Mayfair residential care home Limited

Mayfair Residential Care Home Ltd

Inspection report

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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

Overall summary

This inspection took place on 1 December 2015 and was unannounced. At the last inspection on 7 May 2015 we found the service was meeting the regulations we inspected.

Mayfair Residential Care Home Ltd provides residential care for up to 19 older people. On the day of the inspection there were 18 people living in the home. The service is located on the south side of Scarborough with pleasant views overlooking the South Bay. The service does not offer nursing care.

The home has 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff were able to tell us what they would do to ensure people were safe and people told us they felt safe at the home. The home has sufficient suitable staff to care for

Summary of findings

people safely, they received regular supervision and they were safely recruited. People were protected because staff handled medicines safely. The home minimised the risk of cross infection because staff were training in infection control and knew how to care for people according to the service's policy and procedure.

Staff had received training to ensure that people received care appropriate for their needs. Staff were able to tell us about effective care practice and people had access to the health care professional support they needed.

Staff had received up to date training in Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff ensured that people were supported to make decisions about their care, people were cared for in line with current legislation and they were consulted about choices. We made a recommendation in relation to one record which did not clearly show that the service understood the reasons why a person was being lawfully deprived of their liberty.

People's needs in relation to food and drink were met. People enjoyed the meals and their suggestions had been incorporated into menus. We observed that the dining experience was pleasant and that people had choice and variety in their diet.

People were treated with kindness and compassion, though occasionally we noted that staff spoke to people in a rather directive manner. However, we saw staff had a good rapport with people whilst treating them with dignity and respect. Staff had a good knowledge and understanding of people's needs and worked together as a team. Care plans provided information about people's individual needs and preferences.

People enjoyed the different activities available and we saw people smiling and chatting with staff. Staff made daily records of people's changing needs. Needs were regularly monitored through daily staff updates and regular meetings.

People told us their complaints were handled quickly and courteously.

The registered manager was visible working with the team, monitoring and supporting the staff to ensure people received the care and support they needed. People told us they liked the registered manager and that they were approachable and listened to them.

The registered manager and staff told us that quality assurance systems were used to make improvements to the service. We sampled a range of safety audits and care plan audits which were used to plan improvements to the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People were protected from the risks of acquiring infection because the home was clean and hygienic.

Risks to people's safety were assessed and acted on and risk plans included how to maximise freedom.

People were protected by sufficient, well recruited staff.

People were protected by the way the service handled medicines.

Good

Is the service effective?
The service was effective.

People told us that they were well cared for and that staff understood their care needs.

Staff were supported in their role through training, supervision and appraisal and this meant people received good care.

The service met people's health care needs, including their needs in relation to food and drink.

People's capacity to make decisions was usually assessed in line with the Mental Capacity Act (2005) (MCA). However, improvements were required.

Requires improvement

Is the service caring?
The service was caring.

People told us that staff were kind and caring and we observed staff were kind and compassionate.

Staff respected people's privacy and treated them with regard to their dignity.

Good

Is the service responsive?
The service was responsive to people's needs.

People were consulted about their care.

Staff had information about people's likes, dislikes, their lives and interests to ensure staff had the information they needed to offer person centred care.

Activities and daily pastimes responded to people's interests and preferences.

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

There was a registered manager in place. Leadership was visible and there was a quality assurance system in place so that the registered manager could monitor the service and plan improvements.

Communication between management and staff was regular and informative.

The culture was supportive of people who lived at the home and of staff. People were consulted and surveyed for their views.

Mayfair Residential Care Home Ltd

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 1 December 2015 and was carried out by one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection was unannounced.

Prior to our inspection we reviewed all of the information we held about the service. We considered information which had been shared with us by the local authority. Before the inspection the provider 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 also gathered information we required during the inspection visit.

We spoke with thirteen people who lived at the home, three visitors, five members of staff, the registered manager and registered provider. We also spoke with a health and social care professional following the inspection visit.

We looked at all areas of the home, including people's bedrooms with their permission where this was possible. We looked at the kitchen, laundry, bathrooms, toilets and all communal areas. We spent time looking at four care records and associated documentation. This included records relating to the management of the service; for example policies and procedures, audits and staff duty rotas. We looked at the recruitment records for three members of staff. We also observed the lunchtime experience and interactions between staff and people living at the home.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe. One relative told us, "I've got no safety concerns about my relative in this home. They are nice and safe here."

