Maple Health UK Limited

Maple View

Inspection report

4 Amber Court
Berechurch Hall Road
Colchester
Essex
CO2 9GE

Tel: 01206549401

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23 October 2023
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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

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Maple View is a residential care home providing personal care to people who have a learning disability and/or autistic spectrum disorder. The service can support up to 5 people. Maple View is a detached bungalow located in a residential cul-de-sac in Colchester and is 1 of a group of 5 similar properties in the same cul-de-sac and owned by the same provider.

People's experience of using this service and what we found
Right Support: 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 support this practice. Staff had not always received adequate training to support people safely and this included in the use of physical and chemical restraint. People were not always supported with their medicines in a way that promoted their independence and achieved the best possible outcomes.

Right Care: People were not always protected from the risk of harm. People's care and support plans did not consistently reflect their current needs as accident and incident forms were not reviewed or followed up. The registered manager or staff were not aware how to apply national best practice supporting people with a learning disability and autistic people.

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive, and empowered lives. People experienced or were at risk of harm because of a lack of protection they experienced or were at risk of abusive incidents, including unnecessary restraint. Staff have poor relationships with each other and there was minimal remedial action in relation to staff conduct or competency. The governance systems used were not effective and did not identify concerns related to quality and safety, restraint, medicine administration, risk, food intake or MCA processes.

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

Rating at last inspection
The last rating for this service was good (published 14 February 2019).

Why we inspected
The inspection was prompted in part due to concerns received about the use of unauthorised restraint used at one of the provider's 'sister' services. A decision was made for us to inspect and examine those risks.

We undertook a focused inspection to review the key questions of Safe, Effective and Well-Led only.

For those key question not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Maple View on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding, meeting nutritional needs, consent, and governance.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 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 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 safe. Details are in our safe findings below.	**Inadequate**
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**

Maple View

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 team consisted of 2 inspectors and 1 regulatory co-ordinator.

Service and service type
Maple View 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. Maple View is a care home without 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.

Inspection activity started on 23 October 2023 and ended 02 November 2023. We visited the location's office/service on 23 October 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. 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
Where people were unable to talk with us, we observed people's interactions with staff, and we spoke with 3 relatives. We spoke with the registered manager, and 3 members of staff. We reviewed 5 people's care files and 2 staff personnel files relating to their recruitment. We looked at the provider's arrangements for managing risk, medicines management, staff training and supervision data. We also looked at the service's quality assurance arrangements, including the service's auditing arrangements and the provider's oversight of the service.

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.

Systems and processes to safeguard people from the risk of abuse: Learning lessons when things go wrong
• People were not protected from avoidable harm or abuse. The registered manager told us there was no physical restraint currently being used at the service, and this had not been used for several months. However, we found an incident of physical restraint had been carried out by staff on a person living in the service in October 2023. The person's care plan and risk assessments did not contain information to guide staff on when or how to use physical restraint. There were no follow up reports, lessons learned or debrief sessions found relating to this incident. We identified staff had not completed up to date training in relation to physical intervention techniques since 2019.
• One person was prescribed a PRN ('as required') medicine dose for supporting them when expressing distress. The PRN was contradictory and did not describe or evidence why staff were giving the full dose, what therapeutic methods could be used prior to the administration or the effectiveness of the medicine following the administration. There were also no records or incident reports completed in relation to why staff had needed to administer this medicine. This did not assure us this person's distress was not controlled by excessive and inappropriate use of medicines contrary to the principles of STOMP (stopping over-medication of people with a learning disability, autism, or both).
• We identified other safeguarding concerns which had not been referred to the relevant safeguarding authorities or CQC. There was no effective analysis of themes and trends or follow up by the registered manager or provider to identify any lessons learned to reduce the risk of reoccurrence.

The provider had failed to ensure systems and processes were in place to safeguard people from the risk of abuse. This is a breach of Regulation 13 (safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We informed the provider of our concerns in relation to the use of physical restraint. We also reported this to the local authority safeguarding team.

Assessing risk, safety monitoring and management
• The providers arrangements to identify and mitigate risk were not effective. Chemicals were not stored safely which could have serious consequences for people if ingested or swallowed. During the inspection we found the laundry room unlocked throughout day despite a notice on door saying it must be locked. The coshh cupboard in the laundry room unlocked and coshh items were easily accessible and included hand sanitiser, toilet cleaner, surface disinfection and ant killer powder.
• One person's care file recorded they had been known to drink any sort of liquids left out including perfumes and deodorants. There was no risk assessment found for this hazard and failing to ensure coshh items were kept secure put this person at risk.

