Mayfield Residential Care Ltd

Mayfield Residential Home

Inspection report

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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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The home was inspected on 5 and 6 April 2018 and the inspection was unannounced.

Mayfield Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. It accommodates 29 people in one adapted building. There were 23 people living at the home on the day we visited.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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.

At our last inspection on 7 December 2016 we found that the provider was in breach of Regulation 17 good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question of safe and well led to at least good. At this inspection we found that the provider had started to make the necessary improvements and that they had employed a new registered manager to drive the improvements forwards. The registered manager had identified all the concerns we found during the inspection and had plans in place to rectify issues.

At the last inspection the home was rated as Requires Improvement. At this inspection we found that the provider taken steps to improve the quality of care provided. However, while issues had been identified more time was needed to embed the improvements in the care provided. The rating remained as Requires Improvement. "This is the second consecutive time the service has been rated Requires Improvement." However, the rating for the well-led question improved from requires improvement to good.

The environment was in need of attention to keep it at a standard which supported people's dignity. Risks to people were identified and care was planned to keep people safe. However, pressure care had not always been delivered in line with people's care plans. Care plans contained the basic information staff needed to provide safe care but they did not reflect people's individual preferences. Medicines were safely administered and systems in place to order and monitor medicines were effective. However, where medicines were prescribed to be taken as required there were no protocols in place to support staff to administer these medicines in a consistent manner.

There were enough staff to meet people's needs and checks were completed to ensure that they were safe to work with the people living at the home. Staff received training which supported them to provide safe care to people. However, they were not always up to date with changes in the homes' policies and procedures. People were supported to make choices about their meals and their ability to eat and drink safely was monitored. Where needed soft food was provided so people could eat safely.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The registered manager had systems in place to identify concerns in the home and to drive improvements.

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.

Risks to people had been identified and care was planned to keep people safe. However, pressure care had not always been delivered in line with the care plan.

Medicines were safely administered and accurate records were kept. However, protocols were needed for medicines prescribed to be taken as required to ensure staff administered them in a consistent manner.

Care staff worked to reduce the risk of infection but cleaning schedules did not ensure that soft furnishings were effectively cleaned.

There were enough staff to keep people safe and staff knew how to protect people from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The environment was in needed of attention.

Staff received training to ensure that they had the skills needed to provide safe care for people. However, staff were not always up to date with changes to policies and procedures.

People were supported to eat and drink safely.

Staff were aware of the Mental Capacity Act 2005 and supported people to make decisions.

People were supported to access healthcare when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The environment did not fully support people's dignity.

Staff were kind and caring.

Staff respected people's right to make choices about their lives.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans provided the basic information needed to provide safe care but did not identify how care could be tailored to people's needs.

People enjoyed the activities provided.

People's end of life wishes were recorded and respected.

People knew how to make a complaint.

Is the service well-led?

Good

The service was well led.

The registered manager had systems in place to monitor the quality of care people received.

People's views on the care they received were gathered and used to drive improvements.

Mayfield 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.

The home was inspected on 5 and 6 April 2018 and the inspection was unannounced.

On the first day our team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance the care of older people and people living with dementia. On the second day our inspector returned alone to complete the inspection.

In preparation for our visit we reviewed information that we held about the home. This included the action plan completed by the provider following our last inspection. As well as notifications (events which happened in the home that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams. We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, the head of care, the supervising senior care worker, two care workers, the activities coordinator, a cleaner and the cook. We also spoke with six people living at the home and three visitors to the service.

We looked at a range of documents and written records including six people's care files and two staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Requires Improvement

Is the service safe?

Our findings

We found that risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. Risks to people had been identified and care was put in place to keep people safe. For example, where people were at risk of skin damage due to pressure, appropriate pressure reliving equipment was in place.

We discussed pressure care with staff who had received knew that they needed to reposition people at risk of pressure ulcers every two hours, they also understood the importance of ensuring skin was dry and creamed if needed. However, the chart for one person, who should have been on two hourly repositioning, showed that they had only been repositioned once all day. The daily notes showed that the person had been repositioned more frequently than recorded on the chart but still showed care had not been delivered in line with the care plan and there had been five hours between repositioning at one stage on the day before the inspection. We raised this as a concern with the registered manager, who told us they would ensure that care was improved.

