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Maddalane Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

We carried out a comprehensive inspection on 05 August 2016 and the service was placed into 'special measures'. We asked improvements to be made to ensure people's care records were accurate, changes to people's health was referred to relevant external services promptly and people were protected from risks associated with their care. We also asked that people's medicines were managed safely, infection control practices were adhered to and people's human rights were protected. In addition, we requested effective governance systems were put into place to assess, monitor and improve the ongoing quality of the service, and that the provider informed the Commission of all significant events in line with their legal obligations.

Action was also required to improve the leadership and culture of the service, social activities and vary food choices, protect people's privacy and dignity, review staffing levels, respond promptly to people's changing care needs, work in collaboration with external professionals, and learn from mistakes and safeguarding investigations.

We carried out a focused inspection on 06 December 2017 this was because we had received concerns in relation to the management of the service, medicine administration, and the recruitment of staff. We were also told the temperature of the service was not always warm, and people were not being supported safely with their moving and handling needs. The provider was requested to take action to improve the management of people's medicines, ensure people were protected from risks associated with their care and address the recruitment practices of staff; As well as taking action to improve the leadership and culture of

the service, to inform the Commission of significant events and implement effective governance systems.

Following both inspections, the provider sent us action plans telling us how they intended to meet the associated regulations. During this inspection we looked to see if improvements had been made. We found some action had been taken, but further improvements were required.

We carried out an unannounced comprehensive inspection on 30 May 2017. Prior to our inspection the Commission had received concerns that people were being unsafely supported with their mobility, food was not always handled hygienically and people were not always spoken to in an adult manner.

Maddalane Care Home provides care and accommodation for up to 14 people. The service is on two floors, with access to the upper floor by stairs or a stair lift. Shared facilities include bathrooms, a lounge, a dining room, and a conservatory and patio area. All bedrooms have en-suite facilities.

On the day of the inspection there were only two people living in the home because the local authority were not commissioning with the service. The local authority safeguarding team had an adult protection plan in place to make sure people were receiving safe care. This meant people were being visited three times a week by local authority care staff.

The provider managed the service and was registered with the Care Quality Commission. However, had employed a new manager and deputy manager to assist them with the day to day running of the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always protected from risks associated with their care. For example, risk assessments were not always in place to provide guidance and direction to staff about what action to take and staff had not always received essential training in order to keep people safe. This meant people were at risk of not being supported safely. People's medicines were not always managed safely despite the provider introducing a new medicines system, a new policy and a quality checking process.

People's care plans had been re-written since our last inspection to help ensure they provided guidance and direction to staff about how to meet their individual needs. Staff, told us they felt people's care plans were now much improved and were reflective of the care people required. However, although action had been taken to make improvements, some care plans still did not provide staff with accurate information about how to meet people's needs. This meant people's needs may not be met consistently.

People lived in an environment which had been assessed to ensure it was safe. However, training courses relating to the health and safety of people had not been completed by all staff. The provider told us related subjects were covered in staff inductions, but future training courses would be booked in order to make sure staff were fully trained to meet people's needs.

People and their families told us they felt safe living at the service. People were supported by sufficient numbers of staff to meet their needs. Recruitment checks were carried out to ensure staff working with vulnerable people, were suitable. However, gaps in employee's previous employment were not always scrutinised.

People were protected from abuse because staff knew what action to take if they were concerned about a person's wellbeing. The provider had implemented a safeguarding audit to help identify themes to ensure improvements were made within the service. However, the provider and new manager continued not to

learn from safeguarding investigations in order to keep people safe.

People were protected by infection control practices. The service was free from odour. The kitchen had been awarded five stars. The highest rating available. However, the provider's quality checks had not identified leftover food was not always dated when placed into the fridge.

People and relatives told us staff looked after them well. People and relatives told us staff looked after them well. However, all staff were not always trained in subjects specific to people's individual needs. For example, dementia, nutrition, skin care and to respond to certain types of seizures. Following our inspection the provider told us immediate action had been taken and training had been booked.