• Another person care records indicated they were at risk of absconding and an incident form completed identified this person had tried to run from staff when taken to the car to access the community. Despite this incident the risk level recorded was low. During the inspection we observed the front door to be left open by staff.
• Risk assessments in relation to areas such as physical restraint, choking, nutrition and catheter care were not in place. One person was at risk of choking and recorded all medicines should be in liquid form. However, the person had recently been prescribed a medicine in tablet form which was being administered. There was no review or update in relation to the information found on their medicines care plan and why this was no longer a risk.
• Not all of the provider's fire arrangements were safe, Personal Emergency Evacuation Plan ('PEEPs') lacked sufficient detail relating to people's anxious and distressed behaviours and the impact this may have when supporting each person to safely leave the building in the event of a fire emergency. No information was recorded of the potential impact of sedative medicines on people or that people's 1 to 1 staffing allocation during the day was significantly reduced at night. The PEEP is a bespoke plan for people who may have difficulties evacuating to a place of safety without support or assistance from others. One PEEP we looked at contained information related to another person.
• A fire risk assessment was completed by an external company on 18 August 2023. This highlighted issues regarding fire doors not closing, fire warden hands on training to be completed, smokers discarding cigarettes to the rear of the premises and garden, storage in the loft was not controlled and presented a fire risk. An action plan was put in place but the timescale for action was recorded to be completed by 4 November 2023 which was 2.5 months after the information was received. This demonstrated a lack of urgency by the provider to address these concerns and protect people from the risk of fire.
• There was no effective controls or monitoring in place for the risk of Legionnaires disease. The registered manager told us as they had underfloor heating and did not need to monitor Legionnaire risks, however no risk assessment was in place to explain why controls did not need to be followed. There was no effective monitoring of hot water outlets to ensure controls in place to reduce the risk of scalding were effective.

Using medicines safely
• Systems and processes to administer medicines safely were not always clearly in place or followed.
• Not all PRN protocols were in place for as required medicines.
• Staff were not signing for topical creams so we could not be assured these were being applied as prescriber's instructions.
• Medicine Competencies had been completed for all staff administering medicines. However, the senior staff completing these competencies had only completed the same online medicines training as other staff and the registered managers 'train the trainer' training for medicines had not been updated since 2019. This meant we were not assured these staff had the required level of training to assess competency in this area.
• Medicine audits were completed but did not identify the concerns found in relation to PRN protocols and topical creams.

The provider had failed to ensure risks were effectively assessed or mitigated. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• The provider had not ensured there were sufficient numbers of staff available to support people safely and in line with people's current care and support needs. This included where people were allocated 1 to 1 or 2 to 1 staff for specific hours throughout the day and night. Following the inspection where restraint was identified a person's care file was updated to reflect the possible use of restraint and recorded 3 trained staff would need to be available. The provider had not considered that during the night only 1 member of staff was on duty. When we asked the provider how they could follow this person's plan of care they increased

staffing at night to 3.
• The provider operated safe recruitment processes. Appropriate checks were completed before a new member of staff started working at the service. This included an application form, written references, proof of identification and Disclosure and Barring Service [DBS] checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
• People were protected from the risk of infection as staff were following safe infection prevention and control practices.
• We were assured the provider was supporting people living at the service to minimise the spread of infection.
• We were assured the provider was using PPE effectively and safely.
• We were assured the provider was responding effectively to risks and signs of infection.
• We were assured the provider was promoting safety through the layout and hygiene practices of the premises.

Visiting in care homes
• People were able to visit family and receive visitors without restrictions in line with best practice guidance.

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.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (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.
• We found the service was not working within the principles of the MCA.
• The appropriate legal authorisations to deprive a person of their liberty or put them under constant supervision had expired. This meant the person was being deprived of their liberty without authorisation.
• The registered manager was not clear about why authorisations to deprive people of their liberty were required and told us they thought if they lived here, they needed a DoLS even if the person had capacity.
• Mental capacity information in care plans was confusing, there were no mental capacity assessments found and the registered manager told us 2 people had capacity, however, 1 of these people had an authorised DoLS in place. This person had signed to consent to their care plan, but there was no evidence or assessment completed to assess if the person had capacity to understand what they were signing.
• We found no mental capacity assessments related to the level of supervision and control in place. Some people had periods of 3 to 1 care in place.

Failure to follow the principles of the MCA was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the registered manager confirmed an application had now been submitted for the person whose DoLS had expired.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

• People were not always supported to eat a healthy and balanced diet.
• A person's care file recorded staff were to ensure the person received a well-balanced meal and to advise healthy eating whilst completing weekly menus and buying snacks. Care records indicated this was not happening in practice as the person's weight had significantly increased since May 2022 where they weighed 62.5kg increasing to 87.95kg on 18 October 2023. This was an increase of over 25kg. Records recorded this person was eating a significant number of unhealthy snacks which included on one day they had eaten 7 bags of crisps and on other days their diet included multiple snacks of crisps, chocolate, cookies, and fizzy drinks. This meant staff were not supporting this person with healthy eating or had they considered the risks associated with an unhealthy diet and increased weight gain.
• When we discussed these concerns with the registered manager, they were not aware of this person eating this level of snacks they were being provided with.

People's nutritional needs were not always being met. This demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Relatives told us they felt people were given choice and had not experienced any concerns regarding eating and drinking. A relative explained their family member had put weight on, as was previously very thin. They told us, "[Family member] is enjoying their food, and assists sometimes with making food and is allowed to go out and shop for food with a person attending with them."
• Staff told us menus were devised weekly and included people living in the service.

