Devon County Council

Mapleton

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires Improvement
Is the service effective?	Inadequate
Is the service caring?	Good
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We inspected Mapleton on the 24 and 26 of February 2015. The inspection was unannounced and was undertaken as we had received information of concern in relation to care of people at the home as the result of an ongoing safeguarding process.

Mapleton is a care home without nursing, operated by Devon County Council (DCC). It is registered to provide care for up to 20 people. In 2014 the home was redeveloped as a "Centre of Excellence" for people with dementia. This included a re-design of the home, based on good practice advice with regard to the care of people with dementia. The home now provides two units of 10 single bedrooms with en-suite facilities, each having their own dining and lounge areas. Communal areas in these units have been designed to be homely and domestic in feel, and support people with dementia to orientate themselves independently. In addition there is a landscaped garden with sensory areas and a large communal room on the ground floor.

The registered manager was not available during the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Management cover was being provided by an interim manager from another home operated by Devon County Council which was in the process of a planned closure. The interim manager had only been at the home for just over a week when we began the inspection, but had already made an application to have this location added to their registration to ensure that they were legally responsible for the operation of the home in the absence of the registered manager. They were at the home for both days of the inspection.

People were not protected against the risks associated with their care. Risk assessments were not being completed properly and actions were not always taken to address risk when risks were identified. We found some people did not receive the safe care they needed as a result.

There was poor monitoring of people's eating and drinking which put people who used the service at risk of inadequate hydration and nutrition. We found that people had been put at risk because action plans had not been put in place to assess weight loss or constipation.

The home did not always respond to people's specific or individual care needs. We saw that some referrals to community healthcare or other services had not been made and that care recommended for individuals had not always been carried out. People who presented challenges to their care did not always have this reflected in their care planning. Staff did not have clear and consistent strategies for managing behaviours that presented challenges.

Medication systems were not being managed well enough or reviewed regularly to ensure that people received the medication they needed in a safe way.

Staff were not all working consistently to support people, did not all have the skills or knowledge to support people effectively. They did not understand people's rights under the Deprivation of Liberty Safeguards. One person had not been properly assessed for their capacity to consent to a forthcoming medical procedure and no best interests decision had been undertaken. The CQC had not been informed about the authorisation of a Deprivation of Liberty Safeguard for a person who lived at the home.

Records were not well managed or used. Care files were overly large documents that contained out of date or inappropriate information, such as information on old hospital appointments. Information was difficult to locate and was in places contradictory. This left people at risk of unsafe or inappropriate care as staff could not easily locate information about people's needs or trace through the care that they had received.

There was a lack of understanding and clarity over the ethos and philosophy of the service throughout the staff team. Although changes had been made to the building in line with best practice, changes in other areas such as care planning were not well developed. This led to conflict in how the unit was working.

Quality assurance systems and monitoring systems were not working well. This meant that learning did not take place over incidents and people were not being protected from inappropriate or unsafe care.

Staff had received training in care, and there were enough staff on duty to support people and meet their needs.

The home's recruitment systems helped ensure people were cared for by staff who were suitable to be working with potentially vulnerable people, and staff had received training in how to protect people from abuse.

Staff had developed trusting and caring relationships with people at the service. We saw positive interactions between people with staff involving people in daily living tasks such as laying tables to help maintain their independence and self-esteem. Staff spoke about people affectionately and respectfully.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Risks to people's health and welfare were not always well managed.

The way that medicines were managed was not fully safe.

There were robust systems in place for managing safeguarding concerns and recruiting suitable staff.

Requires Improvement

Is the service effective?
The service was not always effective.

People's health and welfare needs were not always met.

Staff did not all have the skills or knowledge to support people effectively.

Staff did not understand people's rights under the mental capacity act and in relation to depriving people of their liberty.

Inadequate

Is the service caring?
The service was caring.

Staff had developed good and trusting relationships with people living at the home.

People's privacy was respected and staff engaged people in doing tasks that supported their independence.

Good

Is the service responsive?
The service was not responsive.

Staff did not always provide support in a person centred way.

Activities were not person centred and there was little information about the things that people liked to do.

Complaints and concerns were managed well, with clear systems and policies in place.