People's human rights were protected. People's care plans recorded their mental capacity. People's consent to care was obtained. People and or their families had been involved in reviewing their care plans and had consented to the care and support they were receiving.

People were supported to eat and drink and were offered a variety of different meals. People's changing health care needs were not always recognised and responsive action was not always taken to involve external professionals as necessary. Clinical decisions were not always made in consultation with external professionals.

People and their relatives were complimentary of the caring ethos telling us, "Very good here, it's a nice home". Staff spoke respectfully to people and in an adult manner. People's privacy and dignity was respected. People's family and friends could visit at any time and were warmly welcomed by staff. People and / or their families told us they felt involved in decisions relating to care and support, and their views were respected.

People's social activities were tailored to their individual preferences. Volunteers had been engaged to improve the quality of the social care provided.

The provider had a policy to help investigate complaints effectively. The new manager told us they would ensure the policy was in a suitable format for everyone to understand.

The provider's new monthly audits had failed to effectively assess and monitor the service, in order to help identify areas requiring improvement. Policies and procedures were being re-written and staff were being asked to read and sign to confirm their understanding, however these were not always being followed.

The new manager was engaging with people and their families, and there was a suggestions box in place. Families told us they were happy with the leadership of the service and told us they were seeing some positive changes to the service.

The provider and management team were honest and engaged with the inspection process and they told us they were committed to improve the service. The provider had improved their knowledge of when to notify the Commission in line with their legal obligations.

We found breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

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.

People were not always protected from risks associated with their care.

People's medicines were not always managed safely.

People were supported by sufficient numbers of staff to meet their needs. Recruitment checks were undertaken, however gaps in previous employment were not always scrutinised meaning that staff were not always robustly assessed to ensure they were suitable to work with vulnerable people.

People were protected from abuse because staff knew what action to take if they were concerned about a person's wellbeing. However, the provider continued to not learn from safeguarding investigations in order to keep people safe.

People were protected by infection control practices. The service was free from odour.

Is the service effective?

Inadequate

The service was not effective.

People did not always receive care from staff who had undertaken training to be able to meet their individual needs.

People's changing health care needs were not always recognised and responsive action was not always taken to involve external professionals as necessary.

People were supported to eat and drink, however people's care records were not always reflective of the care and support they required. This meant staff did not always have up to date information about the best way to support people in order to meet their individual needs.

People's human rights were protected by the Mental Capacity Act 2005. People's consent to care was obtained.

Is the service caring?

Good

The service was caring.

People and/or their loved ones were involved in making decisions about their care and support.

People's privacy and dignity was promoted.

People and their families, told us staff were kind and caring.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

People had care plans in place which provided guidance and direction to staff about how to meet their individual needs. However, care plans were not always effectively updated to ensure they were reflective of people's current care needs.

People's social activities were tailored to their individual preferences.

People's complaints would be used to improve the service and the provider had a policy to help investigate complaints effectively.

Is the service well-led?

Inadequate

The service was not well-led.

Despite assurances, the provider had not met all of the previous breaches of regulation; therefore the service remained in 'special measures'.

People were not protected by the provider's systems and processes to help ensure the quality of their care was monitored.

The provider did not have robust governance system in place to help drive continuous improvement.

The local authority had lost confidence in the provider and was no longer commissioning placements at the service.

People were living in a service which was now being managed by a new manager.

The provider had improved their knowledge of when to notify the

Commission in line with their legal obligations.

Maddalane Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the care home unannounced on 30 May 2017. The inspection team consisted of one adult social care inspector and a pharmacy inspector.

Before our inspection we reviewed the information we held about the home. We reviewed notifications of incidents that the provider had sent us since our last inspection. A notification is information about important events, which the service is required to send us by law. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted Healthwatch Plymouth, and spoke with the local authority safeguarding and quality assurance and improvement teams (QAIT).

