Beaconsfield Care Limited

# Mayfield House Residential Home

## Inspection report

29 Mayfield Road,
Hersham, Walton on Thames,
Surrey KT12 5PL
Tel: 01932 229390
Website:

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires improvement |
| Is the service safe? | Requires improvement |
| Is the service effective? | Requires improvement |
| Is the service caring? | Good |
| Is the service responsive? | Requires improvement |
| Is the service well-led? | Requires improvement |

## Overall summary

This was an unannounced inspection that took place on 13 August and 1 September 2015.

Mayfield House is owned by Beaconfield Care Limited and is registered to provide accommodation with care for up to 34 people. At the time of our visit, there were 27 older people living at the home. The majority of the people who live at the home are living with dementia, some have complex needs. The accommodation is provided over two floors that were accessible by stairs and a stair lift.

The provider was covering the 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

# Summary of findings

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 were not always safe because there were a number of inconsistencies in the systems and arrangements in place to protect people from harm. Risk assessments were not place to identify and minimise risk of harm to people living and visiting the home. We raised concerns about the conditions of carpet after a toilet overflowed, infection control and building work being carried out at the home.

The medicines administration records (MAR) were not accurate and contained gaps. People told us that they were happy with the support they received to manage their medicines. We found the medicines were stored securely and in appropriate conditions. Any changes to people's medicines were verified and prescribed by the person's GP.

People's rights were not protected when they were unable to make decisions for themselves. People's human rights were not protected as restrictions were put in place which were not in accordance with current legislation.

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 practice.

Those that were able to talk to us, told us they felt safe at the home. The majority of the people living at the home are living with various forms of dementia. Some people were unable to communicate with us verbally, but others told us they felt safe.

People were protected from the risk of abuse because staff knew their roles and responsibilities should they suspect it was taking place. A relative told us, "I feel that mum is very safe here, staff are very caring." There were systems and processes in place to protect people from abuse and staff had received safeguarding training.

Recruitment practices were safe, were followed and relevant checks had been completed before staff commenced work. People who lived at the home and staff told us that there were enough staff on duty to support people at the times they wanted or needed. The home had a call bell system in place that enabled people who chose to stay in their rooms to call for assistance when needed. However on the day of the inspection, there was a staff shortage and we saw how this affected the care and support provided. We made a recommendation that the provider reviews and includes the layout of the building when deploying staff to meet individual's care and support needs.

The design and decoration of the home did not meet people's individual needs and help people find their way independently. We recommended that the provider researches and implements relevant guidance on how to make environments more 'dementia friendly'.

People were involved in how they were kept safe at the home. People's risk assessments regarding their behaviour, health and care needs were discussed with them.

The manager ensured staff had the skills and experience which were necessary to carry out their role. We found the staff team were knowledgeable about people's care needs; however staff's knowledge and understanding of people living with dementia and visual impairment was not sufficient to support their additional needs. We recommend that the provider reviews current best practices regarding people living with dementia, visual impairment and other complex needs.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk. Staff provided care and support which promoted well-being. Healthcare professional were involved when assessing health risks. People were supported to have access to healthcare services.

Staff treated people with kindness and respect. Positive caring relationships had been developed between people and staff. Staff showed kindness to people and interacted with them in a positive and proactive way. Staff were caring. People told us that staff treated them with respect and dignity when providing personal care. People felt that staff knew them well. People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's relatives and friends were able to visit.

The activities that were provided were not always what people wanted and were not always age appropriate.

# Summary of findings

There was no physical stimulation for people living with dementia or complex needs. We recommended that the provider reviews activities in accordance with people's hobbies and interests.

People said that staff were attentive and responsive to people's needs. People's needs were assessed when they entered the home and reviewed regularly. Care records were updated by staff involved in their care. People had access to equipment to assist with their care and support to enable them to be independent.

There was no physical stimulation such as interactive tactile activities or textured surfaces around the home for people that would have provided them with something to do during the day when organised activities were not happening. The manager acknowledged that further work was needed to ensure people received stimulation and enjoyable activities. We made a recommendation that the provider researches and implements relevant guidance on how to make activities for people who live with dementia more 'dementia friendly'.

