Norse Care (Services) Limited

Mayflower Court

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 16 and 17 March 2017 and was unannounced.

Mayflower Court is registered to provide care for up to 80 people. The home supports older people all of whom were living with different forms of dementia. The accommodation comprised of a new purpose built building over two floors. Mayflower Court is part of the Bowthorpe Village. This includes a 'housing with care scheme' The Meadows. This is part of the Bowthorpe Village and was inspected separately and was not part of this inspection.

There was a registered manager in place. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. For the purposes of this report the registered manager will be referred to as the manager. When we make reference to the management team this includes the registered manager, deputy manager, and team leaders.

Mayflower Court has been open for a year this was the home's first inspection.

At this inspection we found breaches of the Health and Care Act and registration regulations. You can see what action we asked the provider to take at the full length version of this report.

People's medicines were not always managed in a safe way. There were some gaps with staff signing to say people had received their medicines. People's medicines were not always stored in a safe way. The management team's medicine monitoring systems were not always effective.

The home supported people living with dementia; however staff lacked the specialist knowledge and skills to meet these people's needs. Staff did not react to people who expressed distress as a result of their dementia. Staff did not have adequate inductions, training, and general support from the management team and provider to support people who were living with dementia.

People were not always supported in a caring and respectful way; people who were distressed were often ignored. People where not always treated in a way which promoted their dignity and in a way which was respectful.

People were not supported to make choices with their meals and drinks. Staff did not always know what people's likes and dislikes were. Staff did not spend time with people chatting and engaging with them, in an effort to get to know people and make their daily lives more interesting. People felt bored and sometimes felt like they did not matter. However, people were motivated and willing to engage with others when given the opportunity.

The management team was not monitoring the culture of the service. Staff received observations of their practice, however the management team had not identified that staff were not responding to people's social and emotional needs.

The manager and the provider had not considered ways to involve the community, and seek the views of people who lived at the home and their relatives.

The management team had completed risk assessments for people at Mayflower Court and obtained information about people's lives. Accidents and incidents were responded to in a timely way. The service had a good health infrastructure to monitor and respond to people's health needs.

At the end of our inspection we raised the issues we found with the management team. They were receptive and open to these issues. We shortly received an action plan which identified these issues. The management team demonstrated a willingness and a commitment for the service to improve. This gave us confidence that the service would improve.

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 always safe.

There were gaps in people's medicine records. People's medicines were not always stored in a safe way. People's property was not always protected.

People's risk assessments were comprehensive.

The safety of the premises was reviewed on a regular basis.

Is the service effective?

Requires Improvement

The service was not always effective in meeting people's needs.

There was a lack of staff knowledge and expertise to support people living with dementia.

Staff were not deployed and directed by managers efficiently.

People's experience with meals and drinks was not consistently positive.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not respond to people when they were distressed.

Staff had not formed positive relationships with people and got to know them.

People's dignity was not always promoted or upheld.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

People did not receive care that was person centred.

Staff did not spend time with people and engage with them.

People did not feel they mattered. People did not always feel they were listened to.

There were limited social opportunities for people.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not monitor staff interaction with people, ask if people were happy with the service, and assess the culture of the home.

Audits were not always robust.

The management team were motivated to make positive changes.

Mayflower Court

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 inspection took place on 16 and 17 March 2017 and was unannounced.

Before the inspection we viewed all of the information we had about the service. The manager had completed 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. We reviewed notifications the manager had sent us over the last year. Notifications are about important events the manager or provider must send us by law. We also contacted the local authority quality assurance team and local authority safeguarding team to ask for their views on the service.

During the inspection we spoke with 15 people who used the service and five relatives. We spoke with one health professional, the manager, deputy manager, the chef and six members of care staff.

We looked at the care records of eight people who used the service and the medicines administration records of seven people. We also viewed records relating to the management of the service. These included risk assessments, three staff recruitment files, training records, audits, and records relating to the safety of the building and equipment.

Requires Improvement

Is the service safe?

Our findings

At the inspection we found that people's medicines were not always managed in a safe way.

We saw that the management team had identified a number of medicine errors since the service had opened. These errors were identified through the home's medicine's auditing processes, to check if people had been given their medicines as the prescriber had intended. We looked at a sample of people's care records which documented medicine administration errors. For example, one person with a severe pressure sore had been prescribed a short course of a particular medicine to assist the healing of their skin. This person had not received this medicine for seven days until this error was identified. In the documented medicine errors we could see that action had been taken to ensure the person was safe. This included the manager raising this issue at a health and social care professionals meeting. This is held at the home on a regular basis. The investigation had concluded that this error had occurred due to poor communication between staff. However, some time had lapsed until this error was identified.