During our inspection, we spoke with two people living at the service, one relative, a member of care staff, the deputy manager, the manager, the business manager and the provider. We observed care and support. We spoke with people in private and looked at two care plans and associated care documentation. We assessed the environment for safety and infection control prevention and looked at training records and catering records. We also looked at three recruitment files, medicine administration records, policy and procedures and quality assurance checks.

Following our inspection, we also contacted a relative, a GP practice and a district nurse to obtain their views about the service.

Inadequate

Is the service safe?

Our findings

At our last inspections on 05 August 2016 and 06 December 2017 we asked the provider to make improvements to ensure people's care records were accurate and people were protected from risks associated with their care. We also asked that people's medicines were managed safely, infection control practices were adhered to, staffing levels were reviewed, staff were recruited safely and that the provider worked in collaboration with external professionals to learn from safeguarding investigations. During this inspection we looked to see if improvements had been made. We found some action had been taken, but further improvements were still required.

Prior to our inspection we had received concerns that people were being unsafely supported with their mobility and that food was not always handled hygienically.

People were not always protected from risks associated with their care. For example, people who were at risk of seizures did not have risk assessments or a care plan in place to provide guidance and direction to staff about what action to take should this occur. Whilst this person had not suffered from seizures since moving into the service, staff had also not received training in respect of how to respond to such an event and when we spoke with staff about what action they would take staff provided us with inconsistent answers. This meant people were at risk of receiving unsafe care which may not meet their needs. This meant people were at risk of receiving unsafe care which may not meet their needs.

People who were at risk of losing weight were weighed and records were kept to determine if any action should be taken. However, when people had lost weight, action had not always been taken to seek medical advice to determine the reasons for the weight loss. For example, one person had lost weight but instead of contacting the person's GP, the provider had made their own judgement that the cause of the weight loss had been the result of the person being unwell. In addition, their care plan and associated risk assessments had not been updated to reflect the recognised weight loss. This meant staff did not have the correct information as to how to support the person. Following our inspection a community nurse told us, they had since visited the person and as a result of their visit they had requested the person was to be weighed weekly and nutritional supplements had been ordered. The community nurse told us, advice should have been sought sooner to enable pro-active action to have been taken.

People who had skin prone to bruising or who were at risk of skin damage, had body maps in place to help monitor any deterioration. However, people's risk assessments and care plans were not always accurate and at times, were conflicting. For example, one person's skin integrity care plan stated the person was "Not at risk of developing pressure sores", whilst their waterlow risk assessment detailed the person was "At risk". Depending which document staff read, this meant the person was at risk of not being provided with the correct care. A community nurse told us the provider had not been pro-active in recognising repositioning charts were required to monitor one person's skin. They explained, they had spent time talking to the provider and new manager about the reasons why these needed to be in place. Following our inspection we were provided with copies of repositioning charts which the provider told us had already been in place at the time of our inspection. However, the forms did not detail what repositioning had taken place, this meant

staff would not know what parts of the person's body may likely be exposed to the risk of pressure.

People had risk assessments in place to help support staff with their mobility. Risk assessments detailed the numbers of staff required and the equipment used, such as hoists and stand aids, and people's care records confirmed they were supported in the correct way. However, one person's mobility had changed three weeks prior to our inspection, which meant they now required more support from staff. Although staff knew how to support this person, their risk assessment and care plan had not been updated to reflect the changes in staffing support. This meant the person was at risk of not being supported in a safe and consistent manner. A community nurse who had recently visited this person, told us a referral should also have been made to an occupational therapist, to ascertain if the person was still being correctly and safely supported. As a result of their visit they made a referral on behalf of the provider, to relevant external services.

People who were at risk of falls had risk assessments in place to help mitigate associated risks. When a person had fallen proactive action had been taken to try and reduce them from falling again. For example for one person, a sensor mat had been put into place to alert staff when they were getting out of their bed. However, when a person had fallen, risk assessments were not promptly updated, therefore not ensuring they were reflective of the care and support the person required. For example, one person had fallen on 28 April 2017 but their risk assessment had not been updated until two weeks later. This meant staff did not have the most up to date recorded information to enable them to know how to support the person safely.