Where people needed equipment to move safely around the home it was recorded in their care plan. Staff had also identified those people whose risk of falling increased at night when getting up independently. Pressure mats had been placed at the side of their beds so that staff were alerted when they needed support.

People told us that staff were good at giving medication on time and that the member of staff remained with the person to ensure the medication had been taken. We found that suitable arrangements were in place to safely order, administer and dispose of people's medicines in line with national guidelines. Systems were in place to monitor the storage and stock levels of medicines. This ensured that medicines were available to people when needed and would be effective. Accurate records of medicine administration were kept as well as records of when stock was received and of any stock returned to the pharmacy. This allowed the registered manager to audit medicines to ensure that no errors had been made. We saw that where errors had been made in administering or recording medicines the registered manager had taken action with the staff involved to reduce the risk of the same incident reoccurring.

Some medicine, such as pain relief had been prescribed to be taken 'as required'. Records showed when these medicines had been taken, what dose had been given and why. However, there was no corresponding protocols in place to support staff to recognise when this medicine was needed. This was important for those people were unable to request medicine if needed. The provider's medicines policy stated that a protocol for each medicine prescribed as required was needed which was person centred and focused on outcomes. Following the inspection the registered manager confirmed that protocols had been put in place for all people prescribed 'as required' medicine. In addition, a review of medicines by a community pharmacist showed no further issues had been identified.

People told us that they were happy with the cleanliness of the home. One person told us, "Everything is clean, the laundry service is good." We found that suitable measures were in place to prevent and control

infection. The cleaning staff told us that they had been plenty of equipment now that the registered manager was in place. In addition to the daily cleaning, two or three rooms each week were deep cleaned. This was where beds and other furniture were moved and skirting's washed and high ducting completed. In addition they knew how to minimise the risk of infection by using different coloured mops and buckets.

However, There was no schedule in place to wash soft furnishings such as the curtains as they were dry clean only. This was an infection control risk. The chairs in people's bedrooms had not been effectively cleaned and were stained and dirty. We discussed this with the cleaning staff who told us that chairs would be wiped down every day and washed if needed.

Care staff were able to tell us how they used protective equipment to keep people safe from the risk of infection. They were also able to describe how they would care for a person with a known infection.

They systems in place to enable lessons to be learned and improvements made if things went wrong were informal. The registered manager told us that incidents were discussed at handover and changes made to individual care plans to keep them safe, but there was no formal learning and sharing in place. We also saw that learning from national incidents had not been fully implemented in the home. We saw that a thickening agent for drinks had been left out on the side. This was a choking risk for people and advice on keeping it safe had been released by the medical devises agency. We raised this as a concern with the registered manager who was aware of the advice and ensured that it was immediately removed from the communal area.

People told us they felt safe living at the home. A person living at the home told us, "I'm safe with the carers, I'm quite happy." A relative told us, "She's safe with the carers."

We found that people were safeguarded from situations in which they may experience abuse. Records showed that care staff had received training and knew how to recognise and report abuse. Staff were happy to raise any concerns they had with the registered manager and were confident that the registered manager would take the appropriate action to keep people safe. Staff also knew they had the option to raise the concerns directly with the local authority safeguarding team.

People told us that there were enough staff to provide care in a timely manner. One person told us, "There is never much of a delay with answering call bells." The registered manager told us that they had carefully established how many care staff and other members of staff needed to be on duty. They said that they had taken into account the number of people living in the service and the care each person needed to receive. They had then used a staffing tool to show how many hours of care was needed to meet people's needs.

Staff told us that the registered manager checked the qualifications of new staff to ensure that they had achieved what was recorded on their application form. The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. Any gaps in people's employment history had been identified and investigated. The required checks had been completed to ensure that staff were safe to work with people who live at the home.

Requires Improvement

Is the service effective?

