Orbital Care Services 2 LTD

Mapleford Nursing home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Mapleford Nursing Home is a residential care home which provides personal care and nursing care for up to 54 older people, younger adults, people with a physical disability, sensory impairment or mental health support needs and people living with dementia. Accommodation is provided in 3 units over 2 floors, with a passenger lift available. At the time of the inspection 37 people were living at the home.

People's experience of using this service and what we found
Staffing levels at the home were not always appropriate to meet people's needs and to ensure their safety. Significant improvements were needed to the quality and safety of the home environment. Infection prevention and control practices at the home needed to be improved. People's medicines were not always managed safely and in line with national guidance. Care plans did not always contain information about people's risks to guide staff about how to support them safely. Not all staff had completed the provider's mandatory safeguarding training. Staff we spoke with knew the action to take if people were at risk of abuse. Staff had been recruited safely to ensure they were suitable to support people living at the home.

People did not always receive support which reflected their assessed needs and preferences. They did not always receive support when they needed it and their safety was not always monitored effectively. Staff had not always received an appropriate induction or completed the training necessary to support people effectively. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice; we have made a recommendation about this. People's care documentation did not always include information about their needs and preferences, including their dietary and healthcare needs. The home environment needed to be improved to ensure it was homely and comfortable and met people's needs; we have made a recommendation about this.

People did not always receive personalised, high quality care which resulted in good outcomes for them. Staffing levels had been reduced without reference to people's needs, the home environment was unsafe and unclean, and staff had not completed appropriate training. Many audits were not being completed regularly. When audits were completed and shortfalls identified, the necessary improvements were not always made. Many of the shortfalls we identified during the inspection had either not been identified by the manager or provider or had not been acted upon. This meant that appropriate standards of quality and safety were not being maintained at the home. There was little evidence of engagement with people or relatives to gain their views about the service and we found evidence of decisions being made about people's care without appropriate consultation. There was a lack of appropriate oversight of the service by the provider; they had not visited the service regularly to monitor how the service was being run, the quality of care people were receiving and standards of quality and safety.

For more details, please see the full report which is on the Care Quality Commission (CQC) website at www.cqc.org.uk

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Rating at last inspection
The last rating for this service was good (published 5 November 2020).

Why we inspected
The inspection was prompted in part due to concerns received about a variety of issues, including medicines, infection control, poor, unclean and unsafe environment, staffing, people not receiving appropriate support and lack of effective management. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
At this inspection, we have identified breaches in relation to staffing levels, medicines, the safety and cleanliness of the environment, the management of people's risks, people not receiving person-centred care or being consulted about their care, staff knowledge and skills and the provider's oversight of the service.

You can see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
In relation to some of the breaches of regulation, we will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

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

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Mapleford Nursing home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors, a medicines 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.

Service and service type
Mapleford Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Mapleford Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was not a registered manager in post. The registered manager had left the service on 8 December 2022 and a new manager had joined the service shortly after.

Notice of inspection
The first day of the inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used this information to plan our inspection.

During the inspection
We spoke with 7 people who lived at the home to gain their feedback about the care and support they received. Most people were only able to give us limited feedback due to their complex needs. We spoke with 10 relatives, 1 person's advocate and 2 visiting healthcare professionals to gain their feedback. We spoke with the registered manager, the deputy manager and the care manager. We also spoke with 11 nursing, care, activities and housekeeping staff.

We reviewed a range of records, including 8 people's care records and a selection of medicines records. We reviewed 2 staff members' recruitment files, staff supervision and training records and a variety of records related to the management of the service, including audits. We contacted 4 community health care professionals who visited the service regularly for their views about the care provided.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- There were not always sufficient staff to meet people's needs. We observed a number of occasions during the three days of the inspection when there were not enough staff available to monitor people's safety and wellbeing in some areas of the home, including communal areas, and to provide people with support when they needed it. We observed people asking for support to go to the toilet being told there were no staff available to support them.
- Staff raised concerns about staffing levels and told us there were not enough staff to monitor people's safety and respond in a timely way when people needed assistance. They told us that staffing levels had been reduced in recent months despite little change in the number of people living at the home or their needs. We saw evidence of this in staffing rotas and staff meeting notes that we reviewed. We were told this decision had been made by the provider.
- A visiting healthcare professional we spoke with raised concerns about staffing levels at the home.