We completed an audit of a sample of people's medicines and looked at people's Medication Administration Records (MAR). We found that people's current medicines were all accounted for. However, when we looked at people's MAR charts we found some examples of missed signatures. We looked at seven people's MARs and we found missed signatures for three of these. One person had twelve missed signatures in a month period. The purpose of staff signing the MAR is a checking process to demonstrate people had been given their medicines. We spoke with the deputy manager about this. They told us that people's MARs were checked twice daily by a team leader to check staff had signed to say people had had their medicines. We were shown this document which showed these checks did take place twice a day. The deputy manager said if a member of staff had not signed a person's MAR this would be addressed with them, and there would be a record of this. However, when we checked with the deputy manager about two missed signatures these had not been identified and no conversation had been had, with the relevant members of staff. This meant that the providers system to ensure people received their medications was not always effective. We spoke with the deputy manager about this. They devised a new system to monitor more closely the signing of people's MAR charts.

People's medicines were mostly stored in their bedrooms in a locked medicines' cabinet. There was a thermometer inside each cabinet for staff to monitor the temperature of these cabinets, as some medicines should not be stored over a certain temperature. When we looked at some of these medicine cabinets we found that some were showing a reading above the specified temperature for certain medicines. This could undermine the effectiveness of certain medicines. We spoke with a member of staff who had just finished administering a person's medicines, during which we observed they had not checked the temperature of the cabinet. They told us that, "It can be difficult to read the temperatures." The home did not have a system to prompt staff to monitor these temperatures. We looked at the recent medication audits and found stated in these reports that the temperatures in people's rooms would not be audited. The manager and provider had not identified this important issue and made changes to ensure the temperatures of people's medicine cabinets were being monitored daily. We later received confirmation that the service is now monitoring the

temperatures in people's medicine cabinets.

The service was however, monitoring people's medicines when they were being stored in locked medicines' rooms. We saw records that this was happening on a daily basis, to ensure these medicines were effective.

The manager and deputy manager told us they had already arranged for a specialist medication team to visit the home to assist them to address these medication issues and improve the administration of people's medicines.

We concluded that improvements needed to be made to ensure people received their medicines safely and as the prescriber intended.

People told us that they felt safe living at Mayflower Court. One person said, "Its lovely around here [the home] I feel very safe." Another person said, "There's always someone to help me so that's why I feel safe." All the relatives we spoke with told us that they felt confident that their relatives were safe.

The management team and most of the staff we spoke with had a good understanding about how to protect people from the potential risk of abuse and harm. We were shown records of referrals the management team had made to the local authority safeguarding team. These often related to safeguarding events between people who were living with dementia at the home, harming one another. These incidents were dealt with in a timely way to try and prevent these individual incidents from happening again. We were shown a document which demonstrated that the manager and provider had analysed incidents which had occurred when people had come to stay at the home, for respite. They had taken actions to try and prevent these incidents between these people who were on respite and unfamiliar with the home from happening again. However, in relation to other incidents of people harming one another the manager and the provider had not investigated these individual events. The purpose of this would have been to see if that individual incident could have been prevented in some way, or could be prevented from happening again in the future.

People's property was not always being protected at the home. One relative told us about their relative's clothes, "Clothes go missing. Often things [relative] has on are not [relative's] like this top today. I wouldn't mind but I name [relatives] clothes." We also spoke with another person's relative who told that their relative's clothes often went missing; they told us that they were regularly replacing their relative's clothes. They also showed us some of the essential new items of clothing they had recently replaced. We spoke with the manager and deputy manager about this. They later sent us an action plan which identified this issue.

Staff felt they could approach the management team and express any concerns they had about people experiencing harm. Staff were able to tell us the different signs of abuse and harm. However, we spoke with a new member of staff, who was working on shift, who said they had not received training on how to keep people safe from potential harm and abuse.

When we looked at people's risk assessments we found that these were detailed, identifying the risks which people faced and what action was needed to minimise these risks. Some people were at risk of losing weight. These people had food and fluid charts in place to monitor the level of food and fluids they were consuming. People were weighed on a regular basis. Where people were at risk of developing pressure sores; there were turn charts and specialist equipment in place as a measure to reduce this risk. This demonstrated that the management team were aware of these individual risks and they had put systems in place to monitor them.

