Mayfield Rest Home Limited

Mayfield House Care Home

Inspection report

41 London Road
Liphook
Hampshire
GU30 7AP

Tel: 01428724982

Date of inspection visit:
26 July 2018

Date of publication:
11 September 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 26 July and was unannounced. At the last comprehensive inspection on 31 January and 2 February 2017 and at our focussed inspection on 13 June 2017 the service was rated requires improvement. We found there was a continuing breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to a lack of safe recruitment processes being sustained.

We found at this inspection that the provider had sustained and embedded the necessary changes to their recruitment process and there was no longer a breach of regulation.

Mayfield House Care Home is a care home for people who require personal care. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Mayfield House Care Home is registered to provide accommodation and support for up to 12 people who may be living with a learning disability. At the time of the inspection there were four people living there.

The service had a registered manager. 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. The registered manager was also the provider.

People were cared for by staff who had received appropriate training, support and supervision in their role, however due to staff challenges this year, there had been a delay in some staff training. We asked the provider to book the relevant training in as a matter of urgency; we received confirmation that this had been done.

People's care and support needs were assessed and care plans developed based on best practice guidance. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. People were supported to eat and drink sufficiently for their needs. People were supported to access healthcare services, such as GPs and specialist nurses and therapists in order to maintain good health and wellbeing.

The provider had systems in place to protect people from risks to their safety and welfare, including the risks of avoidable harm and abuse. Staffing levels were sufficient to support people safely. Recruitment processes were in place to make sure people were supported by staff who were suitable to work in a care setting. There were arrangements in place to store medicines safely and administer them safely and in line with people's preferences. Arrangements to control and manage the risk of infection were established in line with

national guidance.

People experienced good continuity and consistency of care from staff who were kind and compassionate. The registered manager had created an inclusive, family atmosphere at the home. People were relaxed and comfortable in the presence of staff who invested time to develop meaningful relationships with them. People's independence was promoted by staff who encouraged them to do as much for themselves as possible. Staff treated people with dignity and respect and were sensitive to their needs.

The service was responsive and involved people in developing their care plans which were detailed and personalised to ensure their individual preferences were known. People's care plans had information about their care needs, as well as their wishes regarding independence and any risks identified and how to minimise these. If a person's needs changed, their care plans were updated. Arrangements were in place to obtain the views of people and their relatives and a complaints procedure was available for people and their relatives to use if they had the need.

The registered manager provided support to staff. The safety and quality of the support people received were monitored and any identified shortfalls were acted upon to drive recognised improvement of the service. However due to a period of absence by the registered manager, systems had not ensured staff training was up to date, this did not impact on the quality of care provided for people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from risks to their safety and wellbeing, including the risks of abuse and avoidable harm.

The provider employed sufficient staff and carried out recruitment checks to make sure staff were suitable to work in a care setting.

Processes were in place to make sure medicines were administered safely, and to protect people from the risk of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had training and on-going support in their role, however improvements and further training was needed to be put in place to ensure staff were competent and consistent when providing care.

People were given person centred care and had access to healthcare services as required.

People were supported with a diet appropriate to their needs and preferences.

Staff respected people's legal rights and freedoms.

Is the service caring?

Good

The service was caring.

Staff understood people's needs and were caring and attentive.

People were treated with kindness, respect and dignity. Staff interacted positively and patiently with people.

Is the service responsive?

Good

The service was responsive.

People's care and support met their needs and took account of their preferences.

People's complaints and concerns were investigated and dealt with accordingly.

Is the service well-led?

Good

The service was well-led.

People were supported by a service that used quality assurance processes to monitor the service people received.

Incidents were used as learning opportunities to drive improvements within the service.

Mayfield House Care 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.

This inspection took place on 26 July 2018 and was unannounced. The inspection was carried out by two inspectors.

Prior to the inspection we reviewed information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

Throughout the inspection we observed how staff interacted and cared for people during the day, including mealtimes, during activities and when medicines were administered. During the inspection we spoke with the four people. We spoke with two care staff, the registered manager who was also the provider and their business partner who supported them with the service. Following the inspection, we spoke with: two relatives, a quality assurance officer from the local authority and a GP.

