Beaconsfield Care Limited

Mayfield House Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection was carried out on the 20 December 2016. Mayfield House Residential Home provides accommodation and personal care for up to 34 people. At the time of the inspection there were 24 people living at the service.

We carried out an unannounced comprehensive inspection of this service on 22 August 2016. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. After that inspection we received concerns in relation to people's safety and the lack of management oversight of the service. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Mayfield House Residential on our website at www.cqc.org.uk"

There was no registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Risks to people where not being managed appropriately. People were not always being moved in a safe way. Incidents and accidents to people were not being managed appropriately. Where a risk had been identified around a person's behaviour there was not always appropriate guidance in place to reduce the risks.

People were not protected against the risk of abuse. Where safeguarding incidents had been referred to the provider appropriate action had not been taken. Not all safeguarding incidents had been referred to the CQC and the local authority.

Medicines were not managed safely and there was a risk that people did not receive their medicines when they needed. Staff competencies with medicines were not being assessed.

People were not always protected from being cared for by unsuitable staff because robust recruitment was not in place. There were gaps in the recruitment checks and there was not always evidence of why the provider felt that staff were suitable to work at the service.

The provider did not always have systems in place to regularly assess and monitor the quality of the care provided. There was a continued breach from the previous inspection around the competencies of staff and people care plans not being updated that had still not been addressed.

The provider did not have systems in place to regularly assess and monitor the quality of the care provided.

There were continued breaches from the previous inspection that had still not been addressed. The provider had not actively sought, encouraged and supported people's involvement to improve the quality of care. People's records were not always up to date or accurate.

The provider had improved the infection control practices since the last inspection and action had been taken to try to prevent the risks associated when people smoked in a garden area.

There were instances where people were receiving their medicines as prescribed and staff were signing correctly to say the person had taken them. The medicines were stored correctly.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

We found that action had not been taken to improve safety.

Recruitment practices were not always safe and relevant checks had not always been completed before staff commenced work.

People did not always have risk assessments based on their individual care and support needs. Accidents and incidents were not managed appropriately.

Medicines were not administered and managed safely.

Safeguarding procedures in place to protect people from potential abuse were not effective. Staff were not aware of their roles and responsibilities.

Is the service well-led?

Inadequate

We found insufficient action had been taken to improve how well led the service was.

The provider did not have systems in place to regularly assess and monitor the quality of the service the home provided. The provider had not met their breaches in regulation from the previous inspection.

Records were not well maintained and did not reflect the most up to date care that people received.

The provider did not actively seek, encourage and support people's involvement in the improvement of the service.

People and staff were not confident with the management of the service.

Staff were not confident reporting any concerns to their manager.

The provider had not notified the CQC of significant events.

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.

We undertook an unannounced focused inspection of the service on the 20 December 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on the 22 August 2016 had been made. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well-led. This is because the service was not meeting some legal requirements. Prior to the inspection we received concerns that people were not safe and that the service was not being managed appropriately.

The inspection was undertaken by three inspectors. Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). 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.

During the visit we spoke with the provider, six people and six members of staff. We looked at a sample of three care records of people who used the service, medicine administration records and five recruitment files for staff. We looked at records that related to incidents that had occurred and safeguarding referrals. We also looked at documents that related to the management of the service. This included minutes of staff meetings and audits of the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection the service was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People had not been protected against the risk of harm. Risk assessments for people were not detailed and failed to provide sufficient guidance for staff. This had not improved on this inspection and there was a continuing breach of legal requirements.

Risks to people where not being managed appropriately. On four separate occasions we saw staff moving a person in a wheelchair without footplates being attached (which is a known risk of injury for people). Each time we saw this we intervened and asked the staff why the footplates were not attached and they said they did not fit. They indicated to a pile of four footplates in the corner of the room. We reported this to the manager who said the footplates did fit and assisted a member of staff to put them on the wheelchair. Two people who had experienced falls had been referred to the falls clinic and were waiting for an assessment. However we found records that other people had fallen but no accident reports had been completed, no risk assessments were in place to guide staff in trying to prevent falls and no referral had been made. The accidents and incidents that were recorded showed that over a period of nine weeks there had been unwitnessed falls on eight occasions with eight people. There was no information on the forms to identify why people were falling or action taken to reduce the risk of the falls.