Our findings

The home was in need of some attention. For example, carpet in the hallways was threadbare in places, patterned. Patterned carpets are not dementia friendly as people living with dementia may see the patterns as objects and may try to pick them up or step over them increasing their risk of falling. In one person's bedroom we saw that the carpet had been patched in two places and did not match the original carpet that was down. Some of the vanity units in people's bedrooms were worn and wood was showing which staff would be unable to clean effectively. We saw some of the bathroom and toilet floors while cleaned from daily dirt had become stained over time. The registered manager had identified all of our concerns regarding the environment and had submitted a refurbishment plan to the provider which covered these items.

The registered manager had also identified some changes to the home which would improve the environment for people. An example of this was improving the layout of the lounge area to make it bigger as at present it did not give staff enough space to support people, we saw one member of staff went to the side of a person to support them to eat. This meant that they were slightly behind the person and this may be confusing for a person living with dementia.

There was good signage around the home to support people to find their ways to communal areas and facilities. The signage contained pictures as well as words to support people living with dementia.

Arrangements were in place to assess people's needs and choices before they moved into the home so that care was provided which met their needs. Policies and procedures folders were available to staff in the home. The registered manager had updated all the policies as they were concerned that they were out of date. However they had not put systems in place to discuss the changes with staff or ensure that staff had the time to identify and reflect on the changes. We saw only two members of staff had signed to say they had read the updated policies since they had been put in place two months prior to our inspection.

Records showed that new care staff had received introductory training before they provided people with care. A new member of staff told us how they had been required to review the provider's policies and procedures so that they were aware of the standards in the home. They had also shadowed and experienced member of staff for a week so that they got to know the people living at the home and their needs. New staff who had not worked in care before, were supported to complete the care certificate. The care certificate is a set of national standards which cover the basic information staff need to provide safe care.

Staff also received on-going training to keep their knowledge and skills up to date. One member of staff member told us that they had covered subjects such as infection control, moving and handling and dementia. Staff told us that the registered manager was supportive of them when they wanted to complete further qualifications which would support them in their career development. Some of the staff we spoke with were completing nationally recognised qualification.

Staff told us that they had regular individual meetings with their line manager. This enabled them to raise

any concerns they had or identify any training needs. In addition, they also received an annual appraisal which gave them the opportunity to talk about career progression and opportunities for advancement.

People told us that they were happy with the food and the choices available. One person told us, "Not bad food at all, it's always served hot." Another person said, "The food is fantastic. The choices are good and the service is good too." There was a choice of two meals for lunch. Choices for lunch and supper were made each morning. A four week menu was shown on a board near the upstairs lounge but there was no indication which was the current week. People were offered hot and cold drinks throughout the day. We saw staff supported people who were unable to drink independently on a regular basis.

Some people needed support to eat. We saw that staff followed good practice guidance and sat at the side of the people when supporting them. People's ability to eat and drink safely was recorded. Where people needed support this was recorded in their care plan. For example, one person's care plan recorded that they needed help to cut their food into bite size pieces. Staff understood the difference between different types of soft diet, for example, 'fork mashable' and 'pureed' diets. The appropriated food was provided for people to keep them safe while eating.

Some people at the home needed support to maintain a healthy weight and received calorie rich drinks prescribed for them by the doctor. Their weight was being monitored on a weekly basis. Other people were offered the opportunity to be weighed monthly. However, one person, who's BMI was 17 had no record in their care plan of the action staff had taken to support them to maintain their weight. This was important as low weight can increase the risk of developing pressure areas. We raised this with the registered manager who told us they would review the care of this person.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. Systems were in place to ensure that if a person went to hospital or moved to another home that the information about their medicines was available to the people who would be supporting them. Care plans contained emergency grab sheets so that all appropriate information was ready to hand over to other healthcare professionals in an emergency situation.

All the staff work together to care for people. At each shift there was a handover during which the head of care would allocate tasks to staff so they were clear of their responsibilities for the shift.