The provider had failed to ensure there were always sufficient staff available to meet the needs of people living at the home. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns regarding staffing levels with the registered manager and the provider. They told us staffing levels would be reviewed and increased to ensure they were appropriate to meet people's needs.

- The provider ensured staff were recruited safely. Appropriate pre-employment checks were carried out before staff started working at the home, to ensure they were suitable to support people.

Using medicines safely

- People's medicines were not always managed safely or in line with the National Institute for Health and Care Excellence (NICE) guidance. Medicines given covertly (hidden in food or drink) did not have documentation in place to support staff to administer them safely and effectively.
- Records to show prescribed creams had been applied were not always completed. When people's fluid intake needed to be restricted, records to show the quantity of fluids they were having were not always completed correctly.
- Care plans and health records did not always include the information needed for staff to care for people safely. Medicines administration records were not always completed correctly, so we could not be sure people received their medicines as prescribed. The provider's systems for auditing medicines at the service were not effective; the audits completed had not identified some issues found during the inspection, and actions from previous audits had not always been completed.

The provider had failed to ensure that people's medicines were managed safely and in line with national guidance. This placed people at risk of harm. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Preventing and controlling infection
● Significant improvements were needed to the quality and safety of the home environment. We found a number of safety issues, including damaged furniture and fixtures and inappropriate and stained furniture in place. Some safety checks of the home environment were being completed regularly by the maintenance person. However, where improvements/repairs were needed, these were not always completed in a timely way. We noted the same shortfalls identified over a number of consecutive months without improvements being made.
● There was a lack of effective infection prevention and control processes and practices at the home. Dirty laundry was routinely being stored in bathrooms, there were damaged and fabric chairs in people's bedrooms and communal areas which could not be cleaned effectively, rusty bins, odours in some areas of the home, sticky flooring and damaged worktops in one of the kitchens.
● Some staff and relatives raised concerns about the cleanliness of the home environment. One visiting professional told us cleanliness at the home was not always good. Audits of infection control were not being completed regularly. When the limited audits completed had identified shortfalls, the necessary improvements were not always made.

The provider had failed to ensure the safety and cleanliness of the home environment. This placed people at risk of harm. This was a breach of regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care documentation did not always include accurate, up to date information about people's risks to guide staff about how to support them safely. For example, some people were at risk of falling or required a special diet and this was not reflected in their care plans and risk assessments. One person on a pureed diet, who was at risk of choking, did not have a choking risk assessment in place.

The provider had failed to ensure that risks to people's health, safety and welfare were managed appropriately. This placed people at risk of harm. This was an additional breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us people's care documentation would be updated as a matter or urgency, to reflect their needs and risks.

Systems and processes to safeguard people from the risk of abuse
● Safety monitoring and management was not always effective in ensuring that people were protected from the risk of abuse or avoidable harm. There were not always enough staff available to monitor people and ensure their safety. This has been addressed in the staffing section.
● People told us they felt safe and relatives felt their family members were safe at the home. They told us, "I am safe here, no one bothers me. They are all very friendly" and "I feel (relative) is safe as the staff care about her". When accidents or incidents occurred, staff completed the relevant documentation, which detailed the action they had taken. When safeguarding concerns had been raised about the service, investigations had been completed and the local authority and CQC had been notified when appropriate.
● Records showed not all staff had completed the provider's safeguarding training. We have addressed this in the effective section of this report. Staff we spoke with were aware of the action to take if they had any concerns about abuse.

Visiting in care homes

● Friends and family were able to visit people in line with Government guidance and local Public Health advice. We spoke with a number of visitors during our inspection and saw that when relatives and friends visited, they were made welcome by staff.