We reviewed four people's care records, which included their assessments, care plans, risk assessments. We looked at three staff recruitment files, supervision logs and training plans. We examined the provider's records, which demonstrated how people's care reviews, staff supervisions, appraisals and required training were arranged. We also looked at the provider's policies, procedures and other records relating to the management of the service, such as staff rotas, health and safety audits, medicine management audits, infection control audits, improvement plans and minutes of staff meetings. We considered how people's, relatives' and staff members' comments were used to drive improvements in the service.

Good

Is the service safe?

Our findings

At our comprehensive inspection of Mayfield House Care Home on 31 January and 2 February 2017 we found that improvements made to staff recruitment files had not been sustained or embedded into practice, nor had safe recruitment practices been followed. This was a continuing beach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued the provider with a warning notice which they were required to meet by 9 June 2017.

At our focused inspection of 13 June 2017, we found that the provider had taken action to meet the shortfalls in relation to the requirements of Regulation 19 as described above, but further improvements were needed to embed and sustain this.

At this inspection we found the provider had embedded and sustained the improvements required and there was no longer a breach of regulation.

There were sufficient staff to support people safely in the home and take them to activities and external healthcare appointments. Staff told us their workload was manageable, and we saw they could carry out their duties in a timely manner. The provider carried out the necessary checks before staff started work at the home. Staff files contained evidence of proof of identity, a criminal record check, employment history, and good conduct in previous employment. There was no use of agency staff. If required, staff worked extra hours or shifts to cover any sickness or holidays.

Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with people. Two staff files would benefit from having an updated DBS, the registered manager was advised to complete these applications and has done so.

People told us they felt safe with the care provided and made positive comments about the home and staff. One person told us, "Lovely staff, lovely home, they keep us safe."

All of the staff we spoke with knew and could explain what they would do if they suspected abuse. All staff had undertaken safeguarding training, staff were due to have refresher training and the registered manager was arranging this. All were able to identify the types of abuse which people could be at risk from. In addition, they understood the safeguarding procedures to follow should they suspect a person was being abused. They were aware that a referral to an agency, such as the local authority safeguarding team should be made, in line with the provider's policy. One staff member told us, "I would report it (suspected abuse) to the manager. I know they would do something but if not, I would let you (CQC) know."

The provider had identified and assessed risks to people's safety and wellbeing. These included risks associated with falling, and people at risk of developing urinary tract infections. Steps to manage and reduce risks were reflected in people's care plans. We observed staff delivering care in accordance with people's risk assessments, which kept them safe and met their individual needs.

The provider had systems and processes in place to ensure medicines were managed safely in accordance with current guidance and regulations. Staff were trained in medicines management and regularly assessed for their competency of administering medication.

We looked at the Medicines Administration Records (MAR) for people living at the home. We noted there were no gaps in these records. All MARs contained relevant information, such as photographs for identification purposes, whether the person suffered from allergies or preferred to take their medicines in a particular way.

Medications were stored securely in locked cupboards. There were no medicines requiring refrigeration on the day of our visit.

The provider had arrangements in place to make sure the premises were kept clean and hygienic. There were processes and procedures in place to reduce the risk of infection. Staff were aware of their responsibilities with respect to infection control, however we did observe a cracked toilet seat and some areas that were in need of cleanliness being improved. We spoke with the registered manager regarding this who agreed these things would be rectified.

The provider had arrangements in place to learn and make improvements if things went wrong. Staff reported and recorded accidents and incidents so that they could be analysed for any trends and patterns. Where there were lessons to learn, the provider used staff meetings and supervisions to communicate them across the team.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us that they received care and support that met their needs and that choices were given to them about the care they received. One person told us, "They always ask me what I want to do or what I would like to eat."

The registered manager discussed how due to staff shortages and challenges this year, there had been a delay in staff training. Some of this training was mandatory annual training. We asked the registered manager to arrange for staff to attend this as soon as possible, we have received confirmation that arrangements are being made to ensure all staff are up to date with mandatory training. The delay in training had not had any impact on people's care or safety.