People told us if they had any issues they would speak to the manager or provider. People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard.

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

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

**Requires improvement**

The service was not consistently safe.

People were at risk because systems and procedures to protect them from harm were not always in place.

Medicines were administered by staff in a safe manner; however medicines administration records (MAR) were not accurate and contained gaps.

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

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

**Is the service effective?**

**Requires improvement**

The service was not consistently effective.

People's rights were not protected when they were unable to make decisions for themselves. People's human rights were not protected as restrictions were put in place but were not in accordance with current legislation.

Staff received training for their role, however their knowledge and understanding of people living with dementia and other complex needs was not sufficient to support people.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk.

Staff provided care, and support which promoted well-being.

People were supported to have access to healthcare services.

**Is the service caring?**

**Good**

People said that staff were kind and treated with them with respect.

Positive caring relationships had been developed between people and staff.

Staff showed kindness to people and interacted with them in a positive and proactive way. Staff were caring.

People told us that staff treated them with respect and dignity when providing personal care.

People felt that staff knew them well and they were supported to make choices so they could maintain their independence.

People's relatives and friends were able to visit.

# Summary of findings

**Is the service responsive?**

Requires improvement 

The service was not consistently responsive.

The activities that were provided were not always what people wanted and were not always age appropriate. There was no physical stimulation for people living with dementia or complex needs.

People said that staff were attentive and responsive to people's needs.

People's needs were assessed when they entered the home and reviewed regularly. Care records were updated by staff involved in their care.

People were provided with the necessary equipment to assist with their care and support to enable them to be independent.

People told us they knew what to do if they needed to make a complaint. People were encouraged to voice their concerns or complaints about the home and they were dealt with promptly.

**Is the service well-led?**

Requires improvement 

The service was not consistently well led.

The provider's systems to assess and monitor the quality of the service provided were not robust or effective enough to identify, correct poor practice and improve the service provided.

The provider had sought, encouraged and supported people's involvement in the improvement of the home. People's opinions had been recorded but no information regarding action taken had been captured.

People told us the staff were friendly, supportive and management were 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 visited the home on 13 August 2015 and 1 September 2015 as the manager was not present on the first day of the inspection. The inspection on 13 August 2015 was conducted by two inspectors and an expert by experience who had experience of older people's care homes. An expert by experience is a person who has personal experience of using or caring for someone who uses care homes.

Before the inspection we gathered information about the service by contacting the local authority safeguarding and quality assurance team. We also reviewed records held by Care Quality Commission (CQC) 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.

We reviewed the Provider Information Return (PIR) and previous inspection reports before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This enabled us to ensure we were addressing potential areas of concern.

During the visit we spoke to eight people who live at the home, six visitors, one relative and nine staff which included kitchen staff and the activity co-ordinator. We spent time observing the interactions between staff and people and watched how they were being cared for. We reviewed a variety of documents which included five people's care plans, risk assessments, medicines administration records, accident and incident records and five staff files. We also reviewed minutes of meetings, complaints records and some policies and procedures in relation to the quality of the service provided. We also spoke to a visiting healthcare professional to obtain their opinion of the service provided.

We contacted the local authority and health authority, who had funding responsibility for people living at the home. We also contacted one social care professional who visited the home to obtain their views about the service provided.

We last inspected the home in February 2015 and found no concerns.

Requires improvement

# Is the service safe?

## Our findings

Those who were able to speak to us, told us they felt safe at the home. One person told us, "It is lovely here, staff are wonderful and I feel very safe." We observed that people looked at ease with the staff that were caring for them. However people were not always safe because there were inconsistencies in the systems and arrangements in place to protect them from harm.

People were at risk of harm due to concerns with the environment of the home. On the day of our inspection there was a large amount of building work being completed. Risks associated with this work were not always managed well, we saw one of the side doors that was accessible to people was open and led to an area that had a number of trip hazards. We also found that staff were not familiar with how to open the front door which was operated by a coded keypad and this caused them difficulties when trying to open it. This was also a fire exit, we found that when we returned on the second day this problem had been resolved however one other fire exit was propped open by a small table as the door release mechanism wasn't working.