The provider did not take responsive action in order to keep people safe. People's risks associated with their care had not always been assessed and documented to help staff know how to mitigate risks associated with people's care. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not always managed safely. The provider had introduced a new system to manage people's medicines. Medicines were administered to people individually, directly from original packs or from pharmacy prepared medicine pods. These pods contained people's regular medicines and were individually labelled with the person's name; the quantity, name and strength of the medicine and the date and time they should be given. Staff explained they thought this system helped them to give all regular medicines safely. However, we saw one medicine, which should be given on an empty stomach at least 30 minutes before food or another medicine, was given with all other medicines after breakfast. When asked, staff told us as the medicine was in the morning pod they thought it was safe to give with all the other medicines after breakfast. This meant people were not receiving their medicines in line with prescribing guidance and staff were relying only on the pharmacy to ensure people's medicines were correct.

People were prescribed medicines to be taken when required, such as paracetamol. Although, staff could explain when they might offer these medicines to people, there were no care plans in place to provide information to guide staff in their administration; such as what symptoms to look for, the gap needed between doses or the maximum dose. Staff did not monitor or record the outcome of giving a 'when required' medicine, so could not be sure that it was effective. This meant people may not receive their medicines when they actually required them, for example to help manage pain.

People's medicine records were not an accurate account of the medicine they had taken. One person had recently had their medicines reviewed by their GP and some medicines had been stopped. The medicine administration record (MAR) had been amended to show they had been stopped and included the name of the GP and the date. These pods had been returned to the pharmacy so the medicines could be removed. However, we saw the MAR for another medicine also said "Stopped" when in fact it was to continue. Neither staff nor the provider could identify who had written this amendment to the MAR. Staff said this medicine

was given to the person for three days but the MAR was not been signed to show it had been administered.

Medicines were checked for accuracy and recorded when they were received by the service. However, these checks were not also carried out robustly to ensure people were being given the correct medicines. For example, one person used an inhaled medicine, but the MAR did not accurately document the device or the strength of the medicine actually being administered. During the inspection, staff contacted the pharmacy to make sure they were using the correct device at the right dose, and the pharmacy issued a corrected MAR.

People's care plans contained some information for staff, about the way people would like to take their medicines, but the information was not always accurate. This meant people were at risk of not being supported correctly and safely with their medicines. For example, people had medicines lists dated 03 April 2017 in their care plan, but this list did not match their current list of medicines on their MAR. One person's care plan said they had no medicines allergies, yet their MAR showed they were allergic to an antibiotic. For one person who was refusing medicines, a meeting had been held the week prior to the inspection between the service, the GP and a family member. It was decided that it would be in the person's best interest to give their medicines disguised in food (covertly) if needed, rather than them not taking them at all. Since the meeting the person had not refused their medicines, however, if staff had needed to give the person their medicines covertly, there was no information in the person's care plan about how medicines should be given and whether they had been checked to be sure they were safe and effective when mixed with food.

Training records showed staff had received training to administer medicines and were checked by the registered provider to show they were competent to undertake the medicines tasks asked of them. However, the provider themselves, had not had their competency to administer medicines checked. This meant staff may be given advice by the provider, which may not be in line with best practice.

There was a new medicines policy which had been written to underpin practice and all staff had signed to confirm they had read it. However, the policy did not reflect the new medicine system which had been implemented. In addition, the policy made reference to the importance of checking in supplies of medicines, the correct completion of MARs, and making sure people's care plans were accurate and updated following medicine changes. This demonstrated staff, were not following the provider's new medicine policy, regardless of confirming they had read it.

The provider had a medicines error and near miss reporting form, but we were told there had been no errors or near misses which had taken place. However, we saw a staff member had identified a mistake made by the pharmacy which would have meant a person received their medicine at the wrong time. This had been corrected by the service but had not been recorded as a medicines error. This meant the service might not have identified any learning from this.