Assessing people's needs and choices, delivering care in line with standards, guidance, and the law
• People's needs were assessed prior to their admission to the service. However, people's care plans did not always reflect their current assessed needs.
• Information from day-to-day documentation such as care notes, incident and accident reports or distressed reactions records were not used to inform and update care plans.
• A relative told us their family members admission was gradual and the staff told them they could come as many times as needed prior their family member moving into the service. They said, "It was pretty straight forward. I put together a big list of likes/dislikes and where they like to go."

Staff support: induction, training, skills and experience
• The provider failed to ensure staff had up to date training to provide safe care and support to people.
• Staff training was not up to date and the training plan evidenced that staff had not received practical training in the safe use of restraint despite this being used for a person. Following the inspection, the registered manager confirmed this training had been booked for all staff and would be completed for all staff by December 2023. In the interim agency staff who had received this training were being used to support the person whose care plan indicated this could be used.
• The staff training plan also indicated not all staff training was in date. Staff had not received practical moving and handling training, appointed first aid training or fire marshal training. Following the inspection, the registered manager told us this training would be booked.

Staff working with other agencies to provide consistent, effective, timely care
• People had access to health professionals when required. Staff worked with a range of other professionals, including GPs, district nurses, speech and language therapy and social workers. A relative told us, "District nurses and doctor's appointments are made in a timely manner."
• People had a hospital passport. Hospital passports provide hospital staff with important information about people.

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

• Peoples' rooms were personalised and individually decorated with things important to them, for example TV's, gaming equipment, pictures, and photographs.
• The lounge was spacious and this and a conservatory provided people with appropriate communal space.

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 providers quality and assurance and governance arrangements at Maple View were not reliable or effective in identifying the shortfalls in the service. Systems and processes to assess, monitor and improve the quality and safety of the service did not pick up the concerns identified during this inspection.
• The provider made visits to the service and following the inspection we were sent copies of these. These records were basic and did not identify any of the concerns found.
• The provider held meetings with their manager's. However, minutes of these meetings were not shared with the registered managers in a timely way and actions highlighted were not routinely followed up and addressed. Meeting minutes were only forwarded to managers as a result of inspections completed to all of the provider's services.
• This lack of effective oversight and governance by the provider and registered manager has resulted in breaches of regulatory requirements relating to consent, risk management, safeguarding, meeting people's nutritional needs and governance.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Care was not being provided in keeping with the CQC's Right Support, Right Care, Right Culture guidance, or other national best practice guidelines to meet people's needs in this type of specialist setting.
• Staff were not given honest feedback about how they were performing and where improvement was needed. The registered manager informed us of concerns they had in relation to staff performance, however supervision records did not provide any detail as to how this was being addressed or monitored.
• There was a blame culture evident with the registered manager telling us the relationship between day and night staff had broken down but did not explain how they planned to resolve this or what action they were taking except they had asked for support from the provider who was currently not able to travel.

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
• The provider failed to understand their legal responsibility to keep people safe from the risk of harm. The registered manager was unable to meet their duty of candour responsibilities as some incidents were not being identified or escalated. This meant they could not be acted upon openly and transparently.

Effective systems to monitor and improve the quality of the service, were either not in place or robust

enough. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we recommended that the provider's quality monitoring include evidence of discussions with people who used the service, relatives and staff with actions planned in response to feedback received. This recommendation had been partially met as whilst the service was now recording feedback, more work was required on the action plans created following this feedback particularly in relation to staff feedback as recorded below..

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Quality assurance questionnaires had been completed with people using the service and responses were positive.
• Staff questionnaires had also been sent out recently and contained an action plan. Some of the questions did not respond to the key used which was a 1-5 scoring system with 1 being poor and 5 being excellent. One of the questions recorded, "Do you feel that expectations are set too high and cannot be achieved?" This did not correspond or match the 10 questionnaires viewed where some staff had used the scoring system to answer this question and 2 staff had circled a 1 being poor. The action plan recorded all staff had answered 'No' to this question and failed to explain or address why 2 staff had circled poor. Other responses from staff were positive.
• There was mixed feedback from relatives in relation to communication at the service. A relative told us, "I get a phone call of updates, as well as verbal feedback when I am at the location, they informed me that they were decorating and [family member] room would be moved. [Family member] was happy with this too." Another relative said, "They don't keep me informed of anything going on at the service, no newsletter. There is a noticeboard at the front entrance, but it rarely gets seen as the entrance I use is around the back and the noticeboard usually has hardly anything on it when I do catch sight of it. It is a good place, but they have a problem with communication, which should be better."
• Relatives overall were positive about the service. A relative told us, "Staff are really friendly. So far, [family member] has been bowling, swimming. They love the hot tub." Another relative said, "I would highly recommend the location, [family member] has been so happy since they have been there. I have spoken to the manager many times and have a good relationship with them."

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 Failure to follow the principles of the MCA was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 risks were effectively assessed or mitigated. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure systems and processes were in place to safeguard people from the risk of abuse. This is a breach of Regulation 13 (safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional needs were not being met.

This demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.