We saw instructions displayed in the home about how to evacuate the building in the event of emergency. We did not see in people's care plan a 'Personal Emergency Evacuation Plan. (PEEP) ' The manager confirmed they did not have PEEP in place for people. This meant that staff did not have information on how to support individual people in the event of an evacuation.

Failing to ensure that the premises is safe and not assessing risks appropriately is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were involved in how they were kept safe at the home. Risk assessments regarding their behaviour, health and care needs were discussed with them and any issues that arose were discussed, along with the involvement of a healthcare professional, such as the speech and language therapist or falls team. Risk assessments contained information about people's support needs, views, wishes, likes, dislikes and routines of people. These included assessments for moving and handling, behaviour, pressure areas, falls and nutrition; however the information recorded was not always completed or up to date. Staff were knowledgeable about people's needs, and what techniques to use to when people were distressed or at risk of harm. This meant that people were supported by staff who understood their needs. People had access to specialist equipment such as pressure mattresses, cushions, walking frames and wheelchairs.

People were not always protected from the risk of infection. A toilet had overflowed which had led to an overpowering smell of faeces being present throughout the inspection. Staff informed us that they had tried to resolve this by cleaning the area affected but they did not have suitable equipment or products available to them. Due to the risk of the spread of infections and the smell we advised the provider to ensure this was cleaned as a matter of urgency.

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

Medicines were stored securely and in appropriate conditions however the recording of the administration of medicines was not always accurate. The medicines administration records (MAR) charts had gaps, Essential medicines such as beta blockers and anticoagulants were not always recorded as administered and staff were unable to explain why signatures had not been completed. We also noted that a person was prescribed two inhalers. One of which was a PRN [to be taken as required] medicine. Incorrect information was recorded about the correct inhaler used and staff could not tell which inhaler was administered.

People told us that they were happy with the support they received to manage their medicines. Staff attended training in the safe management of medicines were authorised to give medicines. And they attended regular refresher training. Managers assessed their competency by observing them administer medicines to people. All medicines coming into the home were recorded and medicines returned for disposal were recorded in a register. Medicines were checked at each handover and these checks were recorded.

A medicines profile had been completed for each person, and any allergies to medicines recorded so that staff would know which medicines people should receive. A photograph of the each person to ensure that they were giving the medicine to the correct person was present. There was guidance for people who were on PRN [as

Requires improvement

# Is the service safe?

needed] medicines. There were written individual protocols in place for each medicine that people took. This would provide information to staff about the person taking the medicine. Medicines policies and procedures were in place to guide and inform staff. These included policies on covert medicines; this is the administration of any medical treatment in disguised form.

People and relatives told us that there were usually sufficient staff on duty to support them however we saw that, at times, people had to wait for care to be provided as the staff were busy attending to others. One person said, "The carers are always nice. Sometimes they don't seem to have enough time to chat with me as they're so busy." One person was sitting on their own in the lounge area and was visibly upset but there were no staff present to reassure them, another was calling out for help but staff were not available so we had to intervene and find a member of staff to reassure them. We observed two incidents where people displayed challenging behaviour but early intervention to stop this escalating was delayed due to a lack of staff being available to intervene.

We were told by staff that there should have been five care staff on duty in the morning however there were only four on the first day of our inspection due to staff sickness. The provider told us that they would use agency staff to cover unexpected absences but this had not happened. We reviewed the staffing rotas over a four week period and found there were two occasions where the staffing allocation was under the minimum staffing levels to keep people safe as calculated by them. There was a call bell system in place that enabled people who chose to stay in their rooms to call for assistance from staff when needed. We noted that call bells were answered promptly by staff and people were not kept waiting to provide the care they needed.