We saw there were safeguarding policies and procedures in place. Staff had received safeguarding of adults and abuse awareness training which was kept up to date. Staff were clear about how to recognise and report any suspicions of abuse. They could correctly tell us who they would approach if they suspected there was the risk of abuse or that abuse had taken place. They understood who would investigate a safeguarding issue and what the home procedure was in relation to this. They were also aware of the whistle blowing policy and knew the processes for taking serious concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively.

We asked the registered manager how they decided on staffing levels. They told us this depended on the numbers and dependency levels of the people living at the home at any time, but for the current occupancy of eighteen, there was usually the registered manager, a senior care worker and two other care workers on duty during the day time, during the afternoon the staff complement reduced by one care worker and at night there were two suitably experienced waking care staff on duty. The registered manager told us they considered skill mix and experience when drawing up the rota. We saw the rota and spoke with staff about this, which confirmed what the registered manager told us. Staff told us there were enough staff on duty to meet people's needs, to chat and not feel rushed. Our observations confirmed this.

Risk assessments were in place for each person living at the home. These covered such areas as falls, moving and handling, risks around pressure care and food and drink. Staff were able to tell us how they managed risk to ensure people's freedom was maximised while keeping them safe. For example the registered provider told us that if people were able to bring their own laundry down to the basement where the washing machines were then they were supported to do this. If people had been assessed as safe to go out unaccompanied they did so and those people told us they enjoyed having the freedom to come and go as they chose.

We looked at the recruitment records for three recently employed staff which showed safe recruitment practices were followed. We found recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS) and that two references were obtained before staff began work. The DBS checks assist employers in making safer recruitment decisions by checking prospective care workers are not barred from working with vulnerable people. This meant that the home had taken steps to reduce the risk of employing unsuitable staff.

We looked round the home and found the premises were clean and tidy. Most areas of the home were accessible by lift. For those rooms which were accessed by a short flight of stairs the registered provider told us that the risk involved was assessed and that only people who could manage the stairs were offered these rooms. Environmental risk assessments were in place and each person had a Personal Emergency Evacuation Plan (PEEP) to protect them in the event of fire. We saw that entry to the home was controlled and there were keypads on the exit doors for people's safety.

Staff told us that they had received training in the control of infection during their induction, and had received regular updates. Staff correctly described how to minimise the risk of infections. They spoke of the correct use of aprons and gloves and also told us that they washed their hands frequently and always between offering care to people. The service had an infection control policy and procedure which staff told us they followed. This included details of how to manage outbreaks of infection. The laundry room, though small had a suitable washing machine and dryer and the laundry system protected people from the risk of cross infection through keeping dirty and clean laundry separate.

Medicines were stored safely in a trolley which was secured to the wall. Controlled drugs were stored separately and according to policy and procedure. Medicines were supplied to the home in a Monitored Dosing System (MDS). We found appropriate arrangements were in place for the ordering and disposal of all medicines. One member of staff took overall responsibility for ordering and disposing of medicines. They told us they made regular checks on stocks and recording to ensure people received their medicines safely and at the time they needed them. This reduced the risk of error.

Good

Is the service safe?

We looked at the Medication Administration Records (MAR) for two people. The MARs were well completed and medicines were signed for, which indicated people were receiving their medicines as prescribed and any refusals or errors were documented.

Staff told us that they received regular medicine training updates. This meant that staff benefitted from training in best practice around medicines handling. All staff who were qualified to handle medicines were listed on the MAR sheets to ensure only those who were suitably trained were involved.

Requires improvement

Is the service effective?

Our findings

People told us they enjoyed the meals, one person told us, "The food has been super, smashing." Another person said, "We always get a choice of food. One of the staff comes around and asks us what we want. They write it down. I love salmon and every Sunday we have a roast dinner which is also quite good." Another person told us, "I like tangerines, especially this time of the year… I told the staff this and one went out and bought some for me. Wasn't that nice of them?"