Inadequate

Is the service well-led?
The home was not well led.

Quality assurance and risk monitoring systems had not identified risks to people.

The intended ethos and philosophy of the service was not understood by all staff, and as a result was not borne out in practice.

Inadequate

Mapleton

Detailed findings

Background to this inspection

We inspected Mapleton on the 24 and 26 of February 2015. The inspection was unannounced and was undertaken as we had received information of concern in relation to care of people at the home. This had been identified as a part of an ongoing multi-disciplinary safeguarding process.

The first day of the inspection was unannounced and started at 7am in order to enable us to see the handover of information between shifts and see how duties were allocated to staff for the day. The inspection team comprised two adult social care inspectors 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. On this inspection the expert had experience of caring for and supporting people with dementia.

Prior to the inspection the provider had completed a provider information return or PIR. This asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the home before the inspection visit. We looked at the information we had received during an ongoing multi-disciplinary safeguarding process about the operation of the home and well-being of the people who lived there.

On the inspection we spoke with or spent time with 11 people who used the service, eight staff, the interim manager for the home, two senior managers and a visitor. Most of the people who lived at the home had some degree of dementia, and were not able to communicate with us in any depth about their experiences of being at the home. We spent time observing the care of people who were not able to communicate with us verbally, included observations over a mealtime, of medication administration and moving and handling practices. We also spoke with a district nurse who was based at the home carrying out assessments and monitoring people's healthcare needs during the safeguarding process.

We looked at 5 people's care plans in detail and other plans and records to check details of the care they received.

Requires Improvement

Is the service safe?

Our findings

We identified concerns with regard to the assessment and management of risk to people, and relation to how medicines were managed.

Risks to people's health and welfare needs had been identified. However, in some instances there was insufficient guidance for staff on how these risks should be managed. For example, three people had been identified as being at risk of developing pressure ulcers. The care plans for these people did not contain sufficient information to guide staff on how to prevent pressure ulcers occurring and their daily care records did not contain reference to their skin condition.

One person had developed a pressure ulcer in February 2015, as recorded on a 'body map', contained within their care plan. Their risk assessment had not been reviewed or updated in response to this. Their care plan did not include a plan about how to manage the person's pressure ulcer.

Other risks to people's health and well-being had been identified, however actions had not been taken to manage these risk. For example records relating to one person identified they were showing signs of being constipated over a period of time, before action was taken. Staff had not identified the significance of what they had seen and had not referred this person to their GP or to the district nurse for assessment.

We found that the registered person had not protected people against risks associated with their care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009, which corresponds to regulation 9 (1) (a) (b) and (c) and 3 (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of due to the lack of regular review and because of the way medicines were managed.

Some prescriptions were unclear or contained administration instructions that were contradictory to how they should be used. For example, one person's medicine records indicated they should have one of their medicines on a regular basis and as needed. We saw that some people were receiving dietary supplements, because they required additional calories to maintain their nutrition. However, these supplements are medicines and were not recorded in the medication administration records as they should be. Staff were not always recording when people had received and drunk these supplements, meaning it was unclear how much extra nutrition people were receiving, and if this was sufficient to support their nutritional needs.

There were some gaps on the medication charts where it was not possible to see if the person had received their medicine or not. A record showing staff signatures, which allowed the management team to identify which member of staff had administered medicines, was out of date. It did not include all the staff who were administering medicines. Some prescribed creams were not locked away as they should be.

We found that the registered person had not protected people against the risk associated with medicines. This was a breach of Regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2009, which corresponds to regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also saw good practice in relation to how medicines were managed. People's medicines were administered by senior staff who had received appropriate training to carry out the role. We saw the person who was administering medicines during our inspection was new to the home. They were ensuring that they gave the correct medicine to the correct person by checking each person against a photograph of the person which was contained in their care file. People were given time to take their medication and explanations about what the medication was for in an understandable way. An audit of medicines was being carried out by a senior manager.

There were suitable secure storage facilities for medicines which included secure storage for medicines which required refrigeration. The home used a blister pack system with printed medication administration records. Medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises.