However, when we looked at these turn charts we found there were gaps in these recordings. According to some people's turn charts people had not been repositioned for some hours beyond the recommended repositioning periods. These are put in place by health professionals or by the management team for people who spend a lot of time in bed or sitting. This is to aid the recovery of people's pressures sores and prevent people from developing a breakdown in their skin in the first place. We found this was not happening in some cases on a regular basis. We looked at a sample of people's care records who had pressure areas, we could see their level of the pressure sores had reduced in most people's cases over time. We therefore concluded this was a records issue. However, this record is important to demonstrate that the home is responding to this risk.

The service had various emergency plans in place to ensure people were safe. There was a contingency plan in place with appropriate contact details for various utility suppliers. This was to assist the management team in the event of a loss of power for example. There were regular tests of fire related equipment and there had been fire drills. All the people who lived at the home had been assessed to see what level of support from staff they needed, should an evacuation be required. We saw that this information was regularly reviewed and kept in accessible points of the home.

We were shown records of the service monitoring on a weekly basis the water temperatures in people's rooms to reduce the risk of people being scolded by hot water. Electrical items in people's rooms had been tested to ensure they were safe to use. Specialist equipment used to support people to move from one position to another were also checked that they were safe to use.

The manager and deputy manager had a system of monitoring accidents and incidents. A member of staff would report these to the relevant team leader who would document the incident and take action. This could be making a referral to a specialist health care team. The deputy manager would then check daily if an incident or accident had occurred and checked what action the team leader had taken. These incidents and accidents would then be brought to a weekly multi-disciplinary meeting which included health professionals. Where they would discuss individual's needs and what action was required to minimise the risk of a re-occurrence of the accident happening again.

When we asked people if they felt there was enough staff at the home we received a mixed response. One person told us, "They get here quickly when I press my bell." A relative said, "There seems to be enough staff around and they know what they are doing, so I feel comfortable leaving [relative]."

Whereas one person said, "If you push the buzzer nobody comes, it'll ring for half an hour." Another person told us, "I used it [call bell] in my room four times but no one comes, I wanted to go to the toilet really badly, so I had an accident, what they tell us is they're really busy. If I pressed this now [wearing alarm pendant] nobody would come." We spoke with a further person who had a similar experience to this person. They were very insistent that they often waited a long time. They told us that this made them feel, "Bad." We concluded that staff were not always responding to people's request for assistance in a timely way. We also felt that this lack of timely action had caused distress to some people.

We found that the staff shift appeared disorganised and lacked direction. One person told us about their experience of requesting a bath, which they did not receive. They said, "When the carer came in last night I asked if they would book me in for a bath this morning, I laid all my clothes out, aftershave and all that, every so often I like a bath." This person explained that no one was available to support them to have a bath. This person also said that they were told that an agency staff member would be there at eleven thirty, but by mid-afternoon this had not happened. They later told us they felt very depressed and that it had ruined their day. We spoke with the person's relative who said this has happened before.

Staff told us that they did not have verbal handover but they were asked to read the hand over notes. Staff had allocation sheets for individuals with current information about their current needs recorded on these forms. One member of staff felt the team leaders had a lot of administration tasks to complete. We were told there was one team leader on each floor. We observed that staff were not being directed or assisted when they were working on shift. We raised this issue with the manager and the deputy manager. They sent us an action plan stating that there would be two team leaders actively present on the floor during the shift. They also said they would be revising the allocation of tasks given to team leaders.

The manager showed us the last six weeks staffing rotas and we could see that the same amount of care staff who were working when we visited the home were deployed for the last six weeks. Staff told us that they felt there was enough staff working on the shift. We observed staff supporting people in a way which was not rushed. Staff did not look overly hurried during our visit. We also observed a consistent presence of staff in the home and in the communal areas of the home. We concluded that there was enough staff at the home to meet people's needs, however there were issues with how the staff were organised and deployed on shift.

We looked at three staff recruitment files. We could see that the Disclosure and Barring Service (DBS) checks had been carried out. A DBS check enables employers to carry out safer recruitment decisions and prevents unsuitable people from working with vulnerable people. Staff had full employment histories on file. One member of staff had gaps in their initial employment history on their application form. We could see the service had asked this person to explain these gaps. The service had verified people's identities and gained two references for each member of staff that we looked at.