Learning lessons when things go wrong

● We noted that when concerns or incidents identified that improvements were needed, action was not always taken in a timely way. We have addressed this in the well-led section of this report.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People did not always receive care which reflected their assessed needs. There were not always sufficient staff available to provide people with support when they needed it or to ensure people's safety when they were in communal areas.
- Care plans and risk assessments did not always include information about people's needs, including their nutrition and healthcare needs. Many of the care files we reviewed had sections of information missing, such as medicines, skin condition, falls risk and mental capacity. One visiting professional told us care plans needed improvement and one person's representative told us there had been issues with the person's care plans not being updated regularly.
- Some people's care plans did not include information about their special dietary needs, which meant we could not be sure that people were receiving an appropriate diet. Information about people's specific medical conditions, such as diabetes, was not always included in their care plans, to guide staff about how to support them effectively.
- We saw evidence of referrals to community healthcare agencies when people needed specialist support. However, one person's representative told us there had been a delay in staff making appropriate referrals when the person's healthcare needs had changed. One community healthcare professional described shortfalls in the support provided to people in relation to their diabetes and pressure relief needs (to prevent skin damage).

The provider had failed to ensure that people received person-centred care, which reflected their assessed needs. This placed people at risk of harm. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns with the manager. She told us she would address the shortfalls identified and would introduce a summary of each person's risks and needs as a matter of urgency for staff to refer to.

Staff support: induction, training, skills and experience

- The provider had not ensured that all staff received an appropriate induction when they started working at the home. We reviewed two staff members' files and found no evidence in one that the staff member had received an induction. The manager could not confirm that an induction had been provided.

● Staff did not always have the knowledge and skills to meet people's needs. Many staff had either not completed any of the provider's required training or it was overdue. This included safety training, such as practical moving and handling training, fire safety, safeguarding and medicines training. Many people living at the home had complex needs, and their behaviour could pose a risk to themselves or others, but staff had not received any training in supporting people safely with those needs. There were issues with the communication skills of some overseas staff where English was not their first language.

The provider had failed to ensure that staff had the knowledge and skills to meet people's needs effectively. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most people and relatives were happy with the competence of staff working at the home. They told us, "The staff are very good; I think they know what they are doing" and "The staff are smashing, I have no complaints. They all know what they are doing and do a very good job." A number of relatives told us there were a lot of new staff working at the home. One commented, "I can't really say if the staff are well trained because a lot of them are new and they are not as experienced as the staff who have been here for a long time."

Adapting service, design, decoration to meet people's needs
● The home was purpose built to meet people's needs and promote their independence. Adapted bathroom facilities and lifting equipment were available to support people's mobility needs.
● The home environment was generally tired and in need of redecoration and refurbishment. The furniture in many bedrooms and communal areas was damaged or worn and needed replacement. These issues have been addressed in the safe section of this report
● Some people's bedrooms were very basic, with damaged furniture and poor-quality bedding and curtains. Improvements were needed to make them more homely and comfortable. There was insufficient and inappropriate furniture in some dining rooms and lounges to accommodate and meet the needs of people living there. There was some inappropriate furniture in some people's bedrooms, such as fabric, dining room chairs without arms, instead of easy chairs.

We recommend the provider makes the necessary improvements to ensure the home environment meets people's needs and preferences.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Improvements were needed to ensure the service was working within the principles of the MCA. Not everyone's care documentation included information about their capacity to make decisions about their

care. Some capacity assessments had been completed and best interests decisions made in consultation with people's relatives or representatives. However, this information was absent from some people's care files. Applications had been made to the local authority for authorisation when people needed to be deprived of their liberty to keep them safe. We reviewed some DoLS applications which had been authorised and included conditions, however, the manager was unable to advise whether the conditions were being met.

● We observed staff encouraging people to everyday make decisions about their care when they could, such as what they wanted to eat at mealtimes. However, some staff expressed concerns about people not always being given a choice about where they spent their time, for example, being expected to spend most of the day in communal areas where staff could observe them more easily.