The provider had implemented a new monthly medicines audit in April 2017 in order to identify any issues and raise quality. However, the audit had failed to identify the areas requiring improvement found during our inspection.

People's medicines were not always managed safely and their medicine records were not always accurate. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had care plans in place to provide guidance and direction to staff about where and when to apply people's topical medicines (creams or gels) and people's MARs were signed when they had been applied.

Medicines were stored securely at the correct temperatures. Suitable arrangements were in place for medicines that required additional security.

People lived in an environment which had been assessed to ensure it was safe. Fire tests were carried out and equipment was serviced in line with manufactures requirements. However, people did not have personal emergency evacuation plans in place (PEEPs). PEEPs help to give a summary of people's individual needs for the emergency services in an event such as a fire. The new manager told us she was in the process of creating these documents, but in the meantime we were told by the provider that in the event of a fire information about people's mobility needs were in a fire evacuation file.

Training courses relating to the health and safety of people, such as fire, food hygiene and safety, moving and handling and infection control had not been completed by all staff. The provider told us these subjects were covered in staff inductions, but future training courses would be booked in order to make sure staff were fully trained to meet people's needs.

People and their families told us they felt safe living at the service. One person told us, if they did not feel safe they would tell their family.

People were supported by sufficient numbers of staff to meet their needs. People's needs were taken into consideration in determining staffing levels. For example, one person told us, their mobility needs were met safely by two members of staff, both day and night. Recruitment checks were carried out to ensure staff working with vulnerable people, were suitable. For example, Disclosure and Barring Service Checks (DBS) had been applied for prior to staff commencing their employment. However, gaps in employee's previous employment were not always scrutinised. The provider told us, they would update their recruitment policy and amend their application form to ensure this took place.

The provider had implemented a safeguarding audit to help identify themes to ensure improvements were made within the service. However, the provider and new manager continued to not learn from the outcomes of previous safeguarding investigations in order to keep people safe. People's care plans and risk assessments were still not an accurate reflection of their care and some clinical decisions were still being made in isolation.

The kitchen had been awarded 5 stars by the Environmental Health (the highest award). Cleaning schedules and temperature checks were in place. However, leftover food was covered but not always dated when placed into the fridge, despite the provider's protocol for the safe storage of food being displayed on the fridge. The provider explained food was always checked at the end of each day to ensure it was dated, however the checks from the previous day had failed to identify some food which had not been dated.

People were protected from abuse because staff knew what action to take if they were concerned about a person's wellbeing. Staff had received safeguarding training and the provider had a policy in place to help support staff to take action. Staff felt confident action would be taken by the new manager or by the provider.

People were protected by infection control practices. The service was free from odour. The provider had devised a new infection control and laundry policy, and had implemented a new infection control audit to help identify when improvements were required. Staff were observed to wear personal protective equipment (PPE), such as gloves and aprons and were able to tell us how they handled soiled laundry in line with the new policy.

Inadequate

Is the service effective?

Our findings

At our last inspection on 05 August 2016 we asked the provider to ensure people's human rights were protected and that people's nutritional needs were recorded accurately in their care records. We also asked that changes to people's health were referred promptly to relevant external services, and that people were provided with more food choices. During this inspection we looked to see if improvements had been made. We found some action had been taken, but further improvements were still required.

All staff were not always trained in subjects specific to people's individual needs. For example, dementia, nutrition, skin care and to respond to certain types of seizures. Following our inspection the provider told us immediate action had been taken and training had been booked.

Staff joining the organisation undertook an induction which had been designed by the provider. However, the providers training records showed that five out of six staff had not completed an induction prior to supporting people the service. The care certificate had not been incorporated into the provider's induction, but the new manager told us this would be implemented in the future. The care certificate is a national induction, and aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care.

People were not always supported by staff who had the skills and qualifications to meet people's needs safely. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us they felt staff looked after them well. The providers training records showed staff had completed a variety of courses, some of which included, moving and handling, first aid, medicine management, and safeguarding.