Staff had received induction and training in all mandatory areas. This was thorough and covered all required areas. Staff told us they shadowed other more experienced staff when they were first recruited and only began working with people unsupervised when they were confident and the registered manager felt they were competent. Staff had received training in dementia awareness and they told us this was very useful in understanding the challenges facing some of the people who lived at the home. Training in diabetes awareness was planned to support staff to care for people who lived at the home with this condition. A number of staff had achieved the Qualifications and Credit Framework (QCF) level three award and all were enrolled. This award replaced the national vocational qualification (NVQ). This meant staff had covered all mandatory areas of training and had received training over and above what was required in their role. This meant staff were trained to give people the care they needed.

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. Staff told us that they had received training in the MCA and DoLS and training records confirmed this. The registered manager also told us about all areas of training in the Provider Information Return. Staff could correctly tell us the main principles of the MCA and DoLS. This meant staff had the information they needed about the MCA to ensure people were cared for according to its principles.

In three of the care plans we examined, people had been assessed for their capacity to make decisions about their daily lives, and information was in place about how capacity may vary and the importance of assuming a person had capacity.

The MCA, DoLS require providers to submit applications to a 'Supervisory Body' for authority to do so. The manager had made an emergency DoLS application to the local authority, (The 'Supervisory Body'). This application and an application to extend this had been granted. However, the admission to the service had not been carried out according to best practice, as the person had been discharged from the local hospital without notice to the home. The service had recorded information about enduring power of attorney, next of kin and advocacy. The registered manager explained that the documentation about Best Interests and DoLS had not yet been forwarded from the mental health professionals involved and that until the person had completed a period of assessment a full understanding of their mental capacity could not be made. However, there was no narrative record of the home's own assessment of mental capacity to date for this person, no record drawn up by the service of the reasons why the DoLS had been applied for and no record of any Best Interests decision. This meant the service could not be assured that they fully understood why the person was being lawfully deprivation of their liberty within the home.

We recommend that the registered person consults best practice guidance to ensure they clearly understand and record how decisions have been made in people's best interests when they are deprived of their liberty.

People's consent to care and treatment was recorded along with their capacity to make decisions about their care. Where appropriate, Do Not Attempt Resuscitation consent forms were correctly completed with the relevant signatures. Information about advocacy services was available to people, however, none of the people who lived in the home had needed to use advocacy.

Needs relating to nutrition and hydration were recorded in care plans and risk assessments were available. Tables in the dining room were laid attractively with tablecloths, placemats and linen napkins. People had a choice of drinks which included juices, milk, tea, coffee or water with the additional option of sherry. The food was hot, served in good portions and looked appetising. There was a menu available for people to see prior to the meal being served, and the staff told us that they asked for people's preferences for the next day's meals. People told us that if there was a meal they did not like, the cook would ask whether they would like an alternative. We observed a

Requires improvement

Is the service effective?

lunch time meal and people commented on how much they enjoyed the food. The atmosphere was like that of a restaurant with music playing quietly in the background. Almost all plates were emptied and people seemed relaxed and happy at meal time. Most people had decided to attend the dining room for their meal, rather than being in their private rooms or the lounges, though a small number had decided to do this. This made lunch time a sociable occasion with people having the opportunity to chat with each other. We noted that drinks and snacks were available throughout the morning and afternoon. People told us that they could choose almost anything they liked at tea time, and that there were regularly eight or nine choices on the menu. People varied their dining experience with occasional trips out to local cafes for meals and snacks accompanied by staff when appropriate.

The registered manager told us that medical conditions such as diabetes which required monitoring, were managed in consultation with health care professionals. Care plans confirmed this. People were regularly weighed when they were nutritionally at risk which meant that the home could monitor if people lost or gained weight. The service sought external professional support when necessary to meet people's needs in this area.