**We recommend that the provider review their staffing arrangements when there is unexpected staff absence.**

There were robust checks completed before staff were employed to ensure they were suitable to support people that lived here. There was a staff recruitment and selection policy in place. Staff confirmed that they were asked to complete a form which recorded their employment and training history, proof of identity and references. Staff were not allowed to commence employment until satisfactory criminal records checks and references had been obtained. Staff files included a recent photograph, written references and a Disclosure and Barring System (DBS) check. DBS checks identify if prospective staff had a criminal record or were barred from working with people who use care and support services. This meant that all of the necessary checks had been carried out to ensure that people are safe to work with people at the home. People were protected from the risk of abuse because staff knew their roles and responsibilities should they suspect it was taking place. Staff confirmed that they had received safeguarding training and they were aware of their responsibilities in relation to safeguarding. Staff were able to describe the different types of abuse and what might indicate that abuse was taking place. For example, one member of staff said, "If I see something or think anyone is at risk, I would make sure the resident is safe and notify my manager." The manager could not find a copy of the most recent local authority safeguarding policy; they did have a company policy on safeguarding adults. During the inspection the provider downloaded the information to ensure staff had access to the current guidance. This information provides staff with up to date guidance about what to do in the event of suspected or actual abuse.

Requires improvement

# Is the service effective?

## Our findings

People's freedom was sometimes restricted. One person told us, "The carers look after me well, but I would like to get out more, as I feel locked in here." Another person told us, "I would like to go out more often, but the staff here are too busy to take me out, I'd feel awkward asking them to take me for a walk when they've got so much to do. I do feel locked in here though."

The Care Quality Commission (CQC) 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. We saw the front door was operated by a coded keypad and was difficult to operate; the code to open the door was not on display. We saw two people during the inspection trying to get out of the home; staff persuaded them to return to the lounge or dining room. For people who lacked capacity, these restrictions had not been considered by staff and DoLS applications not completed for those people it affected.

The manager and staff did not have a clear understanding of their responsibilities under the Mental Capacity Act 2005 (MCA), and DoLS. The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters.

Mental capacity was not correctly assessed or considered and action taken when a person was found to lack capacity to consent. As a result people's legal rights were not upheld. Information recorded on the mental capacity assessment did not match with the information recorded in the care plan. For example some of the assessments stated that the person did not have capacity to decide what to eat or drink, whereas their care plan stated they did. There was no record on the person's file to show the relative had legal responsibilities to make decisions on their behalf. This meant that people's right were not upheld in line with current guidelines.

The majority of staff had received training on the MCA and DoLS as part of the safeguarding adults training that they had completed. Despite having received training not all staff were able to demonstrate a clear understanding of MCA or DoLS.

**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's care plan contained consent forms for the use of their photograph and for staff to administer medicines. These had been signed by the person. They also had a communication care plan that reinforced to staff the person's abilities. People who had a Do Not Attempt Cardio-Pulmonary resuscitation form in place had been signed by the appropriate healthcare professional.

Staff obtained consent prior to support being given, we observed that staff checked with people that they were happy with support being provided on a regular basis and attempted to gain their consent. During our inspection we observed staff seeking people's agreement before supporting them and then waiting for a response before acting on their wishes. Staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them. They repeated questions if necessary in order to be satisfied that the person understood the options available. Where people declined assistance or choices offered, staff respected these decisions. One person told us, "I spend mornings in my room, then come down for lunch and stay downstairs until around 7pm, when I come back to my room." This showed us that prior to any care and support given staff obtained consent and took into account people's needs and wishes.

There were qualified, skilled and experienced staff to support people living at the home. The manager ensured staff had the skills and experience which were necessary to carry out their roles. Staff confirmed that a staff induction programme was in place. Staff said that they received training that helped them care for people and meet their needs. One member of staff said, "We have e-learning. The last e-learning was Equality and Diversity which was more than a couple of years ago."

Requires improvement

# Is the service effective?

We found that staff team were mostly knowledgeable about people's care needs; however the service has a high proportion of people living with dementia, had complex needs and whose behaviour could be described as challenging. Not all staff had received training in certain areas such as for people who may have challenging behaviour. There were gaps in staff training identified which meant that staff might not always have the most up to date guidance or knowledge. Staff told us they felt supported by the manager; however there were inconsistencies in the frequency of regular meetings to discuss their work and performance. One member of staff told us, "I have had them in the past but not one recently, but there have been changes in the management." Another member of staff told us, "The manager always talks to me, but I haven't had supervision recently. I do feel supported. I just go in and tell her if I need anything."

