinks to reduce the risk of malnutrition. Where people needed assistance with eating or had special dietary requirements, information and guidelines were recorded to ensure their needs were met. Some people required products to be added to their food and drink to enable them to swallow without harm and instructions were given to staff regarding the dosage and consistency required. People had access to healthcare professionals in relation to their nutritional needs. Staff told us," X is not well at the moment, so they are on a pureed diet, when they feel better we will slowly introduce soft food." We observed people were provided with well-presented pureed meals, in accordance with their care plan, to reduce the risks of choking.

People were supported to have their nutrition and hydration needs met. We saw staff assisting people to get ready for lunch, staff assisted people at a slow and steady pace. Where people needed support with eating, they were supported by a member of staff. Whilst one person was being supported and encouraged to eat the carer went on their knees rather than sit on a chair next to them. People who were able to eat independently were prompted and encouraged to do so. Throughout the meal we observed staff interacting with people and asking them about the food. Throughout the day people were encouraged to take regular drinks to ensure that people were kept hydrated.

People had access to healthcare professionals such as the GP, district nurse, optician, dentist, physiotherapist, speech and language therapist. People told us they could see a doctor when they needed to. We saw from care records that if people's needs had changed, staff had obtained guidance or advice from the person's doctor or other healthcare professionals. Outcomes of people's visits to healthcare professionals were recorded in their care records. People had access to specialist equipment such as sensor mats, wheelchairs, walking frames, hoists, specialist beds or bathing aids to assist and support people overcome everyday difficulties caused by their disability or illness.

Requires Improvement

Is the service caring?

Our findings

We found there were inconsistencies in the care that people received. During our observations, we saw examples of good and poor care; staff were very busy which had an impact on the support provided. People's views of the care and the staff that provided the care were positive. One person said, "I get looked after well." Another person said, "I'm quite happy here, it's comfortable." A third person told us, "They moved me downstairs as I was having problems walking. It is a lovely room." One visitor to the home said. "I think the home is very good, staff are very good here."

Staff interacted with people throughout the day, for example, when providing support to assist with people's mobility, they checked throughout the task that the person was happy with what was being done.

People were not always spoken to or treated in a respectful way by staff. A member of staff shouted across the lounge to another member of staff for assistance with a person's room, whilst standing behind a resident. One person was sat on their own in one part of the lounge with their back to everyone. The room was cold as the window was open and the two people in the lounge at the time were both cold to the touch. One person told us that they were cold. One person was given a cup of tea however the member of staff did not warn the person that it was hot, the person took a sip and remarked that the tea was too hot for them. People were sat in the lounge through the morning without much interaction from staff, as a result people were falling asleep. One member of staff was in the lounge and at no point made conversation with people. We saw two members of staff on two separate occasions open the bathroom door without knocking whilst the person was using the toilet. These examples showed a lack of thought and compassion for the people the staff were there to care for.

Staff used derogatory words when describing people. One member of staff told us when questioned about MCA, "I probably have had training, I can't think what it is off hand, is it where people are too ga ga?"

Failure to provide care and treatment in a way that ensures people's dignity and respect was a breach Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were occasions where staff treated people in a caring way and respected people's dignity. We observed staff knocked on people's bedroom doors and wait for an answer before entering. One member of staff said to one person, "Shall we sit in the lounge where it's more comfortable."

Staff knew about the people they supported. Staff were able to talk about people, their likes, dislikes and interests and the care and support they needed. They provided us with guidance and information about how to approach people. There was information in care records that highlighted people's personal preferences, so that staff would know what people needed from them.

People were supported to make their own choices. People could choose when to get up in the morning, what to eat for breakfast, what to wear and activities they would like to participate in. People were able to personalise their room with their own furniture and personal items so that they were surrounded by things

that were familiar to them. People had the right to refuse treatment or care and this information was recorded in their care plans. Guidance was also given to staff about what to do in these situations. One member of staff said, "Ask people what they want and don't tell them, treat them like I would treat my own mum." When staff asked people questions, they were given time to respond. For example, when offering people drinks. Staff did not rush people for a response, nor did they make the choice for the person.

Relatives, health and social care professionals were involved in individual's care planning. Staff were knowledgeable about how to support each person in ways that were right for them and how they were involved in their care.

Relatives and friends were able to visit and maintain relationships with people. People confirmed that they were able to practice their religious beliefs; a person from the local religious community visited the home to provide an individual service to people.

Requires Improvement

Is the service responsive?