We found some issues with the hygiene and cleanliness of the home. We visited two people's rooms which had a lot of debris on the floor, crumbs and tissues. We returned to these rooms in the afternoon one had been cleaned but the other had not. We were shown a cleaning rota which identified those individuals who often placed items of debris on their floor. The aim of the rota was to try and manage these situations. After our visit the manager sent us records demonstrating how they were addressing the malodour of urine in one person's room.

Requires Improvement

Is the service effective?

Our findings

The staff team did not consistently have the skills and knowledge to support people who were living with dementia.

One member of staff told us that they had not received training on dementia care. Four other members of staff told us that they had recently received training on dementia care. The manager and deputy manager told us that a specialist two day course about dementia care had started to be given to the staff team. They also told us that 'dementia coaches' had been appointed. However, given the home was supporting people who were living with dementia, it was disappointing that this training was not provided when the home opened. There were also no robust systems to test staff were implementing this training. There was also no further real consideration about what on going training and support staff needed, to build on this specialist training and knowledge.

We had mixed views when we spoke with staff regarding their training. Two members of staff said they felt that had received training which had prepared them for their work, although one of these members of staff said more face to face training would be better for staff. Two other members of staff said the training they received was limited when they started. One member of staff said they had had little training from the provider. We looked at the training records and we could see that staff had had training in moving and handling, health and safety, fire safety, and safeguarding adults. However, according to this information not all staff had completed this training.

Staff told us and we saw a record which showed that all the staff who were required to, had completed the care certificate; this is a set of standards which outlines what good quality care looks like. One member of staff told us about how the provider was supporting them to progress in their career; with the additional training opportunities they were being offered.

Staff told us that they had supervisions where they discussed their performance with their line manager. We were also shown individual records confirming staff practice had been observed. When individual staff issues had been identified the deputy manager had a conversation about these, with the individual members of staff.

Some people's needs with eating and drinking were not always managed in an effective way.

We found that the lunch time was not organised in a way which supported people who were living with dementia. We saw that staff supported some people to walk to the dining rooms up to thirty minutes before lunch was served. Some people were asked more than once what they wanted to eat. Even though some people had already been asked and made a decision.

The service was completing checks to monitor people's weight and risk of developing a breakdown in their skin. In some cases people's intake of food and drink was recorded on a chart. This is to monitor how much

people were eating and drinking because they were at risk of losing weight, dehydration, or developing pressure areas. However, these food and drinks records did not always have the measurable amounts of what people had consumed. The amounts that people had eaten or had to drink had not been totalled for each day. There was also no total or guide as to what would constitute a good level of food and liquid intake daily for individuals.

We found that some people were not given a choice or supported to make a choice with the food and drinks they consumed. One person said, "It would be nice to see what we are having earlier in the day." Another person said, "The meat is tough. I don't ask for anything else because it's too late, when the food has appeared. I would be able to tell them I didn't like the menu if I knew earlier."

In order to help people make a decision about what they had to eat the chef told us that staff should be plating up the two choices and showing people. This is a system used to support some people who have dementia, to make an informed choice about what they were eating. However, we found this system was not consistently applied and staff needed to be prompted to do this. We saw in two of the three dining rooms which we spent time in, two members of staff needed to be prompted to do this.

We observed throughout our visit that people were offered cold drinks but they were not asked if they wanted a hot drink, unless it was in the morning or evening. People were not able to choose what they wanted to eat because they were not given the opportunity to do so. The chef and the deputy manager told us that staff had the facility to make alternatives in the kitchenettes in the dining rooms. However, this option was not explored by the staff serving and supporting people with their meals.

One person we spoke with told us that, "The food's nice, there's always drink on the table." At this point we observed an empty glass in front of the person and no evidence of drinks in the dining room or kitchenette in that dining room. We observed that drinks were not offered by staff until 30 minutes later. We did however, observe cold drinks being offered in another dining room during lunch.

We received mixed views of the food and drinks from people living at the home. One person we spoke with said, The food is very good, when I go down (to the dining room) for meals I look forward to them. It's always served hot and of good quality." Another person said, "You have to wait, of course you do. Very good food, enough choice." A third person said, "The food is okay but the gravy is horrible. There's always something I like."

We spoke with another person who said, "They're not one hundred percent [meals] but they're alright." A second person said, "The dinners are horrible except for fish and chips." A third person said, "The food is about right. I wouldn't ask them to do anything else if I didn't like it, because they would say no."

When we observed some people being supported to eat and drink, we saw that this support was provided at people's own pace, people were not rushed.