Records relating to medicines that required additional security and recording showed these medicines were

Requires Improvement

Is the service safe?

appropriately stored, and clear records were in place. We checked records against stocks held and found them to be correct. Staff had access to a clear and updated medication policy and protocol.

Risks of abuse to people were minimised because staff had received training in recognising and reporting abuse. Staff had a clear understanding of what might constitute abuse and how to report it. The home had a comprehensive policy and procedure for the reporting of concerns about abuse and relating to whistleblowing. When safeguarding concerns had been raised, the service had taken immediate action to protect people and were co-operating fully with the investigations underway.

People were protected by safe recruitment procedures. We saw that there were robust recruitment procedures for new staff employed by the County Council. This included carrying out checks to make sure they were safe to work with vulnerable adults.

People were being supported by sufficient numbers of staff to meet their needs. However, staff did not always demonstrate they had the skills to fully support the people they were caring for. This including caring for people at risk of developing pressure damage and in responding to people whose behaviour might put themselves or others at risk.

Staff told us they did not always feel they had enough time as people's needs were increasing and they would like to spend more time speaking and engaging with people. However, we did not find evidence of this. People told us they felt safe at the home and with the staff who supported them. They said if they needed help or used their call bell they received this quickly. One said "The staff look after me very well. …I don't want for anything….the staff get anything I want." At the time of the inspection there were 17 people living at the home. Information in the PIR told us that staffing levels were monitored against the dependency levels of the people who lived at the home. This enabled them to make sure there were adequate numbers of staff to meet people's needs.

Inadequate

Is the service effective?

Our findings

We found that the service was not effective. We identified concerns in relation to the monitoring of what people were eating and drinking and the management of people's rights in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff did not all have the skills, or knowledge to support people effectively with regard to some aspects of their care.

Some people needed support to eat and drink. Staff had assessed that their food and fluid intake should be recorded. However, these records indicating people were not drinking enough to maintain their health. For example, it was recorded on one person's record that they had drunk only 200mls and sips of fluid in one day. Staff were not sure who was responsible for reviewing these records and there was no record of how much each person should drink in order to ensure they were hydrated.

Records showed one person had lost a significant amount of weight over a two month period from October to December 2014. Their care had been reviewed in December 2014 and the review stated that the person had had a "dramatic weight loss". However, no action was taken to deal with this. The nutritional risk assessment had not been updated since September 2014 and there was no action plan in place to investigate the concerns relating to this person's weight, or clear instructions for staff on how to manage them.

Nutritionally enhanced drinks were provided but on two out of three occasions for one person there was no record of how much of this had been taken. Records for one person showed they had eaten very little over a period of 4 days. Staff on duty were not aware of who was at risk of not eating enough. Catering and care staff said they had not received training in the nutritional care needs of people with dementia.

Although people had choices about what to eat, the way that these choices were presented might be difficult for people with dementia to understand.

Some people living at Mapleton had diabetes controlled in part by their diet. Their care records did not provide guidance for staff regarding how their diabetes should be monitored and whether blood glucose levels should be checked periodically. One person's notes indicated they should be checked 6 monthly. Their last test had been in April 2014 (10 months previously). The care plan for one person indicated they were a diabetic and that their diet must be "low in sugar". However it also stated that the person enjoyed fruit and liked to snack on "biscuits, chocolates and sweets". Catering staff told us low-sugar meal alternatives were not provided.

One person had been admitted to hospital with a bowel related health issue. We found staff did not have sufficient knowledge relating to bowel care or had not taken sufficient action to meet this person's needs. Advice from medical or nursing staff had not been taken in a timely manner. We asked the person in charge to take advice about one person's complex needs and they have confirmed this has been done.

The majority of the people who lived at Mapleton had some degree of dementia. Staff confirmed they had received training in supporting people with dementia; however, for some this had not been recent, and they said they would benefit from an update in training to care and support people with more complex care needs.

We saw staff lacked confidence and were not provided with strategies for working with people who presented challenges, for example with regard to people who called out or were resistant to receiving care. For example, we saw staff were hesitant in assisting someone who showed signs of becoming agitated. Some staff expressed concern over a person who called out throughout the day and they were unsure about how to manage this.