Our findings

People's care plans did not always contained a completed pre-assessment. Pre-assessments should be carried out before people move into a home to ensure that the home can provide the care and support in accordance with their needs. Although some information was recorded such as people's personal details, care needs and details of health and social care professionals involved in supporting the person. Other information such as medical history, medicines, allergies, physical and mental health needs and potential risks were missing. This meant that salient information was not always obtained to ensure that people's needs could be met prior to them moving in and then develop care and support in accordance to people's needs.

People's care was not always based on individual's needs and care. Where people had specific health care needs such as living with dementia these had not been taken into account when planning the care or identifying what support they needed. One person's assessment (carried out before and after the person moved into the home) provided information about the person's needs and support. It stated X 'suffers' with severe anxiety, schizophrenia and a history of self-harm. However there was no care planning in place to guide the staff in knowing what care this person should receive to meet their specific needs. There was no mental health or behavioural support guidelines in place to guide staff in supporting them. Where a person was diabetic and required insulin, there was no information provided to staff about what they should look for should this person become unwell. There were several people whose feet were very swollen however no one was encouraged or supported to put their feet up. One lady said, "I can't walk at all, I have never been told I should put my feet up." Staff were knowledgeable about people's every day care needs but they did not have a full understanding of people's specific needs or potential risks.

Daily records were completed to record support provided to each person; however these were written in a very task orientated way. There was no information about people's well-being, interactions, activities or mood, providing a picture of the person's day and highlighting any issues. This showed us that although there was up to date information about the support provided, the information was not person- centred which would enable staff to monitor any issues that might arose.

There were inconsistencies in the monitoring of people's health and support needs. Where people required their health needs to be monitored, this was not always put into practice. Although the provider had identified that people were not being weighed there was no evidence of how this was being addressed. There was no system of recording and monitoring people's fluid and food intake for people who were at risk of malnutrition and dehydration.

During our previous inspection, we had identified an issue with the environment not being 'dementia' friendly. During this inspection very little had changed. It was not easy for people living with dementia to find their rooms or their way around the service as all areas looked the same. Areas of the service were not easily identifiable; walls and doors were painted the same colour and the carpets were patterned. A large or busy pattern can confuse people and cause hesitation if it looks like an obstacle or a hole. Although there were signs on the doors describing rooms and toilet doors were painted green, there were no visual aids to help

people, such as photographs outside of their bedrooms. An environment decorated in contrasting colours may help people's orientation and support people's independence.

There were no specific areas in the home where reminiscing objects or pictures could be found and there was no equipment that created sensations that could assist relaxation or stimulate people's senses. There are many sources of information about creating 'dementia friendly' environments available. The provider could have accessed and used these between the last inspection and this one to enhance the quality of life and respond to the needs of people living with dementia.

People told us that the activities that were provided were not always what they wanted. People told us they didn't get out enough. One person said, "I don't think there are a lot of activities, we do a quiz" although they did say that they did not get bored. Another person said, "There is not enough to do, the activities don't suit me, I could do with something more demanding." They said, "If they took people out I would go. I rely on my TV, I miss going out."

An activity programme was in place, but was not person-centred. It consisted of bingo, exercise, board games, arts and crafts. It did not take into account people's interests such as going out for walks. We also noted that some people's capabilities were limited due to living with dementia and this also had not been taken into account when organising activities. We observed an activity taking place and the majority of the people who took part appeared to be enjoying it. However one person who sat away from everyone was not encouraged to participate. We did not see any one to one activities taking place, which would provide social interaction and reduced isolation to people who remained in their rooms or who did not wish to participate in group activities. One person told us, "I complained about not going out, they took me out three times and they haven't taken me out since."

Failure to provide care and treatment in a person centred way was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff responded to people's changing needs. The deputy manager told us that she had noticed that four people were lethargic and thought they were not eating enough. They had encouraged staff to sit with them during meals to ensure that they stayed interested in their food and that this had, "Paid off." She said that these people were much more alert now. Staff told us that they completed a handover sheet after each shift which relayed changes to people's needs. We looked at these sheets and saw, for example information related to a change in medication, healthcare appointments and messages to staff.