We saw in people's care records that people were being weighed on a monthly basis. We could see that people had gained weight and some people moved from being a high risk of weight loss to a low risk, because they had gained weight. We could also see in people's records that staff had made contact with the nurse practitioner on site and referrals had been made to specialist health teams, to address people's weight loss. We saw referrals were made to dieticians and to speech and language teams. If a health professional did not feel a referral was required this was explained in people's individual records.

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 application 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.

People told us that they were being asked for their consent to care or support from members of staff. We saw staff offering some choices to people with their daily needs and where they wanted to go within the home. Some people were asked if they wanted to go outside. We looked at people's care records and we could see the team leaders had assessed individual's ability to make certain decisions. At times the 'best interests' decisions and assessments had been carried out. These included what action was needed to promote individual's safety and wellbeing. Where some people had relatives who had legal powers to make certain decisions on their relative's behalf, this was recorded and evidenced in individual's care records. Some people had a DoLS authorisation in place from the local authority. We looked at a sample of these and we could see the staff and the management team were compliant with these authorisations. We concluded the home was compliant with the MCA and DoLS.

The people we spoke with were positive about how the service supported their health needs. One person said, "You ask to see a nurse and we always get advice on what to do, they're good on things like that."

We could see from looking at people's care records that people had access to health care services. People received support from specialist health teams and from District Nurses. The service had a nurse practitioner on site five days a week and a GP visited twice a week. The service also had clinical health meetings which were held weekly where the manager and a team leader would attend, to discuss people's health needs. We spoke with a visiting health professional who spoke positively of how responsive the staff and management team were if a person's health needs changed. They said, "They [staff] are a lovely lot here, they [staff] are aware of patient's needs and identify quickly any changes."

Requires Improvement

Is the service caring?

Our findings

We observed and were told about a mixture of different responses from staff towards the people who lived at Mayflower Court. Some of these were caring interactions and others were not.

We spoke with one person who said, "I like it, they're [staff] ever so good to me, lovely people. I feel well looked after, I'm happy with how things are." Another person said, "They're [staff] fantastic, genuine people." A relative told us, "The carers are good with [relative]. They move [relative] about and support [relative] in a way which is reassuring and they talk in a calm friendly way too."

During our visit we observed some kind and thoughtful interactions with people. One person had spilt a little of their drink over their blanket. A member of staff then went and got a fresh blanket for this person. We saw another member of staff visit a person in their room to support them with their lunch; they noticed that the sun was shining onto this person's back so they closed the curtain. We heard this member of staff chat in a nice and kind way with this person.

However, we also observed staff not interacting or acknowledging people. We saw staff walk past people on at least five separate occasions when they were clearly distressed. At these times staff did not stop and offer support or assistance. On one occasion a person was walking in the corridor holding a doll and was crying. We saw two members of staff walk past this person without interacting or reassuring them. We saw one member of staff writing in care records sitting in a room with a small group of people and not engage with them. We also saw two members of staff sitting in a room with two people there was also no engagement from staff with these people. We spoke with the manager and deputy manager about this issue. We later received an action plan which identified this issue.

We looked at one person's care record which stated they became very distressed when being supported with their personal care; this had been identified as a support need for more than two years. We heard two members of staff assisting this person to wash and dress. This person was verbally expressing that they were not happy. We heard the two members of staff talking to one another about their own social plans for the summer and about their own relatives, whilst supporting this person to get washed and dressed. They did not engage with the person or demonstrate any techniques to try and enable the person to engage with the activity. They did not address their distress or try and comfort this person.

Some people told us that they did not feel they were important or mattered to the staff who supported them. One person said, "The carers help me in a nice, polite way. If I need help walking they are there for me, but if I am honest, although they do the job well, do I really matter as a person? I'm not sure about that." Another person told us, "I sometimes feel I am just a job to them." A relative told us, "They [staff] seem to be doing a job that needs to be done. They aren't very chatty. You are processing human beings here; it feels a bit like mass production."

We observed one person who had walked to a communal part of the service in a state of undress. We saw

two members of staff assist this person in a swift way to protect their physical dignity, but they covered their mouths whilst laughing and giggling. We believe this situation was not managed in a way which promoted this persons dignity.

The above concerns constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did say they were asked about their care needs on a daily basis. One person told us that, "My nurse, she says to me it's six o'clock [name of person] are you getting up or laying in? I'll say I'll do as I please, if I've got nothing on I'll lay there a bit longer." Another person said, "They're [staff] pretty good, they [staff] say when do you want to get up? They'll help you any time that you want them to."