There was no evidence in people's files of staff monitoring behaviour in an attempt to identify what made it worse or what helped improve this: a timely referral relating to these behaviours had not been made to the Community Mental Health Team for advice and support.

One person had been seen by a physiotherapist in December 2014 and given exercises to do daily. On 20 February 2015 we saw that the person's care plan had been reviewed and there were instructions for staff that the person needed to do the exercises they had been given in December. There were no records to show these instructions had been followed. Staff told us they were not aware of the exercises to be carried out.

People who lived at Mapleton were prevented from leaving the home unaccompanied by the use of locked doors for their own safety. In order to do this lawfully this service had made applications for authorisation to do this from the

Is the service effective?

local authority's DoLS team. However, staff were not clear about the implication of the DoLS in relation to supporting people. They did not know who was subject to an authorisation or what this meant for the person concerned. People who lived at the home told us that they were not allowed out "in case I fall". We found that staff could not protect people's rights as they did not understand them. Staff had not notified the Care Quality Commission a DoLS re-authorisation had been granted.

Where significant decisions were made for people who could not make these decisions themselves, good practice was not always followed. For example, one person needed a medical intervention and staff had not followed the Mental Capacity Act code of practice in relation to this decision. Since our inspection staff have taken action to ensure that an appropriate assessment of this person had been undertaken, and a best interests decision process had taken place.

We found that the registered person had not informed us of a DoLS re-authorisation. This is a breach of Regulation 18 (4) (b) of the Care Quality Commission (Registration) Regulations 2009.

Mental capacity assessments had been undertaken for other people where their ability to consent or make decisions was impaired. These involved relevant people such as family and clinical professionals.

People said they enjoyed the meals, comments received included "the food is excellent", "the food is quite all right, "the food is perfect for me" and "they do the food very well here for all of us and we get a variety". One person said that the only complaint about the food was "there's too much". Staff said that drinks and snacks were available throughout the day and people could make their own drinks with assistance if necessary in the small kitchenette areas on each floor. We saw jugs of juice and water available in the lounge areas and staff encouraged people to drink throughout the day.

The premises had been designed in accordance with good practice. The home had recently undergone extensive refurbishment carried out in consultation with Stirling University, who provide specialist advice regarding the care of people living with dementia. However it had been identified that some of the equipment and furnishings were not suitable for the people being accommodated. For example we saw a review of one person's care, as a part of a more recent review, had indicated that different seating options were needed to support their care. Concerns had also been expressed over the beds in use. We saw that DCC were undertaking an assessment of this and had taken action to provide additional equipment from other homes that were closing to manage the concerns.

Both the ground and first floor units provided lounge, dining and kitchen areas, where people could make drinks and snacks for themselves their visitors, with the assistance from staff if necessary. Each floor had a quiet lounge room where people could meet their visitors or to spend time alone. On the ground floor a café / activities room provided a large comfortable area for activities and entertainment. There was also a library area and board games available.

All bedrooms had en-suite shower rooms and were furnished to a high standard with adapted furniture such as wardrobes with glass doors to allow people to see their clothes more easily.

Throughout the home doors were colour coded and signage was used to aid recognition. People were assisted to recognise their own room with the use of a photograph that means something to them, such as their dog or a picture they found attractive, such as butterflies.

The gardens were secure and attractive. Although the doors were locked, we saw staff accompanying one person out into the garden at their request. Staff said that during better weather the garden doors were left open for people to wander freely. Raised flower beds had been created to allow people to continue to garden more easily.

Staff training records showed that staff had received training relating to their roles and responsibilities. This included training to keep people safe including moving and handling, infection control, food hygiene and fire safety. In addition, records showed that staff had either completed or were undertaking training in health and social care.

These records also showed us that staff had received regular one-to-one supervision to allow them to review their work performance, including through direct observation, and to identify any training needs: annual appraisals were also undertaken to support staff's future development.

Good

Is the service caring?

Our findings

People said they were supported by kind and caring staff. We saw pleasant conversations and laughter whilst going about the home and during the period of direct observation.. Staff sat next to people, or crouched down to make eye contact before they initiated conversations. The way staff used photographs and other objects stimulated interaction with people and provided comfort. During lunch we saw staff assisted people who required help with their meal in a respectful and unhurried manner. People were encouraged to take their time over their meal and were seen to be in conversation with the staff and each other.