The registered manager carried out assessments, which were comprehensive and included a person's medical history. People's needs were identified with their input and a person-centred care plan created, which was reviewed and updated regularly. This included details of their eating and drinking preferences, personal care, and likes and dislikes. Assessments, risk assessments and care plans were person centred following national guidance.

People were supported to have enough to eat and drink and were encouraged to maintain a balanced, healthy diet. We observed the people having meals and staff provided appropriate support to enable people to eat and drink at their own pace. If people required a food for example to help control diabetes this was put in place. There was food and fluid charts for staff to use where they identified any concerns about a person's food or fluid intake. This helped to monitor people's food and fluid intake if they were at risk of malnutrition or dehydration.

The provider had developed a good working relationship with local healthcare providers. There were records of visits by GPs, opticians and health and social care professionals. One health and social care professional told us the standard of care was good although they had had concerns regarding staff training and were supporting the registered manager to make improvements to this.

People were supported to access health care and referrals had been made on behalf of people to agencies such as hospital consultants, dieticians and the community team for people with learning disabilities. Staff were evidently aware of people's health needs and acted accordingly. For example, one person had developed new symptoms that concerned the registered manager, the GP was called and the person has now been referred to a consultant neurologist for investigation.

People's rooms were personalised and contained personal belongings that were important to them. The building was appropriate for its purpose and did not require adaptations to meet people's needs.

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 are called the Deprivation of Liberty Safeguards.

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. 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 support this practice. We noted a number of people had been referred to the local authority for a Deprivation of Liberty Safeguards assessment. The registered manager had ensured they made appropriate and timely applications and reviews were carried out in the timescales given. Appropriate records were kept to show the correct process was followed. There was evidence of best interests meetings being held where this was required.

Good

Is the service caring?

Our findings

People, staff and professionals gave us positive feedback about the quality of care at the home. People were supported by staff who demonstrated kindness and compassion to the people they supported. One person told us, "Staff are nice and caring." One staff member told us, "It's like a family home. I think the people are really well cared for." One professional told us, "They really genuinely care about what they do."

There was a friendly and relaxed atmosphere in the home, we observed person centred care being delivered throughout the inspection. The staff we spoke with were knowledgeable about the people they were caring for and were able to explain to us people's individual needs and requirements. Staff saw people as individuals. We observed staff being respectful, kind and caring.

It was evident staff cared about people, people were asked, "How are you?" Staff checked whether people were comfortable and asked if they were enjoying their meal or an activity they were doing. We observed people's achievements being praised for example when a person completed a task for like helping prepare food, this made the person smile and feel good about themselves. The provider told us they observed the care staff provided to ensure they were forming positive and caring relationships with people.

Records showed people and where appropriate their relatives were involved in the planning and reviewing of their care and support. People's care files included details of; their personal history, family, who was important to them, their communication needs, preferred foods, what they liked or did not like and the areas they required support with. If a person had a preference regarding the gender of staff they wished to support them with personal care, these were noted. Staff were familiar with all people's care plans which enabled them to provide people with individualised care.

Staff and people told us that they were able to spend time doing things they wished to do. We heard people being given choices with regard to food and activities. One person liked to help prepare meals and go shopping. We observed staff asking them whether they would like to help with preparation of lunch. Another person's records documented that they liked to have time to relax on their own. We observed this person spent time alone which staff respected.

We saw staff treating people with dignity and respecting their privacy. Staff knocked on people's doors before entering their rooms. Staff showed an awareness of the need to protect people's dignity. One staff member told us, "People need their privacy and to be respected, I always knock before entering and ensure their dignity is respected as much as possible when carrying out personal care." One person told us, "I am given privacy in my room."

Good

Is the service responsive?

Our findings

People received assistance with their personal care that met their needs and took into account their preferences and wishes. One relative told us, "Any concerns I have I can speak with the manager and it will be sorted".

Care plans were detailed and individual to the person, with guidance for staff about how to meet the person's care needs. Care plans covered topics such as communication, mobility, eating, drinking and medicines. We also saw that care plans included details of other professionals who supported people, for example; opticians and podiatrists.