Some people told us that they were treated with dignity and respect. One person told us, "Oh yes they do treat me with respect and dignity, they knock and come in." Another person told us how they were supported with their personal care in a way which promoted their dignity.

We observed some respectful and caring interactions when staff supported people with their mobility needs. We saw staff assisting individuals to transfer from one position to another. When staff assisted people in this way, staff spoke with these people in a kind and respectful way.

People told us that staff supported them to maintain their independence. One person said, "They [staff] make me do things for myself which is a good thing, they [staff] make me walk instead of putting me in a wheelchair." Another person told us, "They [staff] keep an eye on me, but try to make me do things for myself." People told us how staff supported them with their personal care needs, but encouraged and assisted them to complete elements of these daily tasks themselves.

We found that people's confidential information was stored in a locked room and was protected. We looked at people's care records, on one occasion we found elements of another person's care record with a different person's care record.

We concluded that although there were elements of people being treated in a kind and caring way, this was not consistent practice by staff. This resulted in people not always receiving care that that promoted their dignity and respect. People did not always receive their support in a caring manner. We spoke with the registered manager and deputy manager about this. They sent us an action plan which identified these issues.

Requires Improvement

Is the service responsive?

Our findings

The staff and the management team were not consistently responsive to people's care and emotional needs.

We noted that some people had dark matter under their nails. We spoke with two people's relatives who also told us that sometimes their relative's nails had dark matter under them. We spoke with the manager about this issue and later received an action plan detailing how this was to be addressed and monitored by staff in the future.

We observed some staff on at least four occasions walking past people who were expressing signs of distress. Staff did not stop and offer support or assistance to these people. We looked at some of those people's care records which stated they were living with dementia. Some people expressed signs of distress regularly and consistently throughout the day. There was a lack of information in people's records to guide staff about how to provide support on these occasions.

Some people were left alone in groups without staff checking they were okay. On one occasion we saw that a group of three people who were living with dementia and had mobility issues had limited staff involvement. On three occasions some of these people tried to get up and either walk when they used a wheelchair, or try to walk using their walking frame whilst holding a cup of tea or large item of clothing. On each occasion we intervened and asked for a member of staff to support them. On one of these occasions the member of staff we asked to assist said they did not know the person, and went to walk off. We had to ask them to find another member of staff while we stayed with the person.

Some people told us that there was a lack of meaningful activities and social opportunities for people to engage with. One person told us, "They [staff] do the odd thing but I've felt extremely bored by them. "The staff think I'm just staying in my room and watching TV, but I'm selective with what I watch, they have a library here and I have used it." Another person told us, "They [staff] let me do some knitting, they gave me the wool and the needles, but I'm not going no more because everyone was asleep, there was no one there to help me, so I just came out."

We were shown a list of social events which took place in the Meadows. This is a housing with care scheme next door. We were also shown some records of activities that had taken place in February 2017. There was an activity person and an activity programme for the week with activities daily, displayed in the reception area. However, this was not in a format that most people living with dementia would be able to access. Staff were not promoting the activities during the morning. For people who spent most of their time in their rooms, there were no one to one activities taking place.

During our visit we saw two small group activities taking place. We saw people reacting positively to these activities. However, with one activity 'colouring in' there was only one member of staff who was having a conversation with a person in the group.

We saw that staff suggested some activities with people but these were not acted upon. For example, one person was asked if they wanted to go to the Meadows to attend a quiz, they said yes. However, no action was taken, when they were later asked again, they said no. Staff did not try and encourage this person or consider an alternative activity. This person was left in the reception area sitting alone.

People told us and we observed that staff did not spend time chatting or engaging with people. One person said, "The staff are working very hard and on occasions get frustrated, you can see it in their faces, just an observation." We asked this person if there was time to have a chat they said, "Not really, they're busy." Another person told us, "I think they [staff] are a bit preoccupied with their tasks, it would be jolly nice if they could get to know you better." A further person said, "They [staff] are friendly, they never come and sit and talk."

One person's relative told us that their relative did not leave their room very often. They felt that people who stayed in their rooms and who had issues with communication were isolated. One relative said, "They [staff] cherry pick those to go to the Meadows." This is 'a housing with care scheme' next door. This service often has social events which have taken place on a regular basis. Another person's relative said, "They [relative and people in a particular lounge] just sit here watching TV all the time." We asked if their relative was watching TV programmes which their relative would have watched before, they said, "No, and even they [people] say they have watched it [TV programmes and films] six times over and over."