People's care plans provided staff with guidance and direction about how to support people, and when required, daily records recorded the amount of food and drink people were consuming. However, when external professional guidance had been provided, such as specialist dietary plans, this had not prompted the review of people's nutritional care plans to help ensure staff had the most up to date information to be able to meet people's needs effectively.

People's care plans were not always reflective of how their nutritional needs should be met. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to eat and drink and were offered a variety of different meals. Individual discussions took place with people to ensure the meals provided met with their preferences. People were provided with the equipment they required, such as large handled cutlery, to enable them to eat their meals independently.

People's changing health care needs were not always recognised and responsive action was not always

taken to involve external professionals as necessary. For example, one person's mobility had been deteriorating since 06 March 2017 however the persons care records detailed that the provider had not discussed this with the persons GP until 08 May 2017, when a referral to a reablement team was made. The person's mobility continued to deteriorate during this time however the reablement team referral which had been made on 08 May 2017 had not been followed up by the provider. A community nurse told us there had been a delay in the provider reporting the changes. Following a visit to the service, the community nurse took action and requested the provider updated care records; and a referral to the occupational health team was requested. A community nurse expressed that this action should have been taken by the provider and not by external health professionals.

Care plans for people living with dementia did not always detail information which would help trigger responsive action in order to contact necessary external health care professionals. For example, we were told one person may become increasingly verbally or physically aggressive towards staff if their mental health was deteriorating. However, the specific action which may be required of staff was not documented. This meant there could be a delay in the person receiving the necessary professional support.

Clinical decisions were not always made in consultation with external professionals. For example, a specialist mattress had been implemented for one person because staff had recognised the person was staying in bed more frequently, and that their muscles were becoming stiff. Whilst, this decision had been made in order to protect the person, the type of mattress had not been discussed with nursing staff nor had a referral been made to carry out a clinical needs assessment. This meant we were unable to determine if the person's individual needs were being suitably met. The provider told us that following our inspection they would contact community nursing staff to ensure professional advice was obtained. However, when we spoke with nursing staff seven days after our inspection, they confirmed a referral had not been made. As the provider had failed to take action, we raised a safeguarding alert with the local authority.

People's care plans did not always detail information in order for staff to take responsive action in conjunction with external advice. External health care professionals were not always consulted in decisions relating to people's care. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to access health and social care services to promote their ongoing health and wellbeing. People's care records detailed when GP's, district nurses, mental health staff, or chiropodists had visited the service. A GP told us communication had improved and staff had been contacting them and following advice given.

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

When someone did not have the mental capacity to make certain decisions, such as in respect of their personal care this was detailed within their care plan to enable the person to be supported effectively.

Where decisions were being made for people, there was evidence to show best interests meetings had taken place to ensure the least restrictive options were considered. For example, a meeting had been held to discuss making changes to a person's medicines. Not all staff had received training in respect of the legislative frameworks but did have an understanding of what mental capacity meant, and how this impacted on the care and support they provided to people. Deprivation of Liberty Safeguards (DoLS) applications had been made to the supervisory body when necessary and the details were recorded in people's care plans.

People's consent to care was obtained. People and or their families had been involved in reviewing their care plans and had consented to the care and support they were receiving. One person, had recently moved bedrooms but did not had the mental capacity to agree to the move so a meeting had taken place to ensure that it was in the persons best interests.

Good

Is the service caring?

Our findings

At our last inspection on 05 August 2016 we asked the provider to improve the culture of the service to ensure all staff provided people with compassionate care. We also requested people's privacy and dignity were respected. During this inspection we looked to see if improvements had been made and found action had been taken.

Prior to our inspection the Commission had received concerns that people were not always spoken to in an adult manner.