People told us they liked the food that was provided. One person told us they "Loved the food", another said the food was "Great." We observed the lunchtime experience; people were able to choose where they wanted to sit. Most people had their lunch in the dining area. People who were unable to eat independently were supported by staff. However some staff did not always provide this support in a way that was dignified. We saw some staff standing up whilst assisting people which meant they were standing over them. Other staff sat with people and engaged with them. People were offered a choice of drinks with their lunch and condiments were placed on the dining table for people to use freely. People were supported to have enough to eat and drink. People appeared to enjoy the meal and the mood throughout lunch was relaxed and friendly and people were enjoying each other's company. Some people had adapted cutlery and crockery to help them eat or drink independently and staff provided support to them wherever possible.

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. People had access to healthcare professionals in relation to their nutritional needs. Staff told us," X was on a pureed diet, but it is now on a soft diet. They were not eating the pureed food. We contacted the GP and finally got the speech and language therapy team (SaLT) to come in and do a review and moved her to a soft diet. She is eating a bit more now." This meant that where staff identified nutritional needs people were referred to the appropriate healthcare professional.

The design and decoration of the home did not meet people's individual needs and help people living with dementia orientate independently. During our inspection, we observed that the majority of people spent their time in the lounge. Carpets throughout the communal areas were patterned and walls, doors and frames were all painted the same colour which did not help people to find their way around the home easily. People's names were on their bedroom doors and some included a photograph of the person but no further objects of reference were located in any parts of the home that would help people who were living with dementia to find their way around without the assistance of staff. People's bedrooms were personalised with pictures, photographs or items of personal interest.

**We recommend that the provider researches and implements relevant guidance on how to make environments used by people who live with dementia more 'dementia friendly'.**

People had access to healthcare professional such as doctors, district nurses, chiropodists, opticians, dentists and other health and social care professionals. One healthcare professional told us, "People were cared for. Staff were attentive and aware of people needs, they follow the instructions we provide very well." People were supported by staff or relatives to attend their health appointments. Outcomes of people's visits to healthcare professionals were recorded in the care records. This showed the management and staff ensured people's health needs were met.

Good

# Is the service caring?

## Our findings

Staff showed kindness to people and interacted with them in a positive and proactive way. People said that staff were kind and treated with them with respect. One person told us, “I may stay here rather than go home as it’s so nice, as I keep falling over at home.” Another person told us, “I’m very happy here, I’ve got all I want. The carers are all nice.” A third person told us, “It is lovely here, staff are wonderful.”

Positive caring relationships had been developed between people and staff. Staff were observed smiling at people as they went about their roles. One person told us, “She (pointing to a member of staff) is lovely; she knows me and is always willing to help.” A relative told us, “X is well looked after here. We never see anything wrong; the carers are all attentive to him.”

Staff were caring. Staff were observed knocking on people’s bedrooms doors before entering. When they assisted people to move from one part of the home to another staff were heard offering encouragement and words of reassurance to people. Comments included, “That’s good” and “You’re doing fine.” People were seen to smile in response.

Staff respected people’s privacy and dignity. People told us that staff treated them with respect and dignity when providing personal care. When people needed assistance with personal care we observed that staff did this behind closed doors in bedrooms and bathrooms. Attention to detail had been given with people’s appearance. People felt that staff knew them well and people were able to make choices about when to get up in the morning, what to eat, what to wear and activities they would like to participate in, so they could maintain their independence. One person told us, “I spend mornings in my room, then come down for lunch and stay downstairs until around 7pm, when I come back to my room.”

People were able to personalise their room with their own furniture, personal items and choosing the décor, so that they were surrounded by things that were familiar to them. Staff knew about the people they supported. They were able to talk about people, their likes, dislikes and interests and the care and support they needed.

People were involved in making decisions about their care and support. We reviewed notes from a resident’s meeting held in August 2015 where issues in regards to the hairdresser visiting the home, someone wanted to sit closer to the TV in the evening and suggested that a notice board displaying staff pictures.