One member of staff felt there was not enough interaction with people who are in wheelchairs with complex needs. Another member of staff felt there was not enough social engagement with people who are in their rooms all the time. We observed there was limited interactions with people who were in their rooms a lot of the time. During our visit we saw people in various lounges or in their rooms watching TV alone, with no engagement from staff. We saw some people expressed signs that they were distressed and staff did not respond to these people's needs until we were present. Staff did not try and encourage people to chat with one another when they were sitting in the same room. However, when we spoke with people, they responded to our conversation and often spoke in detail with us. People appeared very motivated to chat about any given subject. We concluded that people wanted to engage socially with staff but they were often not given the opportunity to do so. We raised this issue of a lack of social stimulation with the manager and deputy manager. We later received an action plan which identified this issue.

The service did not always ensure those who had sensory needs, for example, people who were deaf, had the equipment they needed to be fully involved in the service. We spoke with one person's relative who told us that their relative was not wearing their glasses and hearing aids. They told us that this had happened on many previous occasions. They also told us that staff needed to be prompted when there were issues with this person's 'hearing aids' to have these fixed or reviewed by a hearing specialist.

We looked at people's care records and we found that the service had gathered information about people's personal histories, who were important to them, and their likes and dislikes. We found that this information was detailed from the sample of care records we looked at. We also found detailed information about people's individual communication needs, their moving and handling needs, and their abilities to understand and make certain decisions about their lives.

However, we found that this information was not always put into practice or known by staff. One person was sitting in one of the dining rooms for an hour and did not want to eat their lunch. We noted the meal choice they had been given and stated as a 'dislike' in their care record. The meal had been left in front of them and was cold. Their care assessment also stated that they were at risk of not maintaining a healthy weight and was to be encouraged to eat and drink. During lunch we observed very minimal interactions from staff.

We also observed occasions when staff offered individuals certain choices with food and drinks and people made decisions about these, that these were not always followed by staff. At lunch one person was given a different meal to the one they had just chosen. Another person was asked if they wanted a hot drink, they said "Yes" but was given a cold drink.

Some people followed a particular religion which did not follow 'Christian celebrations,' however although this was documented no plans had been put in place to support these people who potentially did not want to be a part of these celebrations. The management team had also not considered if some of these people's faith needs were being met.

We concluded that people's needs were not consistently met in a person centred way. We raised this issue with the manager and deputy manager. They sent us an action plan which identified this issue.

The above concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were shown a 2016 survey where an outside organisation had spoken to 'residents, family and friends.' We were also shown 'feedback cards' aimed at relatives and visitors which were left in the reception area. However, the service had not made provision to encourage the views and feedback of the people who lived at Mayflower Court. People's needs were not being reviewed on a regular basis and people were not encouraged to give their views on the care they received. The relatives we spoke with had not heard of any plans to hold relative's meetings and they had not received any questionnaires. The relatives we spoke with said they would like an opportunity to express their views on the service. We spoke with the manager and deputy manager about this who said they were committed to involve and seek the views of relatives. They told us that they had tried to organise a 'relatives meeting' but had little response to their invites. We later received confirmation of another planned invitation to relatives.

We were shown a sample of complaints which had been raised by relatives. We saw that most of these had been investigated and action taken to address and resolve the individual complaints. We found one complaint which had not been investigated. The relative making the complaint said they did not want this treated as a formal complaint. However, the complaint should have been investigated with a potential outcome to make improvements and learn from the issues raised. This particular complaint had highlighted the lack of person centred care which the complainant had felt their relative and others had at times experienced from staff.

Requires Improvement

Is the service well-led?

Our findings

When we visited Mayflower Court we found issues with how the service was being led. Most issues that we had found had not been identified by the manager or by the provider.

There was no active culture at Mayflower Court to involve the people who lived there, their relatives, and the staff who worked there to develop and improve the service. With the exception of professionals there were no links with the local community and no plans in place with how the management team and provider could potentially achieve this. We spoke with the manager and deputy manager about this and they told us they intended to make plans to achieve this in the future.

The management team did not have insight into the day to day culture of the home. We found issues with how staff interacted with people and responded to them. People did not always feel that they mattered to staff. We observed that staff did not respond to people who were distressed. Staff did not spend time chatting or engaging with people. There was no social atmosphere to the service. Staff appeared task focused. When we raised these issues with the manager and deputy manager they were not aware of this issue of staff interaction with people. This element of culture or atmosphere of the home was not being monitored or reviewed by the management team or by the provider.