People said that they felt they were getting the care they needed and spoke well of the staff, one person said “the staff help me and assist me with my clothes as necessary”, another, “all the staff are very understanding”.

Staff coming on duty greeted people with hugs and caught hold of their hands. People told us that staff came quickly when they called for assistance, and that passing staff stopped and exchanged words with them.

Staff told us about their caring role. They told us they felt caring was “to make people happy”, “I love it, I love to know I am doing something good” and about “treating people with respect”. Staff spoke about people affectionately and respectfully..

People’s privacy was respected and all personal care was provided in private. When people received care in their rooms, doors were closed to respect their privacy. All rooms were for single occupancy with en-suite facilities. People also told us that their belongings were safe and respected in their rooms. One person told us “I can lock things away in my room” and another “there is a safe in the office for valuables”.

We asked people how they were involved in making decisions about their care. We saw people were offered choices about their care. Everyone spoken to who was able to express an opinion told us that they chose their own time for getting up and retiring. Some people told us they enjoyed a cup of tea in the mornings before they got up. One person told us “The staff sometimes ask if I am ready to go to bed, but they are not pushy and it is up to me”.

People had their care needs reviewed on a regular basis which enabled them to make comments on the care they received. In some instances this was done with visitors or family members as acting as advocates for the person. Some people had impaired communication. We saw a visual aid for supporting people communicate about pain and one file we saw contained a specialist pain assessment tool for people with dementia.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people’s care needs with us they did so in a respectful and compassionate way. Staff spoke quietly and discreetly with people to ask them if they needed to go to the toilet or receive care. This helped to ensure people’s privacy and dignity were respected.

Inadequate

Is the service responsive?

Our findings

Records relating to people's care and welfare needs were not completed in sufficient detail to enable staff to understand the care and support people might need to prevent them suffering harm. Some care plans contained inconsistencies that meant they type of support that was needed was un clear.

People's individual care needs had not been adequately assessed or planned. People's needs assessments and care plans did not always give enough clear or up to date information to ensure people's needs were met appropriately. One person's needs had not been fully assessed prior to moving to Mapleton. Their file contained out of date information in relation to their care at the previous home.

Care plans were not individual to each person and did not contain information in sufficient detail to assist staff to provide care in a manner that respected their wishes. They did not provide information about how each person's dementia affected that person's communication or day to day abilities. One person's file indicated that they had been diagnosed with a specific type of dementia. This included a one line statement that people with this type of dementia may suffer from hallucinations or delusions. There was no information about this person's experiences to allow staff to understand how this impacted on this person or how to support the person appropriately.

Some staff had a good understanding of the interests of people who had lived at the home for some time. However, they did not have a good understanding of the past history or social interests of those people who had been admitted to the home more recently. Staff who had recently transferred to work at the home, from other services, said they had not had time to read people's care plans or risk assessments before starting to care for them. They felt this placed them at a disadvantage in being able to meet people's individual needs. One staff member said she didn't know anything about one person other than where they used to live and what they liked to eat and drink. Care plans did not include detailed information about people's past social history which meant that staff were not able to talk to them about people or events that were important to them.

Where there were instances of people potentially being reluctant to receive care there were limited strategies recorded for staff to support the individual. Moving and handling assessments were not always comprehensive enough to enable staff to meet people's needs where people may resist being supported in this way. We witnessed staff assisting two people whose mobility needs required the use of equipment to stand or transfer from one chair to another. On the first occasion this was managed well, with the person transferring safely from the armchair to the wheelchair, and staff explaining what they were doing. On another occasion staff were struggling to transfer the person safely, and made the decision not to continue as the person was not co-operating. Staff told us that they were confident in the use of the equipment, however they did not feel it was safe to continue at that time with the person not being able to assist them. This resulted in the person remaining in their wheel chair rather than sitting in an armchair in the lounge area. One member of staff said that the guidance in the person's care plan was not clear what to do in this situation. This told us that plans were not personalised to take account of the individual's holistic needs.