People were at risk of inappropriate care as guidance for staff was not always in place. One person's records stated they could show some aggression. There was a risk assessment in place which stated 'Can become aggressive towards others and agitated'. The guidance for staff included 'Try to keep aggression to a minimum by making her surroundings safe so free to wander. Provide activities suitable.' One member of staff said this person only got aggressive when they were stopped from doing something they enjoyed such as walking round the home. We saw staff trying to get this person to sit down when they tried to walk about. There were no specific activities arranged to engage the person. Staff had not received training on how to manage challenging behaviours. One member of staff said (in relation to the care of another person with challenging behaviour), "I have no idea how to deal with (the person), we get scratched and hit, it's so stressful." There were no risk assessments in this person's care plan around how to manage the behaviour. No training had been provided to staff on how to safely manage this person's challenging behaviour to protect themselves, the person or others.

The provider had failed to act to protect people from possible abuse. The provider had been made aware of two incidents of alleged abuse and in both cases they failed to follow their own disciplinary procedures or Surrey County Council safeguarding procedures. They allowed the situations to continue without taking action to protect people or report the allegations. There was a service policy that stated 'any suspicion, allegations or disclosures of abuse or neglect must be reported immediately' and that 'allegations of misconduct against (a member of staff) will normally result in the immediate suspension of that person from duty, pending an investigation.' The provider was not following their own policy in relation to safeguarding allegations. Shortly after the inspection the provider emailed us to tell us what they had done, in response to our concerns, to take action in these instances.

We reviewed the staff communications book and found that there had been instances of unexplained bruising to people that had not been referred to the local authority as a safeguarding incident. There was no evidence that the provider had taken action to identify cases of unexplained bruising or to report these. On one occasion one person had returned from hospital and it had not been noticed by staff until the following day that the person still had a cannula (plastic tube for the delivery of medicines of fluids) in their arm. This had not been recorded as an incident or referred to the local authority safeguarding team.

People's medicines were not always being managed safely. When people had been prescribed medicines more than once a day we saw that staff had not been signing to say people took these at the prescribed times. Therefore the provider was unable to evidence that these medicines had been administered to people at the correct times. In one instance someone had been prescribed an inhaler, one or two puffs twice a day. This had only been signed for once each day between the 11 and 19 December 2016. A member of staff responsible for administering medicines said they gave the inhaler every time they gave medicines which is four times a day at 8 am, 10 am 2 pm and 6 pm. If the inhaler was give this often it would indicate an over dosage of inhaler. When we pointed out the staff only signed to say it was given once a day the member of staff said, "She does have it in the afternoon, sorry I didn't know it was that". There was a note in one person's medicine record that they had been prescribed a cream for a skin condition. There was a note in the persons care plan for staff to observe the person's skin and apply cream as needed. The cream had not been signed for as applied. We asked the manager about this who told us, "The cream should be used and it is in the bathroom". We saw a note from a relative reminding staff to use cream on their family member's legs as they had become inflamed.

One person had been prescribed a pain killer three times a day but staff had signed that it had been given four times a day between the 11 and 19 December so the person was receiving more than the doctor had prescribed. One person had not been given their medicine for four days as stock had run out and staff were waiting for an order to come in. The medicine was for pain relief.

Staff who were giving medicines had been trained but their competency had not been checked to make sure they were still following good practice. The provider knew staff were not signing to say they had giving the prescribed medicines because a member of staff had reminded other staff in the handover book the week before inspection and followed this up with an email to the provider but action had not been taken to make sure people were receiving the correct doses at the right times or that the records were correct.

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

At our previous inspection the service was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The recruitment processes were not robust and we found on this inspection that this had not improved.

People were not always protected from being cared for by unsuitable staff because robust recruitment was not in place. The service policy required two satisfactory references to be provided before staff started work. In one file only one reference was provided, there was no detail on the reference only that the member of staff worked at the employment. Regulation 19 requires that all items in schedule 3 are required for an employer to assure themselves that anyone they employ is of good character and safe to work with people who may be vulnerable. Schedule 3 requires that there is satisfactory evidence of conduct in previous employment concerned with the provision of services relating to health and social care. Health questionnaires had not always been fully completed by staff. There was no criminal convictions (DBS) check

for one member of staff and where a criminal conviction had been identified for another member of staff there was no risk assessment around why the provider felt that it was suitable for the member of staff to work at Mayfield. Evidence of one member of staff's identity was badly copied and you could not read the information or see the photograph of the member of staff. There were no dates of previous employment for one member of staff and there were no interview notes for any of the staff. All of these concerns had been identified at the previous inspection for other members of staff. Despite this the recruitment processes had not improved.

As there were not robust recruitment procedures in place this is a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were instances where people were receiving their medicines as prescribed and staff were signing correctly to say the person had taken them. The medicines were stored correctly.