People told us they were supported to access healthcare. One person told us, "I have no trouble seeing my GP." Another person said, "The GP visits us here and so does an optician." Records showed that people were supported to access healthcare advice and support on an ongoing basis. For example, we saw that people were able to have their eyes tested and that they were supported to attend for any healthcare screening they were invited to. In addition, people were able to access care for a GP or community nurse when needed. Where people were living with conditions that may be more complex to manage, staff liaised with specialist nurses for guidance and support.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes

and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Where staff identified concerns that people living at the home may not be able to give their consent to living at the home the registered manager had ensured that appropriate applications were submitted to the relevant local authority DoLS team for assessment and formal authorisation. Some people living at the home had an authorised DoLS in place and the home was secure so that they could not leave unaccompanied. Conditions can be place on a DoLS by the assessor to limit restrictions on people. There was no one living at the home who had conditions on their DoLS.

Staff had received training in the Mental Capacity Act 2005 and understood that some people may not be able to make decisions for themselves. Staff were clear on the need to involve family in the decision making process if a person lacked capacity. They also understood that these decisions needed to be made in a person's best interest. However, there was inconsistent evidence in people's care files on who had the legal responsibility to make decisions on their behalf. Therefore staff may not be aware of which family members were legally able to make decisions on the person's behalf.

Requires Improvement

Is the service caring?

Our findings

We saw that the layout of the home did not always support people's dignity. There was a toilet off the lounge area. The toilet door had a full length semi-opaque glass panel that allowed anyone passing to see in. Whilst it would not have been possible to identify who was in the toilet, there was still a lack of privacy and dignity.

We saw that towels on a trolley ready to be put in people's bedrooms were worn and had frayed edges and bedding was worn and stained. These showed a lack of respect for people living in the home. We raised this concern with the registered manager who told us that they had recognised these concerns and had started to replace linen. This was confirmed by staff who told us they had been authorised to discard worn linen. Following the inspection he registered manager told us all worn linen had been replaced. In addition we saw that staff had not taken the time to observe concerns when making beds. For example, one person's bed had been made when the pillow was stained with blood and the bedding was upside down. This meant that the buttons to keep the duvet closed would be near the person's neck and uncomfortable.

We saw that an upstairs bathroom had been left in a mess by care workers. We saw that clothing and towels had been left on the floor and a razor and used gloves had been left in the sink. This showed a lack of respect for people's belongings and posed a risk to others as the bathroom was not secured.

People told us that they had good relationship with the staff and we saw that people were treated with kindness and that they were given emotional support when needed. One person told us, "They are always friendly and cheerful." Another person told us, "'They are lovely [staff], nothing is too much trouble." A third person commented, "I'm treated with respect. They stop for a chat."

We found that people had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. One person told us, "I can get up when I want and go to bed when I want." Another person had wanted to bring their cat with them when they moved in and this had been agreed. They told us, "There wasn't a problem when I said I wanted to bring my cat." Where people needed support to make a decision staff simplified the choices available to people by offering options. For example, by showing them a choice of clothing to choose from. In addition each person had a communication plan in place which highlighted how they best communicated with people, how information should be presented to them and any aids they required.

Suitable arrangements had been made to ensure that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of staff.

Requires Improvement

Is the service responsive?

Our findings

People had a pre admission assessment which meant that the registered manager was able to asses if they could meet the person's needs. People were asked to sign consent to the care being received. Where people were unable to consent then a relative who had the authority to consent for them had signed the agreement.

The information in care plans was brief and contained no person centred information. For example, one care plan stated that the person required the support of one care worker for all bathing, showering, washing and dressing. There was no record of if the person preferred a shower or a bath or how often they wished to bath and at what time of day they would like the support to do this.

The registered manager had identified that the care plans were disordered and information about people's needs was difficult to find. They had asked staff to rewrite the care plans in a new format to make the information more accessible. However, we saw that the new care plans contained only the basic information needed to provide safe care and did not support staff to provide care tailored to individual needs. In addition we saw at times unclear information was carried forwards into the new care plans with no checks being completed. An example of this was one person who was eating a normal diet was recorded as requiring soft food in their care plan. We raised this as a concern with the registered manager who explained the information about a soft diet was in their previous care plans but there was no evidence of an assessment by a qualified healthcare professional. The registered manager told us they would arrange for an assessment to be completed so that they could ensure that the person was not at risk of choking.