People and their relatives were complimentary of the caring ethos telling us, "Very good here, it's a nice home", "All the staff take time to come in and sit with my mum and talk to her which she enjoys very much" and "The reason I chose Maddalane in the beginning was because it felt like a home from home, the staff were and are genuine… Our mum is very happy there which makes us happy". Staff described the service as being like a family.

During our inspection all staff spoke respectfully to people and in an adult manner. People's privacy and dignity was respected, for example bedroom doors were closed when people were assisted with personal care. The provider no longer used closed-circuit television (CCTV) in people's bedrooms or within shared areas of the service. They explained they would like to re-install CCTV to external and shared areas of the building in the future, but would be following guidance to ensure people's ongoing privacy was respected.

The provider and new manager ensured staff culture was compassionate by monitoring staff practice; obtaining feedback from people as well as assessing an employee's values during the stages of recruitment.

People and their families were being asked to contribute to a 'life story book', to help capture what people had achieved in their life, prior to coming to live at the service. This would help to ensure staff were able to have meaningful conversations with people. One member of staff was already able to share their knowledge of one person's love of dogs, as they knew they had previously run a kennel.

People's family and friends could visit at any time and were warmly welcomed by staff, who offered tea or coffee on their arrival. One relative told us, "We visit our mum every day and are always greeted with a smile at the door, offered drinks during our stay and someone always pops in for a chat which is really nice".

People and or their families told us they felt involved in decisions relating to care and support, and their views were respected. One person told us how staff were vigilant in recognising if they needed to see a GP and discussed this with them, before taking any action.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 05 August 2016 we asked the provider to ensure people's care records were accurate and social activities met with people's wishes and preferences. During this inspection we looked to see if improvements had been made. We found some action had been taken, but further improvements were still required.

People's care plans had been re-written to help ensure they provided guidance and direction to staff about how to meet their individual needs. Staff, told us they felt people's care plans were now much improved and were reflective of the care people required. The new manager explained of the hard work which had been put in to make the necessary improvements. This had included speaking with people and their families to make sure care plans met with people's needs, wishes and preferences.

However, although action had been taken to make improvements, some care plans still did not provide staff with accurate information about how to meet people's needs. For example, one person had recently been diagnosed with a urinary tract infection and the person had been prescribed and had been taking anti-biotics. However, their continence and nutritional care plans had not been updated to ensure staff were aware of this and the impact on the person's care delivery.

People's care plans were not always reflective of how to meet their health care needs. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the provider submitted a copy of a new nutritional care plan which had been written and implemented.

People's daily care records were now a more detailed account of the care they were receiving, this helped to ensure people's care plans were being followed and to highlight if any changes to their care was necessary.

People's social activities were tailored to their individual preferences. Volunteers had been engaged to improve the quality of the social care provided. One person's daily records showed they had been participating in knitting, reminiscing, watching films and board games. During our inspection, one person was supported into the garden to enjoy the sunshine.

People told us staff were respectful of when they wanted to spend time on their own. One relative told us, "Our mum is very happy and enjoys interaction with the staff but also enjoys staying in her room. She is encouraged to go to the dining room or if the weather is nice to go outside but she would rather stay in her room…she is encouraged to join in with activities".

Since our last inspections, the provider had not received any complaints, but told us people's complaints would be used to improve the service. The provider had a policy to help investigate complaints effectively which people received a copy of, when they moved in. The new manager told us they would ensure the policy was in a suitable format for everyone to understand.

Inadequate

Is the service well-led?

Our findings

At our last inspections on 05 August 2016 and 06 December 2017 we asked the provider to make improvements to the leadership and culture of the service, ensure effective governance systems were put into place to assess, monitor and improve the ongoing quality, and that the provider informed the Commission of all significant events in line with their legal obligations. During this inspection we looked to see if improvements had been made. We found some action had been taken, but further improvements were still required.

We were told by the provider at the beginning of our inspection that they felt the previous breaches in regulations had been met, however this was not the findings our inspection.

