Orbital Care Services 2 LTD

Mapleford Nursing home

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 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, 28 people were living at the home.

People's experience of using this service and what we found
People's medicines were not always managed safely and in line with the provider's own policy. We observed enough staff on duty to meet people's needs, although, staff felt the staffing levels could be increased. Staff had been recruited safely to ensure they were suitable to support people living at the home. All required health and safety checks had been completed and infection control procedures were being followed. Staff had received safeguarding training and people felt safe living at the home.

People and their relatives had not always been involved in the care planning process and care plans needed to be reviewed to ensure they were accurate; we made a recommendation about this. People were not supported to have maximum choice and control of their lives and staff did not 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. Staff had received appropriate training for their role. Significant improvements had been made to the design and decoration of the service.

Further improvements were needed to systems for auditing, assessing, monitoring and improving the quality and safety of the service. Policies and procedures were in place to guide staff. However, they were not always being followed. Staff did not always feel able to approach the management team with concerns. The provider had a development plan which they were working towards to improve the service. People told us they had no complaints and felt Mapleford Nursing Home was a nice place to live.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 23 March 2023)

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. 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.

The overall rating for the service has changed from inadequate to requires improvement based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Mapleford Nursing Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to medicines management, person-centred care, consent and governance at this inspection. We made a recommendation in relation to care plans and referrals.

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
The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over 2 consecutive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, 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 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

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 2 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.

Registered Manager
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 a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 all this information to plan our inspection.

During the inspection
We spent time in the communal areas observing the care and support provided by staff. We spoke with 4 people who use the service, 7 relatives and 15 members of staff including care workers, senior care workers, team leaders, clinical lead, housekeepers, activity coordinator, maintenance, registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. These included care records, records relating to medicines, staff recruitment, training and supervision, building maintenance, cleaning and equipment checks, accidents and incidents and safeguarding logs. We also looked at a variety of records relating to the management of the service, including audits and policies and procedures.

Requires Improvement

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 inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

At our last inspection the provider had failed to ensure that people's medicines were managed safely and in line with national guidance. This place 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.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Information was not always available to support the administration of medicines when there was a variable dose, for example an option to give 1 or 2 tablets. Therefore there was a risk people might not get the correct dose.
● Records to support staff to apply topical preparations were not always available and accurate. Therefore, we were not assured the topical preparations were applied as prescribed and people's skin was cared for properly.
● Staff were not always following the provider's medicines policy. For example, medicines were not always disposed of in a timely manner when no longer prescribed, therefore we were not assured medicines were managed safely.
●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 systems and processes were in place and being followed to ensure medicines were managed safely. This was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were always sufficient staff available to meet the needs of the 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18

● Staffing levels were safe and in line with the dependency tool. During the inspection we observed enough staff on duty to meet people's needs. However, some staff felt there needed to be more staff to care for people.
● When we asked about staffing levels, one staff member said, "There is the right amount of staff for the residents but not for their needs." The provider was in the process of recruiting staff to ensure sickness and holidays were covered.
● Relatives felt there were enough staff. Their comments included, "There always seems to be enough staff about."
● There were safe systems of staff recruitment in place. All required checks had been undertaken prior to people commencing employment. This included Disclosure and Barring Service (DBS) checks which provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management

At our last inspection 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of the regulation

● Individual risks were managed safely, and staff were aware of people's specific care needs.
● Equipment was maintained, and the required health and safety checks had been completed.
● Emergency evacuation plans were in place which included the level of support each person needed in the event of a fire. We saw evidence of mock fire drills taking place.
● Accident and incidents were recorded, and we saw evidence of referrals to the appropriate healthcare professionals. The registered manager looked at trends and themes following on from any accidents and took action to reduce risk.

Preventing and controlling infection

At our last inspection the provider had failed to ensure the 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or

managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● There were no restrictions on relatives visiting their loved ones. We observed visits taking place during the inspection.

Systems and processes to safeguard people from the risk of abuse; Learning Lessons when things go wrong
● People were protected from the risk of abuse and safeguarding referrals were made in a timely manner. However, we did find 1 incident that had not been reported. This was rectified during the inspection process.
● Staff had received safeguarding training and they were aware of their responsibilities and how to raise any concerns.
● People told us they felt safe living at Mapleford Nursing Home. One person said, "I feel safe because of the staff, they look after me. If I was worried, I would talk to one of the staff."
● Information was shared with staff during team meetings and we saw evidence of lessons learnt as a result.

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

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.

At our last inspection we recommended the provider consider current guidance on the principles of the MCA and takes action to ensure the principles are being followed.