Activities offered to people were not always based on their individual likes or wishes or targeted at an appropriate level to meet their abilities. Staff made attempts to involve people in activities such as a jigsaw or reading. However care plans gave limited information about people's interests and social and personal history, and most staff we spoke with had not had opportunities to read this information.

On the second day we saw people enjoying a visit from 'The Dancing Ladies' who encouraged people to dance and enjoy music whatever their ability. Staff said students from the local college visited regularly to provide manicures and nail care. People were also involved in the normal daily activities around the home such setting and clearing the tables, washing the dishes and making their beds.

Staff we spoke with were not aware of anyone with religious preferences. However when we looked through people's care plans we saw that people's religious preferences or choices were noted.

Inadequate

Is the service responsive?

We looked at the response that had been made to concerns or complaints made about the home. We saw that the service had responded quickly to investigate and respond to concerns raised and had responded to the person who raised the concern with their findings.

Inadequate

Is the service well-led?

Our findings

Mapleton had recently been redeveloped to provide a service for people with dementia. The building had been adapted and re-designed in line with best practice guidance to make it suitable to meet the needs of people with dementia. However, the model, ethos and philosophy of care was not well understood or implemented by the staff team. Staff did not all demonstrate a good understanding of what individualised care for people with dementia is. Some staff showed a poor understanding of the how the design of the building could be used to enhance individualised dementia care. Some staff were very positive about the changes that had happened at Mapleton, and others were very negative. The changes to the model of care had not been sufficiently well implemented or managed, and this was having a negative impact on people.

The quality assurance systems in use at this home had not identified concerns and risks relating to people's care and welfare, and as consequence appropriate action had not been taken. For example, the falls monitoring systems recorded when people fell and these falls were reported to the management team. Records showed that one person fell repeatedly. Their risk assessment did not alter although each falls record was reviewed by management. The likelihood of further falls or of injury was marked as low after each fall.

The lack of information for staff in relation to meeting people's needs had not been identified through the quality and risk monitoring systems. These systems had not identified that sufficient action was not being taken to prevent harm to people who had needs relating to nutrition, hydration and pressure damage. As a consequence, some people had suffered harm. The system did not identify that information in care plans was difficult to locate and that care plans were overly large and contained out of date information.

Care plans were not personalised for each person so they could receive care individualised to their abilities and communication needs. The quality and audit system had identified this to some extent, however action had not been taken to address this.

The quality assurance systems for the home included sending questionnaires to relatives, visiting professionals or other people with an interest in the service. This had not been carried out in 2014. Senior management told us that they were looking into electronic ways of gathering feedback from visitors and others, including through the internet.

Information about the home in the statement of purpose and the guide to Mapleton did not inform staff or users about the model of care being used. It did not provide people with information about the ethos, visions or values of the service. It did not set the standard of care that people should expect.

We found the registered person had not protected people through the operation of effective systems to assess, monitor and improve the quality and safety of the services provided, and mitigate risks. This was a breach of regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2009, which corresponds to regulation 17 (1) (2) (a) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When concerns were raised about the care at this service, the provider took immediate action. Changes have been made to enhance the management team and actions have been taken to ensure staff are supported to develop the skills they need to care for the people living at Mapleton.

There were meetings held for people who lived at the service to discuss any changes they might like to make. We saw the minutes of the last meeting where people had been asked about menu planning. The service user guide to the home stated that the service welcomed feedback, and copies of the corporate complaints leaflet were available in the service's entrance hallway. They contained a freepost feedback form to be returned to the provider, external to the home's management structure.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had not protected people against the risks associated with medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered person had not notified the Care Quality Commission of the authorisation of a Deprivation of Liberty Safeguards application.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not ensured that the care and treatment of service users was appropriate or met their needs. The registered person had not ensured that an assessment of each person's needs for care and treatment had been carried out, or that care and treatment had been designed to ensure people's needs were met.

The enforcement action we took:
Warning notice issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not established and operated an effective system to improve the quality of the services at Mapleton. The registered person had not established and operated an effective system to ensure an accurate, complete and contemporaneous record in respect of each service user, including a record of the treatment provided and decisions taken was maintained. The registered person had failed to operate an effective system to monitor and mitigate the risks relating to the health, safety and welfare of service users.

The enforcement action we took:
Warning notice issued