Relatives and friends were encouraged to visit and maintain relationships. People confirmed that they were able to practice their religious beliefs, because the provider or relatives offered support people to attend the local religious centres. We also saw that religious services were held in the service and these were open to those who wished to attend. This showed us that care and support was provided with due regard for people’s religious persuasion.

Requires improvement

# Is the service responsive?

## Our findings

Although people were provided with activities and could access the community, not all were relevant or in accordance to people needs or interests. One person told us, "I like the bingo and music." An activity programme was in place, but was not person centred. It consisted of bingo, board games, arts and crafts and board games. It did not take into account people's interests such as reading newspapers, doing crosswords or going out for walks. We also noted that some people's capabilities were limited due to living with dementia or sensory impairment and this also had not been taken into account when organising activities. We also noted that a pianist visited the home to play music on the piano, this occurred in the afternoon of the inspection. Lots of people joined in and were singing along to the music. We did not see any one to one activities taking place, which would provide social interaction to people who remained in their rooms or who did not wish to participate in group activities.

People did not have access to the garden due to the building work and they told us they did not go out unless visitors took them out. One person told us, "My family always visits me and they take me out." There was no physical stimulation that people could interact with around the home that would have provided them with something to do during the day when organised activities were not happening. We noted that in the morning people who were sitting in the lounge were either sleeping or watching television, there was very little interacting with staff.

**We recommend that the provider researches and implements relevant guidance on how to make activities for people who live with dementia more 'dementia friendly'.**

Staff responded to people's changing needs. People said that staff were attentive and responsive to their needs. Relative told us, "The carers spotted a lump while they were washing X and they called the doctor immediately and had it treated at hospital, we would have never have spotted that if she'd been at home." They went on to say "The carers seem to be well trained and are attentive to Mum." People told us they were happy and comfortable with their rooms and one that we were invited to view was attractively decorated with some personal touches including photographs and memorabilia. They told us, "As you can see my room's very comfortable."

Most people were encouraged to spend their days in the lounge areas, where they were attended to by staff. People told us that there were no restrictions and that routines were flexible. One person told us, "I can get up or go to bed when I like." Another person told us, "We eat what we want, I'm happy here." There were no restrictions when relatives or friends could visit the home. Relatives felt welcomed by staff when they came to visit. One told us, "They make me feel welcome."

Assessments were carried out before people moved into the home and then reviewed once the person had settled into the home. The information recorded included people's personal details, medical history, mental health and current care and support needs. Details of health and social care professionals involved in supporting the person such as their doctor or care manager were recorded. Other information about people's medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were also recorded. This information was used to develop care and support in accordance to people's needs. For example, arrangements had been made for one person to be seen by a dietician when staff identified that they had lost weight and were not eating properly. As a result, the person was prescribed food supplements and their weight monitoring to continue.

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 medicines, healthcare appointments and messages to staff. Daily records were also completed to record support provided to each person; however they were very task orientated. For example "X was a bit out of breath this morning, washed, dressed, bed was made and brought down for breakfast." There was no information about interactions, activities or mood. This showed us that although there was up to date information about the support provided, the information was not person centred.

People were provided with the necessary equipment to assist with their care and support needs such as wheelchairs, walking frames and hoists. People and relatives confirmed they were involved in the planning and delivery of their care. Care records were reviewed regularly and any healthcare visits, treatment given and instructions to staff were noted. Information was also recorded if any changes had happened such as wound care, falls, medicines, incidents, accidents and dietary needs.

Requires improvement

# Is the service responsive?

We noted that relatives freely spoke to the manager about any concerns they had with the care being provided to their family member. People were provided with information on how to raise a concern or make a complaint. People had the opportunity to voice their concerns about the service. People told us they knew what to do if they needed to make a complaint. People we spoke with felt able to express concerns or would complain without hesitation if they were worried about anything.

One person said that if they were unhappy, "I would speak to management but I've no complaints." A relative said that if they have any concerns they would immediately speak to the manager. We saw that information was provided in written form and not in pictorial or other formats which may assist people who have dementia or sensory disabilities to make an informed choice. Information about the complaint procedures was displayed throughout the home. Staff told us that they were aware of the complaints policy and procedure as well as the whistle blowing policy. Staff we spoke with knew what to do if someone approached them with a concern or complaint. There have been no complaints received in the last 12 months. This meant the people had the opportunity to voice their concerns or opinions about the service provided.