Not enough improvement had been made at this inspection and the provider was still not following the principles of the MCA

- Improvements were needed to ensure the service was working within the principles of the MCA. People and their relatives had not always been consulted when best interest meetings took place. This meant decisions were being made for people without appropriate documentation or consent.
- Consent to care forms were either not always in place or not always signed. This placed people at risk of receiving care they had not always consented to.

The provider had failed to ensure appropriate consent had always been gained. This put people at risk of abuse. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider had failed to ensure 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

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9

● Although we saw an improvement to people's care plans and risk assessments, there were still shortfalls in this area.
● People had care plans and risk assessments in place. However, people and their relatives had not always been involved in this process. When we asked relatives if they had seen a care plan, one responded, "No I have not seen it or reviewed it."
● Where risk had been identified in relation to people's dietary needs, this had not always been followed up with the appropriate referrals to healthcare professionals.
● One person's diabetic care plan held conflicting information on the appropriate diet, meaning it was unclear what food and drink should be offered.

We recommended the provider reviews all care plans to ensure they're accurate and appropriate referrals are made. We also recommended involving people and their relatives with the care planning process.

The provider responded to these concerns during the inspection process and ensured appropriate referrals were made. The provider was also in the process of transferring over to electronic care records to reduce future risks.

Staff support: induction, training, skills and experience

At our last inspection 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18

● Staff received the induction, training and support they needed to carry out their roles effectively.
● Training records evidenced a high completion rate for training courses and staff received regular refresher training.
● People and their relatives told us staff were experienced. One relative said of the staff, "The patience of these carers, they are always there doing things for [people]them."

Adapting service, design, decoration to meet people's needs

At our last inspection we recommended the provider makes the necessary improvements to ensure the home environment meets people's needs and preferences. The provider had made improvements.

● Significant improvements had been made to the design and decoration of the home. The home had been decorated throughout and new furniture purchased.
● The provider was working through an action plan to ensure all areas of the home were clean, homely, and attractive for people to live in.
● People's bedrooms were spacious and personalised to their wishes and there were secure gardens for people to access should they wish to.

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 inadequate. At this inspection the rating for this key question has remained 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

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

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

- There was a range of audits and monitoring in place. However, they were not sufficiently detailed or robust and had not identified or addressed the issues found during the inspection or ensured the warning notice issued had been met.
- The auditing system for medicines was not always effective in monitoring the safety of medicines and did not pick up on the concerns found during the inspection.
- The care plan audit had identified concerns and it was evident these concerns had been acted on. However, it had not picked up on concerns found during the inspection, such as consent forms not being signed.
- Referrals to other healthcare professionals were not always made in a timely manner, meaning people could be at risk of harm due to the lack of management oversight.
- Although we saw evidence of staff supervisions, not all staff had received one. One staff member said they had not had a supervision for over 1 year.
- A range of policies were in place. However, they were not always followed, meaning the provider was working against their own policies and procedures.

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

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

At out last inspection the provider had failed to involve people and their representatives in decisions about their care. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9

● Staff worked well with people to ensure they received the best possible outcomes. Staff spoke positively of the work they had done to ensure people thrived in their environment. One staff member told us, "This is more than just a job for me."
● Care plans held detailed information in relation to people's equality characteristics and staff appeared to know people well.
● We saw evidence of regular staff meetings. However, relatives' meetings had not taken place for some time. The provider responded to this during the inspection and arranged a relatives' meeting.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff did not always feel able to approach the management team with their concerns. Some staff felt when concerns were raised, they were either not acted on or the issues were not resolved. The provider acted on these concerns during the inspection and took steps to improve staff morale.
● Throughout our inspection, we observed staff and senior management were very pleasant and accommodating and there was a relaxed atmosphere throughout the home.
● People told us Mapleford Nursing Home was a nice place to live. One person said, "It is very good, it is near enough excellent. I have no complaints the staff are nice; the home is nice, and it is kept nice."

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; Working in partnership with others
● Statutory notifications are reports of certain changes, events and incidents that the registered providers must notify us about that affect their service or the people who use it. CQC had received notifications as required.
● The provider and registered manager had regular contact with the local authority and were continuously trying to improve the service they offer.
● The provider had a development/improvement plan outlining future actions to improve the quality of the home and the care and support being delivered.
● The registered manager gave out satisfaction surveys to seek feedback from people, their relatives and staff.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure appropriate consent had always been gained. This put people at risk of abuse. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure systems and processes were in place and being followed to ensure medicines were managed safely. Regulation 12 (2) (g)

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	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality of the service. Regulation 17 (2)

The enforcement action we took:

We have served a warning notice