The care plans we looked at showed people had been seen by a range of health care professionals including GPs, district nurses and chiropodists. We saw from the records that staff contacted health care professionals to resolve issues, including the Community Mental Health Team. Staff maintained records of all specialist involvement. We saw care workers had involved the GP in a timely way and kept clear notes about consultations. Needs in areas such as pressure care, moving and handling and any clinical care needs were recorded. A health care professional told us that the registered manager involved them appropriately and that they followed their advice.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring with them. One person told us, "I love the staff, they are so thoughtful and they make my life a real pleasure." Another person told us, "This home is beautiful. It's wonderful staying here. I'm so happy. The staff can't do enough; they're always willing and ready to help." A visitor told us, "The care staff are very welcoming. The residents always come first." Another visitor said, "We can visit whenever we like and they're good at keeping us up to date. I can rely on them to contact me if my relative is ill or has had a fall. They are very prompt. That's important when you're a relative." Overall people who lived at the home and their visitors spoke highly of the staff, their competence, kindness and caring qualities.

However, we noted that staff were occasionally a little over directive in the support they gave to people, which sometimes gave the feeling that people were being 'told' to do something rather than supported. We also noted that at times staff chatted together without involving people who were sitting in the lounge. We felt this was a missed opportunity for staff to engage with people in an inclusive way.

Despite this, staff demonstrated individual care and personal support for people. One member of staff spoke with one person who had just returned to the service after a stay in hospital and said, "It's nice having you home again". We noted that staff showed their affection and warmth towards people by a gentle touch or hug when this was appropriate. People responded to this in a positive way, smiling and appearing to enjoy this.

Staff told us how important it was for them to treat people with respect. For example one member of staff said, "I always say to myself, imagine if a resident was my mum or dad. Wouldn't I want the best for them? Well that's the way I try to treat the residents here. Giving them choice about things can make harder work for the staff but it's not a problem."

We observed the registered provider treat people with regard to their privacy and dignity. As we looked around the home, the registered provider knocked on doors, and waited for a response before asking if they could enter. The wishes of people who preferred not to be disturbed were respected. Staff spoke about the importance of respecting people's dignity when giving personal care. Staff had received equality and diversity training which they told us had given them guidance on how to avoid treating people in a discriminatory way.

Throughout our observations, staff appeared cheerful and there was a great sense of camaraderie between them and people who lived at the service. This created a positive and caring atmosphere.

People were comfortable around staff and there was kindness between them as they chatted. We saw that staff encouraged people to express their views and listened to their responses. Staff gave the impression that they had plenty of time and were respectful in their conversations with people. Throughout the visit, we saw that all staff knew people, their likes and dislikes and their relatives and friends very well. We saw all staff address people by name in a kindly manner.

A number of visitors called during the day and they were welcomed warmly by staff who clearly knew them well. Visitors were offered refreshments and we heard staff giving visitors an update on their relative's well-being. Some visitors told us they were welcome to stay for meals which gave them a greater opportunity to spend quality time with the person they were visiting.

Some people were able to express their views clearly but there were others whose voices may not have been so easily heard. The staff made efforts to make sure these people's views were heard and acted on. For example, staff spent time with those people who had difficulty expressing themselves to ensure their wishes were listened to. Staff told us they had time to visit people in their rooms and chat so that they did not feel isolated.

Staff spoke with enthusiasm to us about how they could improve the experience of care and compassion for people. They talked about creating a stimulating atmosphere for people with activities and different entertainers. They emphasised encouraging relatives and friends to visit so that the atmosphere within the home was homely and inviting.

Good

Is the service responsive?

Our findings

One person told us, “This is a haven, a paradise for me. I love my room, looking out over (the view) and I love that I can go out and do what I want.” Another person told us, “We went to Whitby on the bus. It was lovely, a really lovely day out.” Another person told us, “On Wednesday and Thursday afternoons we have activities like dominoes, cards and plastic skittles. On Fridays we have music quizzes and aromatherapy. In summer we also go to the Rose Garden and to a local hotel for a drink.”

However, one visitor told us that they felt their relative spent too much time alone in their room, and rarely went out on outings or for a short walk outside. Two people confirmed that they did not know they could go out of the home accompanied by staff for safety and that if they had known this they would have wanted to do so. Staff reminded people when they told us this that they could go out and that they only had to mention it. We felt that people would act on this information in future.

We found that staff gave care in a personalised way. Some of the people we spoke with told us that they had worked with the registered manager and senior staff to draw up their care plans and remembered being asked questions and their preferences. People told us that reviews took place in consultation with them when risk levels changed.