People's choices and preferences were documented. We noted personal and social histories were very detailed; it was possible to 'see the person' in care plans. The staff we spoke with were knowledgeable about the people they were caring for. The daily records we looked at were person centred; an insight into people's daily lives could be obtained by reading them.

We did note that people living at the home were subject to yearly care reviews, usually attended by staff and external agencies if relevant, such as social workers and day centre staff. However, no review for any person had been carried out in 2018. We asked about this and were told this was in the process of being organised.

People were supported to take part in a range of activities both within the home and externally. These included a number of regular activities such as, music, bingo, sing-alongs, balloon art, walks out and minibus trips. A new mini bus had just been purchased to enable people to go out and do external activities more often. One person told us, "I like taking part in all the activities and I like the music best of all." One relative told us, "The activities are good, they play bingo, hoop and get musicians in."

People had individual activities scheduled. In these there were details of four people who spent time away from the service at least one day a week. They attended a day centre where they engaged in activities or socialised. Staff supported people with transport to the day centre. One person's health needs had changed recently, the registered manager was in communication with staff at the day centre to arrange training regarding this health condition so the person could still attend the day centre for activities that they enjoyed.

People were also supported to attend activities such as church if they wished, and to assist with the food shopping for the service if they wanted. Staff told us they spent time with people baking and helping with household chores which they enjoyed. There were books, cards, games, a TV, bingo, puzzles, and arts and crafts for people to engage in. People were observed to spend time on the activities they enjoyed as detailed in their care plans. People's activity records showed they were provided with a range of stimulating activities.

We noted the complaints procedure was available for all to view in communal areas. It contained information about how and to whom people and representatives should make a formal complaint. There

were also contact details for external agencies, such as the Local Government Ombudsman. The provider's complaints policy was up to date and relevant. There was one written complaint registered. We noted it was managed in line with the provider's policy and resolved in a timely and satisfactory manner. Records showed that there had been no complaints since our last inspection. People and relatives reported that they felt confident raising any issues and that they would be listened to and addressed accordingly.

There had been no people requiring end of life care at the service. People did have the choice to have end of life care plans in place but no one had wanted to go ahead with this at this time.

Good

Is the service well-led?

Our findings

People told us that they thought the service was well led. One person told us, "It's lovely here, I am kept safe, cared for and it is like a family, the manager sorts anything that needs sorting."

The registered manager had a vision to deliver personal and individual care in the home. There was a positive culture within the staff team in order to achieve good outcomes for people. Staff told us they enjoyed working at the service and felt well supported. Staff told us the registered manager operated an 'Open door' policy, which enabled them to raise any issues or concerns they may have. The registered manager was visible within the service. They spent time working with people alongside staff on the roster. Staff told us they could talk with the registered manager about any issues.

Systems were in place to monitor the quality of the service and identify any risks or areas where the service might be able to improve. The registered manager carried out audits and fed back to the team through meetings or supervisions to facilitate learning and changes to be put in place. Audits carried out included medicine management, health and safety, and environmental audits. The quality of the service was also assessed through supervisions and team meetings. Following a period of absence by the registered manager, audits had failed to identify some training requirements and some of the staff recruitment files had lapsed DBS checks, these were however in the process of being applied for.

The registered manager scheduled regular team meetings and staff supervisions. These allowed staff to express their views on the service and to be informed of updates. People and their relatives were asked to complete questionnaires regarding their care. Residents meetings were also held so people could feedback on how the service could be improved upon. The provider was proactive in facilitating change to meet people's and staff's needs.

Measures were in place to monitor incidents people experienced and to ensure appropriate actions had been taken for people. The registered manager analysed any incidents that occurred, identified the cause and made a person-centred plan to avoid re-occurrence. Records showed that following incidents relevant measures had been taken for people such as the provision of equipment required for a person.

There was evidence of partnership working within the service. Social workers and GPs attended regularly. There was open communication with other agencies and where the service had concerns about a person this was communicated to the relevant agency.