People showed us and records confirmed that they were offered the opportunity to pursue their hobbies and interests and to enjoy taking part in a range of social activities. One person told us, "The activities are fun." Another person said, "The activities are good, there's different things we can do. You're not forced to do them if you don't want to."

Suitable provision had been made so that people could be supported at the end of their life to have a comfortable, dignified and pain-free death. The wishes of people and their family regarding the care at the end of their lives were discussed, recorded and respected. In addition, staff liaised with other agencies to ensure they had the right medicines available to help people remain pain free at the end of their life.

People living at the home told us that they knew how to raise a complaint if needed but that they had never had cause to. One person told us, "I've no complaints whatsoever." Staff told us that if anyone raised a complaint with them they would raise the concern with the registered manager. There had been two complaints since our last inspection and both had been dealt with by the previous manager in line with the providers' complaints policy.

Good

Is the service well-led?

Our findings

At our inspection on 7 December 2016 we found that the provider had not always taken effective action to improve care where they had identified issues. This was a breach of regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance. Following our inspection the provider wrote to us and told us they would ensure that they would implement all the changes needed.

At this inspection on 5 and 6 April 2018 we found that the provider had taken action to improve the quality of care that people received. We found all of the issues highlighted in out last report had been actioned. For example, at the last inspection we identified that there had been missing signatures on the medicine administration records (MAR), at this inspection we found the MAR had been appropriately completed. We also saw that the audits to monitor the quality of care provided had been reviewed and were not identifying concerns. The provider had employed a new registered manager. Since working at the home the registered manager had identified a number of areas that were in need of improvement. These included, training, reviewing care plans, updating the policies and procedures. In addition they had identified some changes to reduce the risks to people. For example, the room where the medicines were stored had also been a staff room this had changed to a dedicated medicines room for security and so that people administering medicines could work undisturbed. The registered manager was aware of the need to make improvements in all the areas of concern that we identified during our visit. They had identified all the areas of concern before our visit and had started to put action plans in place to drive improvements. Following the inspection we confirmed with the registered manager that they had already completed actions in relation to the concerns we found. They had ensured that all people prescribed a medicine to be administered 'as required' now had a protocol in place, new bed linen and towels had been purchased and old linen had been removed from use. Work was on-going with the environment with two bedrooms and one bathroom having been decorated and work on the outside environment had also been completed. The registered manager also confirmed that half of the care plans had been updated to include more information about how people liked to receive their care and plans were in place to ensure the work continued. This showed that the registered manager was able to respond to concerns and take appropriate action to drive improvements in the home.

Staff working at the home had recognised that the registered manager was having a positive effect on the quality of care provided. One member of staff told us, "The new manager is brilliant. I cannot fault her. She is firm but fair and listens, watches and takes notice and will sort things out. Most staff think it is the best thing that has happened to the home in years." Another member of staff said, "The registered manager wants to improve the care and wants the residents to feel more at home and for staff to follow guidance." People living at the home and their relatives had also identified that the manager was driving improvements in the home. One relative told us, "The decor has improved and the front door is now answered a lot quicker than it used to be."

The provider was now meeting the regulation.

We noted that the provider had taken a number of steps to ensure the service's ability to comply with

regulatory requirements. There was a registered manager in post. The registered manager had ensured that they notified us about any significant incidents when they occurred at the service.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed this in the home.

We found that people who lived in the service and their relatives had been engaged and involved in making improvements. Residents' meeting had been held and more were planned to happen on a regular basis. In addition the registered manager had recently sent out questionnaires to people living at the home and relatives to see what ideas they had to improve the care. Residents meeting were held but there were no notices of any scheduled meetings or meeting minutes on notice boards.

We found that the registered persons had made a number of arrangements that were designed to enable the service to learn and innovate. This included members of care staff being provided with written policies and procedures that were designed to give them up to date guidance about their respective roles. However, recent changes in polices had happened at an increased rate and staff had struggled to remain up to date with all the changes. The registered manager had set up regular team meetings to keep the staff informed about changes in the care home. The senior care workers had a monthly staff meeting and then all staff met.

We found that the home worked in partnership with other agencies to enable people to receive 'joined-up' care. They ensured that they shared information with other agencies to support people's joined up care when people moved between services.