Where people had the capacity to do so, they gave us a clear account of the care they had agreed to, some had signed care plans and we saw that written plans were regularly reviewed with people’s involvement.

People had identified areas of interest within their care plan, and people told us they were supported to pursue their interests. For example, the registered manager told us that a person went out at their request with a small group of staff to visit a local hotel bar for a social evening. The registered provider told us they had carried out a joint trip with a person who lived at the home to a town some distance away so that they could visit close friends. Another person told us how staff took an interest in their creative writing.

Care plans included a life history document which contained details of significant events, people, pets, preferences for meals, entertainments, clothing, cosmetics and toiletries, books, newspapers and magazines among other details. Staff told us these gave them valuable information about people’s lives and preferences and supported them to offer personalised care.

Staff told us that they offered exercise sessions, singing, quizzes, and external entertainment, such as a magician, music therapy and aromatherapy. People told us that they played dominoes, and enjoyed cards, art and craft work. They mentioned that they went out for walks to look at the sea and to local cafes.

We observed a chair exercise session in the front lounge. The facilitator was an external person brought into the service. All except one person, who was asleep, were actively engaged. The facilitator appeared to know each person by their first names and took opportunities to talk to some individuals about the music they were playing, much of it topically Christmas related, and people’s memories of the singers. People seemed to enjoy this session very much.

Staff kept daily records which though succinct gave sufficient information about people’s daily lives. All records gave details of any changes in care needs or any cause for concern.

All care plans were regularly reviewed with required actions recorded with outcomes. Reviews focused on well- being and any improvements which could be made to people’s health and well-being. Relevant specialists were consulted for advice at these reviews. Monthly updates were recorded by keyworkers and again these contained useful and relevant details to assist staff to plan responsive care. Staff could tell us about people’s care needs and how these had changed.

People told us they would feel confident telling the staff if they had any concerns and felt that these would be taken seriously, though all told us they had never made any formal complaints. Staff told us that they encouraged people to speak up if they had any concerns and confirmed that people were confident to do so. The service had a complaints procedure and the registered manager told us they followed this to ensure people’s complaints were appropriately dealt with; however, there had been no recent complaints.

Good

Is the service well-led?

Our findings

People were complimentary about the way the home was managed and about the registered manager and provider. One person said, “The manager is nice and lovely. She’s approachable, pleasant and helpful. She always calls me by my first name and can’t do enough for me.”

There was a registered manager in place who was visible in all areas of the home throughout the day. They were approachable and worked with the team.

Staff told us that the culture of the service was focusing on good quality care and to be open and honest about any concerns. We observed that the culture was inclusive and put people at the heart of care. Staff told us they were encouraged to ask questions and to offer suggestions about care and that the registered manager took these seriously and acted on them when possible.

Regular staff meetings took place, between the senior staff team and the wider staff team. There was a handover at each new shift which was recorded so that staff could keep a track of changes for individuals and where any significant events or developments were discussed.

Staff understood the scope and limits of their roles and responsibilities which they told us helped the home to run smoothly. They knew who to go to for support and when to refer to the registered manager. They told us that mistakes were acknowledged and acted on in an atmosphere of support.

There were systems and procedures in place to monitor and assess the quality of the service. For example we saw records of care plan, infection control and health and safety audits. Staff told us that the registered manager discussed infection control, care planning, and changes in care needs with them regularly. The member of staff who had responsibility for medicines told us that they regularly checked that the stocks of medicines matched the records and that medicines had been correctly signed for and disposed of.

The registered manager told us that they consulted with people regularly on a one to one basis and through surveys and people confirmed that this was the case. People told us about food choices and outings which they had requested and that the manager had arranged. We saw surveys which had been carried out with people and staff told us that they had discussed the results of these in staff meetings. The registered manager explained how they had made improvements to people’s care based on results from surveys.

The registered manager worked well in partnership with health and social care professionals to ensure people had the benefit of specialist advice and support. Daily notes and monthly updates contained detailed information about how advice was to be incorporated into care practice. Health and social care professional told us that they were consulted and that the registered manager worked well with them.

Notifications had been sent to the Care Quality Commission by the service as required.