People knew how to make a complaint. One person said, "If I was unhappy about anything I would tell them (staff)." We looked at the provider's complaints policy and procedure to review their processes. We reviewed the manager's complaints log and noted that one complaint had been received in the last twelve months; it was processed in a timely manner. We saw information about the complaint procedure displayed in the home, which provided people with the information about the process, contact details for the registered provider, CQC, the local adult social care team and the Local Government Ombudsman. Staff had a clear understanding of what to do if someone approached them with a concern or complaint and had confidence that the registered provider would take any complaint seriously.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 13 August and September 2015, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have effective systems in place to monitor the quality of care or drive improvement. Staff had not been well supported and shortfalls in staff training and care documentation had not been identified or addressed. During this inspection there were still shortfalls in the quality assurance monitoring systems as they had not identified missing information in care plans, or that best practices and recruitment procedures were not always followed.

We found that there was a lack of effective management and leadership in the home. The provider who was acting as the manager lacked knowledge of people and they were unable to answer our questions in relation to people. Some information could not be obtained until the deputy manager arrived. The provider told us, "I have only just returned from annual leave, I am just catching up with things." This meant that the manager who was in day to day control at the time of the inspection would have been unable to guide the staff and ensure they were effectively monitoring quality if they did not know people well and how their needs should have been met.

Although policies and procedures were in place it was clear that they were not always put into practice. Staff and management did not have clear working knowledge of the current changes in legislation to protect people's rights and freedom. Mental capacity assessments had not been fully completed in accordance with current legislation. Staff did not always follow best practices which put people at risk of harm.

Management observed staff in practice and any observations were discussed with them however the monitoring of staff was not robust. We observed incidents of poor practice during our inspection such as a bathroom floor still left with faeces on it. Staff opening doors without knocking when people are in the bathroom or on the toilet.

Care records did not reflect up to date information regarding people's care or support needs which meant new or agency staff who did not know people might not be working to the most up to date information. The records were completed in an inconsistent way. People's care and support could be affected due to records not being fully completed or kept up to date. Risk assessments were not always person centred or relevant to the person's health needs. Where risks were identified, information and checks were not always carried out, updated or monitored to minimise risk. Their care plans lacked information on how to identify and manage these situations.

There were a number of systems in place to monitor and review the delivery of care. We saw there were various audits carried out such as care plans, medicine administration records, health and safety, room maintenance and housekeeping. However we noted that these audits were not effective in identifying shortfalls or poor practices.

Failure to assess, monitor and improve the quality and safety of the service, not identifying and mitigating

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

The registered provider was not aware of their statutory requirements to notify us of particular incidents. The manager had notified the Care Quality Commission (CQC) about a number of important events which the service is required to send us by law. However we noted that not all notifiable incidents or events had been submitted. This meant that we were unable to effectively monitor the service or identify concerns.

There was no registered manager in place which is a condition of registration with the Care Quality Commission (CQC). The provider was covering the manager's role at Mayfield House. We were informed following the inspection that the deputy manager had commenced the application process to be registered as manager with the CQC.

Staff were involved in the decisions about the home. We reviewed staff meetings where staff discussed a variety of topics. These included food, supervision, people's care needs, and medicines. One staff member told us, "I do like working here, it is a good team and we all help each other."

People were involved in how the service was run in a number of ways but expressed the view that they would like more involvement. One person told us, "I have never been asked to complete a survey; it would be a good idea." Another person told us, "I know who the manager was but never got asked my opinion on the service." There were 'residents' meetings for people to provide feedback about the service. We saw minutes of the meeting where people discussed issues regarding, food, care and external visits from the hairdresser. A questionnaire was in the process of being sent to people to obtain people's views about the service provided.

People and staff told us that the management team were approachable. There was an open door policy as we saw people come into the office to share information, asks questions or if they required assistance. The manager of the service promoted an open culture. One person said, "X is the manager, I see her occasionally, she brings my mail to me." One member of staff said, "The manager is very kind hearted, she is approachable, I feel you can go to her at any time."

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider failed to people's care and treatment be appropriate, meet their needs and reflect their preferences. Regulation 9 (1)(a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider failed to gain appropriate consent in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Regulation 11 (1)(2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider failed to ensure the premises were kept clean and cleaning done in line with current legislation and guidance. Regulation 15 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider failed to have effective

recruitment and selection procedures that comply with the requirements of this Regulation.

Regulation 19 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs. Regulation 18 (1)

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 10 HSCA RA Regulations 2014 Dignity and respect The registered provider failed to ensure that people were treated with dignity and respect. Regulation 10 (1)(2) (a)

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to have systems and arrangements in place to protect people from the risk of harm. Regulation 12 (1) (2) (a) (b) (d)

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 registered provider had not ensured good governance in the home.

The enforcement action we took:

We issued a warning notice