We recommend the provider considers current guidance on the principles of the MCA and takes action to ensure the principles are being followed.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created, did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The manager was responsible for the day-to-day running of the home, with support from a deputy manager, care manager and the nurse on duty. Care staff told us they were clear about their roles but, due to staffing levels at the home, they were not always able to support people as they should or to monitor their safety. Some told us they had raised their concerns with management.
- Many of the shortfalls and breaches of regulation we found during our inspection had either not been identified or addressed by the manager or provider. This included staffing levels not being sufficient to meet people's needs, the environment not being safe, care documentation not always reflecting people's risks and needs, medicines not being managed safely and staff not always receiving an appropriate induction or completing appropriate training.
- Some audits were not completed regularly, including infection control and care plan audits. The limited audits that had been completed showed that where shortfalls had been identified, for example with the environment, infection control practices and medicines, the necessary improvements had not always been made. This meant that the audits being completed were not always effective in ensuring appropriate standards of quality and safety at the home.
- There was a lack of effective oversight by the provider. We requested evidence of provider visits and audits and received a copy of one audit of one of the units completed in January 2023. Most of the shortfalls identified in the audit had not been addressed. This meant that the provider had little knowledge of how the service was being run, the standard of care being provided to people and levels of quality and safety at the home.

The provider had failed to assess, monitor and improve the quality and safety of the service. This was breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Statutory notifications about people using the service had been submitted to CQC in line with current regulations. A statutory notification is information about important events which the service is required to send us by law.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- We found little evidence of management or the provider engaging with people using the service. On the first day of the inspection, the manager told us there were plans to reconfigure the home and move a

number of people into different bedrooms and onto different units. We saw no evidence that people or relatives had been consulted about the changes and staff told us they had not been involved. The manager had only been in post five weeks and was not familiar with everyone's needs and risks. By the second day of the inspection, people had been moved. One person was distressed about the move and we were told the person had moved four times in recent months. During a recent staff meeting, one staff member had raised concerns about moving people more than once and the impact it had on them. A relative raised concerns with us about the move and the lack of consultation with relatives.

The provider had failed to involve people and their representatives in decisions about their care. This was breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We reviewed a satisfaction survey given to people in August 2022, when 5 people had responded. Feedback had been mostly positive; however it was clear that some people had struggled to understand the questions and participate fully. No satisfaction surveys had been issued to relatives.
● Staff told us that staff meetings took place regularly and they had had meetings with the new manager since she had started in December 2022. We received mixed feedback from staff about management; some staff found them approachable, while others did not and felt they were not listened to. Some expressed a lack of clarity about the roles and responsibilities of the management team.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider had not always ensured that the care provided at the home was high quality, reflected people's individual needs and resulted in good outcomes for them. There were not always sufficient staff to provide people with support and to monitor their safety, the home environment was not always safe, clean and comfortable and people's care documentation did not always reflect their needs, risks and preferences to guide staff about how to support them safely and effectively.
● None of the people or relatives we spoke with expressed concerns about the management of the home. They told us, "I have had a chat with the new manager and she seems to be alright" and "I don't know who is in charge but everyone seems to know what they are doing."
● One community healthcare professional told us improvements were needed, however, they felt the management team and staff were working hard to improve systems and documentation at the home.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had a duty of candour policy and the manager was aware of their responsibilities. No incidents had occurred that we were aware of that required action under the provider's duty of candour.

Working in partnership with others
● The management, nurses and care staff worked in partnership with community professionals when people needed additional support. This included GPs, community nurses, speech and language therapists and dietitians. Feedback received from community professionals suggested improvements were needed to some aspects of care and documentation at the service; these are mentioned throughout the report.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people received person-centred care, which reflected their assessed needs. The provider had failed to involve people and their representatives in decisions about their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that people's medicines were managed safely and in line with national guidance. The provider had failed to ensure that risks to people's health, safety and welfare were managed appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure the safety and cleanliness of the home environment.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We have issued a warning notice and the provider is required to be compliant by 6 March 2023.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were always sufficient staff available to meet the needs of people living at the home. The provider had failed to ensure that staff had the knowledge and skills to meet people's needs effectively.

The enforcement action we took:

We have issued a warning notice and the provider is required to be compliant by 6 March 2023.