The new manager and provider had created a monthly auditing system to help monitor the quality of care people received and to help drive continuous improvement. Some of which included, care plans, medicines, recruitment, infection control, catering, accidents and safeguarding audits. However, these audits had failed to identify when action was required in respect, of the management of risk, the accuracy of people's care records, staff training, medicines management and the safe storage of food. The provider had also devised a new quality assurance policy which stated, "These (audits) provide statistical information for the home manager and the registered provider to review the incidence of key quality indicators in the home to analyse and review working practices". However, as the providers audits had failed to identify areas requiring improvement, this demonstrated the policy was not effective or representative of current practice.

A local authority quality assurance and service improvement plan had been in place since September 2016 which the provider told us was now complete. However, some areas identified at our inspection as needing improving were also identified within the improvement plan, therefore determining that the improvement plan had not yet been met. For example, further action had been requested in respect of risk assessing, weight management and quality assurance.

The provider did not have systems and processes in place to ensure the ongoing monitoring and quality of the service. The provider did not seek and act on feedback from external professionals in order to improve the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The local authority had made a decision in December 2016 to no longer commission placements at the service.

As part of a local authority safeguarding adult protection plan, local authority care staff were visiting three times a week to ensure people's ongoing safety and to maintain a continued overview of the service.

The provider had made changes to the management structure. A new manager and deputy manager had been employed to support them with the day to day management of the service. The new manager, who had been employed since April 2017, was described by staff as "approachable". Staff also expressed they felt

there was a noticeable improvement at the service, this included a change of atmosphere and to the quality of people's care records. The new manager explained they had previous experience of managing services which required improvement and they were passionate about making things better.

The provider had not undertaken a formal documented induction when the new manager had commenced employment, but instead had introduced the new manager to policies and to fire procedures. Despite this, the new manager told us they felt well supported by the provider and the business manager.

The provider did not have a documented action plan in place to help capture the previous beaches of regulation, but told us they met with the new manager on a weekly basis to provide them with tasks for the week ahead. The new manager told us this was helpful and used a diary to note immediate actions taken and improvements made.

Policies and procedures were being re-written and staff were being asked to read and sign to confirm their understanding. To ensure staffs understanding, the new manager had introduced a policy of the week, meaning a policy was discussed on a weekly basis with staff at daily handover to ensure their ongoing competence.

During our inspection we found the provider and management team were honest and engaged with the inspection process. The provider and business manager told us they were committed to improve the service. They explained that on reflection, they now recognised the service did require improving, and that whilst some improvements have been made and that changes to the staff team have helped to raise standards, they recognised there is still work to be done.

The provider had improved their knowledge of when to notify the Commission in line with their legal obligations. They had done this by creating a prompt sheet to remind them when a notification was due, so as not to rely on advice from external professionals.

The provider had displayed their latest rating in line with legislation and in order to obtain feedback about the service, the new manager was engaging with people and their families, and there was a suggestions box in place. The new manager told us family forum meetings were also going to be arranged for the future. Families told us they were happy with the leadership of the service and told us they were seeing some positive changes to the service.

Staff told us they would feel confident to whistleblow to the provider or new manager if they had any concerns about staff conduct or poor practice.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not take responsive action in order to keep people safe. People's risks associated with their care had not always been assessed and documented to help staff know how to mitigate risks associated with people's care. People's medicines were not always managed safely and their medicine records were not always accurate. People's care plans did not always detail information in order for staff to take responsive action in conjunction with external advice. External health care professionals were not always consulted in decisions relating to people's care.

The enforcement action we took:

We have issued a notice of decision (NOD) to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's care plans were not always reflective of how to meet their health care needs. People's care plans were not always reflective of how their nutritional needs should be met. The provider did not have systems and processes in place to ensure the ongoing monitoring and quality of the service. The provider did not seek and act on feedback from external professionals in order to improve the service.

The enforcement action we took:

We have issued a notice of decision (NOD) to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not always supported by staff who

had the skills and qualifications to meet people's needs safely.

The enforcement action we took:

We have issued a notice of decision (NOD) to cancel the provider's registration.