The provider had improved the infection control practices since the last inspection. A member of staff showed us the laundry where separate bags were being used for clothes, bedding and soiled items. Soiled items were now being washed in a red bag at the correct temperature. Action had been taken to try to prevent the risks associated when people smoked in a garden area. A fire retardant apron had been bought but the person refused to wear this. Fire extinguishers were nearby and the area had been cleaned and the floor made more even.

Inadequate

Is the service well-led?

Our findings

On the inspections in August 2015 and August 2016 we identified breaches in regulation of the Health and Social Care Act 2008 (Regulated Activities) regulation 2014. The provider did not have effective systems in place to monitor the quality of care or drive improvement. The provider told us on the last inspection and on this inspection that there had been reliance upon the previous two managers that the quality assurance was being undertaken. The provider had not taken responsibility to ensure that the appropriate work was being carried out or to assess the quality of the service and people's wellbeing.

We asked the provider and the manger what actions they had taken to improve the service since the last inspection and to meet the warning notices we had served. They said they had changed the colour of doors and decorated some rooms and had got carpet samples to make the place more dementia friendly. We saw that window restrictors and radiator covers had been fitted. These reduced the risk of accidents. A checklist had been put in place to monitor water temperatures and this had been completed.

However the warning notices also required the provider to improve the safety of people, the way staff demonstrated compassion and respect and the systems for monitoring the quality of the service to make improvements. We asked to see an action plan but the provider said they did not have a current one. They said they had talked with the manager about what to do to meet the warning notices but had not recorded their discussions, planned what actions to take, who was responsible or when they would be completed. We found the warning notices had not been met. The provider told us they had trusted the previous manager who had since left and had failed as a legally responsible provider to ensure that actions were being taken. They told us, "We made a grave and serious mistake and we hold our hands up, we put faith in the last manager".

The provider had been required to provide future rotas to the local authority to ensure that the correct numbers of staff were on duty to provide care. However the future rotas that we reviewed still included staff that had been subject to safeguarding allegations.

There were aspects to the quality assurance that were not effective and had not identified the shortfalls in the service that we had identified on the day or that had been identified previously and not improved. There was no system in place to identify and mitigate risks or to analyse accidents to learn from them. Accidents such as falls or incidents such as unexplained bruising were recorded by staff in the handover book. Not all of these reports had been followed by the completion of an accident form. The provider was unable to determine how many falls had occurred and they had not investigated the possible causes of unexplained bruising. The provider was unable to provide us with any evidence of quality assurance including audits, quality surveys or resident and relative meetings. There was no evidence that people's view had been obtained to drive improvements. The provider told us, "As things are unfolding we have begun to realise that we need to make sure we are checking."

During the inspection we found shortfalls with the care that was being provided. This included people's rooms smelling strongly of urine, a lack of stimulus, activities and trips out for people. One person

commented in the dining room, "It's like a morgue in here can't we have some music on". We asked a member of staff to listen to this persons request and they repeated it directly to the member of staff. The staff member responded that music was only played at Christmas in the dining room. We asked why music couldn't be organised whilst people waited for their lunch. The member of staff said because the radio has been moved to the lounge. We asked if it couldn't be brought back for a short time. They said no because some people liked music and some didn't. No attempt was made to satisfy the people who would have liked music. In relation to outings the manager told us that unless families took people out they had not arranged any other outings. One person told us they were lucky as they had family who visited and took them out.

The provider failed to follow their own policies in relation to safeguarding incidents, whistle blowing, recruitment of staff and training. These policies were readily available to staff and the provider however when we spoke to the provider about the policies they were not familiar with the content of them. The provider told us that they were aware of the conduct of a member of staff however there was no evidence to show that any action had been taken to address this.

People and staff were not complimentary of how the service was managed. One person told us that they did not like the management of the service. The said, "They tell me what I can and can't do." Comments from staff included, "The service is unorganised especially with staffing. It doesn't run as smoothly. We don't really see (The provider and manager)." Whilst another described management as, "Somewhere in the middle of good and bad." Another member of staff said that they would not have any confidence in reporting concerns to the manager. Whilst another said, "There is no direction from the manager."

Records were not maintained well. The provider said they spoke to staff informally but had not recorded these discussions. Two members of staff said the manager was supportive and came to ask if they were alright in the mornings. One member of staff said "We rarely have staff meetings". We asked the manager for staff meeting minutes but these were not made available to us. When we asked to review the recruitment files the manager took some time to locate the various records that were not kept together. Care plans and risk assessments were incomplete and did not contain the detail needed to guide staff in how to care for people. The lack of accurate and up to date records meant the provider was unable to monitor the quality of the service, the performance of the staff or the welfare and health of the people. The provider found it hard to provide evidence due to a lack of record keeping.

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

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had not informed the CQC of significant events including injuries to people and allegations of abuse. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009