The management team had introduced specialist training with supporting people with dementia and introduced 'dementia coaches' to improve the knowledge and skills of staff at the home. However, the service had been opened for a year and supported people who were living with dementia. This key training need had not been identified until recently. There were no plans to follow up on this training to ensure staff were using it in their daily practice. The role of the dementia coach had not been fully explored and explained to staff. We concluded based on our observations and speaking with some staff that the inductions staff received had not fully prepared all staff for their roles working in the home, supporting people living with dementia.

The management team had checks in place to ensure that audits completed by team leaders were carried out robustly. However, some of these were not effective. We found that staff were not completing people's charts on a regular basis and some charts lacked important details. These records were audited but issues had not been identified. The management of people's medicines were not always audited effectively. The service had no robust way to monitor that medicines in people's rooms were stored at the correct temperatures. Missed signatures when administering people their medicines were also not always being effectively monitored and audited.

During our visit we identified there were some issues with the care people received. Relatives told us about their relative's property had gone missing. Some relatives told us and we saw that some people had long finger nails with dark matter under them. These issues had not been previously identified by the management team, during their quality checks of the home.

The daily deployment of staff and the organisation of the working shift was not well organised. We found

that there was enough staff working on shift at the home. However, staff appeared to lack direction, we saw staff talking in groups and entering communal rooms without purpose and then leaving. Some people were left alone in groups without staff presence.

We noted there had been a number of incidents of people potentially harming each other. In each individual incident that we looked at action was taken to try and prevent a re-occurrence of this incident after the event took place. However, given the number of these incidents there was no overall investigation to see if there were other factors which could be influencing or causing this behaviour, which the manager or the provider could change or improve.

People were not being offered choice with their food and drinks. People were not being supported to have the kind of meals that they wanted to eat. People were not involved in the planning of their meals. The management team was not auditing or monitoring people's meals and drinks experiences.

Following our inspection the registered manager and deputy manager produced an action plan. In this action plan they had included the above issues and put plans in place to make improvements to the areas we had identified. The management team were already aware of the frequency of medication errors and had sought professional advice about how to prevent these from happening in the future.

However, the management team had not responded to all the areas we had identified. They had not considered ways of seeking people's views on the service they received. The management team had not considered a way to monitor people's food and drink experiences.

The above concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most of the people we spoke with did not know who the managers were. Some people thought the deputy manager was the manager. Most people we spoke with about the management of the service, only took issue with the fact they had not been asked their views on the service.

The manager was not fully aware of the information they must send by law to the Care Quality Commission (CQC). We identified that the manager was not informing the CQC about certain safeguarding events which had taken place. We looked at a sample of these and we could see that the manager had made timely referrals to the local authority safeguarding team. We were shown various incident reports concerning these types of incidents. We noted that in February there were twelve separate safeguarding incidents involving people at the home. We spoke with the manager about this who said they would correct this.

The above concerns constituted a breach of Regulation 18, the Care Quality Commission (Registration) Regulations 2009 (Part 4) Notification of other incidents.

Staff spoke positively about the manager and deputy manager. Staff told us they felt they could approach the managers and team leaders, and raise any concerns they had. The manager regularly invited health and social care professionals to the service. Staff meetings took place and staff had regular supervisions, and reflective conversations when issues or errors occurred. When we spoke with the registered manager and deputy manager, despite the size of the home, they had a good knowledge of people's needs.

The manager and deputy were highly motivated to make positive improvements to how people were supported at Mayflower Court. Following our visit the manager and deputy manager sent us an action plan which identified the issues we had found. In this plan they had made plans to make improvements about

the issues we had identified.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Care Quality Commission (Registration) Regulations 2009 (Part 4): 18 Notification of other incidents. The registered persons had failed to notify the commission about important events which they must notify us by law. Regulation 18 (1) (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (RA) Regulations 2014: Person Centred Care The service had failed to ensure that people's emotional and social needs were met by staff. Regulations 9 (1) (b) and 3 (b) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (RA) Regulations 2014: Dignity and respect. The service had failed to ensure that people were always treated with dignity and respect. Regulation 10 (1) and (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance The management of the service had failed to have effective systems and processes in place to monitor and improve the safety of the service provided. Regulation 17 (1) and (2) (a) (b) and (e).