Requires improvement

# Is the service well-led?

## Our findings

Policies and procedures were in place for staff to follow to help ensure safe and appropriate care was provided to people. However, all those we sampled were out of date and did not reflect current legislation and guidance such as MCA and DoLS. The provider told us that she was aware that the policies and procedures needed to be updated and had subscribed to an external organisation who would be supplying these in the future.

It was clear that staff and management did not have a clear working knowledge of the current changes in legislation to protect people's rights and freedom. For example the restrictions placed on people' leaving the home was a deprivation of people's freedom. This restriction had not been authorised by the local authority's supervisory body.

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. For example, one record stated that staff managed the person's finance when in fact a relative who had power of attorney did. Another care plan had a repositioning chart completed when we reviewed the information it had been used to record daily tasks conducted. Another care record noted the person was at risk of severe self-harm, there was no reference of healthcare professional involved. Staff confirmed that the person was not at risk of severe self-harm and described the circumstances surrounding it.

Risk assessments to identify risks to the safety of the premises and minimising risk to people were not completed. The systems and arrangements in place were not robust or effective to identify and manage risks. There was no information in people's care plan on how to support individual people in the event of an evacuation.

The provider showed us a draft business contingency plan that identified how the service would function in an emergency. Staff knew what to do in the event of an emergency such as fire, adverse weather conditions, power cuts and flooding. The provider had not identified alternative locations which would be used if the home was unable to be used. This meant there were not robust arrangements in place to minimise the impact to people if emergencies took place.

There were a number of systems in place to make sure the service assessed and monitored its 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 to identify, monitor and review issues and correct poor practices.

**Failure to have robust and effective systems in place to protect people from harm was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

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. This meant that we were able to effectively monitor the service or identify concerns.

We found during our inspection the senior carer in charge had a good knowledge of the home and the people living there and was able to answer our questions easily or provide us with the information we required.

Staff had a clear understanding of the ethos of the organisation and the purpose of their role. This was embedded in staff induction and training and staff were encouraged to reflect on their practice.

Staff were involved in the decisions about the home. We reviewed staff meetings where staff discussed a variety of topics. These included food, supervision, 'residents' care, absences, medicines and new policies. Staff told us "I do enjoy working here and I feel supported. If I have any concerns I would talk to the manager."

People told us that the manager was approachable, "I have had a lot of dealings with the manager" and "I can approach the manager; I will say what I feel." Relatives told us, "We always see the manager about the place" and "The manager is approachable." "I will talk to her if I have any concerns or questions about my relatives care."

There was an open door policy as we saw people come into the office to share information about their activities, where they were going out or if they required assistance. The manager of the service promoted an open culture.

People were involved in how the service was run in a number of ways. We noted that there were 'residents' meetings for people to provide feedback about the service. We saw minutes of the meeting where people discussed

Requires improvement

# Is the service well-led?

issues regarding seating in the lounge, food, care and external visits from hairdresser. A survey conducted in July 2015 recorded comments such as 'Very happy with the kindness and care my dad is being given' and 'I am impressed with all the services at Mayfield house. They do their work wholeheartedly.'

A visiting healthcare professional told us, "The staff are caring, they are aware of the people's care needs. They have a good attitude and respect people wishes."

We saw accident records were kept which contained a description of the accident, time it occurred and if people required hospital treatment. Each accident had an accident form completed, which included immediate action taken, injury evaluation; follow up investigation and action taken. Management observed staff in practice and any observations were discussed with staff. We noted that fire, electrical and safety equipment was inspected on a regular basis.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Regulation 12 (1) (2) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment<br><br>The registered provider failed to have systems and arrangements in place to protect people from the risk of harm. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br><br>Regulation 15 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment<br><br>The registered provider failed to ensure the premises were kept clean and cleaning done in line with current legislation and guidance. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>Regulation 11 (1)(2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for Consent<br><br>The registered provider failed to gain appropriate consent in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Action we have told the provider to take

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|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance<br><br>The registered provider had not ensured good governance in the home. |