St. Matthews Limited

Maple Leaf House

Inspection report

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Ratings

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

Overall summary

This inspection took place on 8 and 14 October 2015 and was unannounced. Maple Leaf House is a care home which provides care for up to 30 people. This includes older people, younger adults and people with mental health conditions including dementia. On the day of our inspection there were 16 people living at the home.

The home had a manager but they were not registered with us. A registered manager is a person who has registered with the Care Quality Commission to manage 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.

People we spoke with told us they liked living at the home and felt safe. However, we found risks associated with their care were not being identified and effectively managed to keep them and staff safe from harm.

Medicines were not always managed effectively. Sometimes medicines prescribed for people had not been given and it was not clear from records why this was. In some cases people had not been given the

Summary of findings

medicine they needed to manage their health conditions because it was out of stock. Staff competencies in regards to medicine management were not routinely checked to ensure safe medicine management within the home.

There were sufficient numbers of staff to meet people's needs on the day of our visit, but we could not be confident this was always the case because duty rotas were not accurate. New staff went through recruitment checks to ensure their suitability prior to working with people in the home.

People were positive in their comments about living at the home but some people's needs were not being met effectively. This particularly applied to those people who had behaviours that challenged themselves, staff and others. This was because many staff had not completed training linked to people's needs to support them in their role.

People had a choice of meals and most comments were positive about the food provided. We saw people who needed assistance to eat were not rushed and were supported to eat at their own pace. Where people had additional needs associated with eating and drinking, advice had been sought from a health professional although this was not always followed.

The provider was not meeting their legal responsibilities under the Deprivation of Liberty Safeguards. There were people in the home who were subject to restrictions in regards to their care which had not been authorised by the local authority.

The service was not consistently responsive to people's needs. Although people's choices were mostly respected and listened to, people who had difficulties communicating had limited stimulation and opportunities for their social care needs to be met. A lack of background information about people's interests and preferences meant there were people who did not experience person centred care.

There was a system to record complaints and people told us they felt able to approach the manager if they had any concerns. However, complaints had not always been recorded in a way that would enable the provider to monitor them and ensure people were satisfied with the responses made.

The provider and manager did not have sufficient systems and processes in place to assure themselves that the home was providing a quality service to people. People had limited opportunities to provide their opinions of the service and to be involved in decisions related to their care. Audit processes were not effective in ensuring sufficient improvements to the service were made in a timely manner.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service will therefore be placed 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.

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 consistently safe.

Risks to people's health and safety were not identified and were not sufficiently managed to protect people from harm. People's medicines were not always managed effectively.

Inadequate

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

Some people who lived at the home did not receive effective care and support because staff did not always have the skills and knowledge to meet their needs. People told us they mostly enjoyed the food but when they had additional care needs in relation to eating and drinking or had lost weight, it was not always clear sufficient actions had been taken to address these. The manager had not complied with their responsibilities in relation to the Mental Capacity Act 2005. People were being deprived of their liberties and were at risk of improper treatment. Appropriate referrals had not been made to the authorising authority for restrictions to be agreed in relation to how people were supported and received care.

Requires improvement

Is the service caring?
The service was not consistently caring.

People and relatives were mostly positive in their comments about the staff and most staff were friendly and caring in their approach to people. Sometimes people's privacy and dignity was not consistently maintained.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

Some people's preferences were being supported to enable them to maintain their independence. However, information in care records was sometimes not followed or was not sufficiently detailed to enable staff to support all people's preferences to maintain their health and wellbeing. Social activities were provided but they did not always reflect people's interests and needs.

Requires improvement

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

The provider had not ensured that effective quality assurance procedures were in place to assess and monitor the quality and safety of the service people received. This meant that a number of shortfalls in relation to the service had not been identified. The manager was not registered at the time of our inspection but was in the process of registering with us.

Inadequate

Maple Leaf House

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 was planned to check 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.

This inspection took place on 8 and 14 October and was unannounced.

We reviewed the information we held about the service. We looked at information received about the home and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We spoke with Coventry local authority commissioners who funded the care for some people at the home. They told us they had identified some areas for improvement and they were working with the provider in relation to these.

The inspection was carried out by four inspectors over a two day period. We spoke with two people who lived at the home, six relatives, five care staff, three nurses and a health professional. We also spoke with the manager, a business development manager at the home and the provider.

We observed the staff interactions with people and the support they delivered in the lounges and dining areas situated on each floor of the home. There were some areas of the home not in use as they were being refurbished. We reviewed the care plans of three people and viewed some of the records in the files of others to see how their support was planned and delivered. We also looked at other records such as medication records, a staff communication book, recruitment files, complaints records and quality assurance records including meeting notes.

Inadequate

Is the service safe?

Our findings

Many of the people who lived at Maple Leaf House had complex mental health needs which meant we were unable to have detailed conversations with them about their care. We identified a number of people who required close supervision and monitoring to manage their behaviours and care needs. This included some people who required a staff member allocated to them on a one to one basis to ensure their health and safety.

We found people were not always protected from potential abuse and harm. Care staff had completed training on safeguarding people and could tell us about the different types of abuse. They knew to report any incidents of concern to the nurse in charge or the manager. However, nursing staff did not always recognise that some incidents that had happened in the home could be considered as abuse and needed to be referred to the local safeguarding team and us. This was so we could ensure appropriate action had been taken by the service to address them.

Accident and incident records showed there were numerous occasions when people's behaviours had become challenging towards staff and sometimes other people. Some of these incidents had resulted in injuries. Staff spoken with did not always know enough about the triggers to people's behaviours. They also did not know about the actions they needed to take to prevent people's behaviours from escalating further to prevent them and others coming to harm. One staff member told us when a person was challenging towards them they would, "Give them a bit more space and explain to them." Another stated, "You have to leave [person] five minutes and then go back again." However care staff said they sometimes found it difficult to know what to do when people's behaviours escalated and they could not calm them down. Numerous staff had been hit by people which suggested the actions they were taking to prevent this happening were not effective.

We asked one staff member about a person's triggers to their challenging behaviour. This was to understand how these were identified and managed to reduce the risk of their behaviours escalating. The staff member did not know about the triggers to help them support the person safely. They told us, "We don't know enough about his background so it is only about getting to know him when you are on shift. All I know is [person] came from hospital and he has challenging behaviour." A care plan we looked at for a second person stated, "Can be violent and aggressive and hit out at staff attempting to care for him." There was no risk assessment or care plan that provided guidance for staff on how to manage this behaviour.

We saw from reading an accident and incident record that one person who had been taken to the shops had become agitated and hit out at staff. Staff had been unable to encourage the person to return to the home which had resulted in the police being called to provide assistance. There was no resulting action recorded on the form to show that lessons had been learned and to indicate how this risk would be managed in the future to prevent it from happening again.

Records showed a person had slipped from a chair twice in the same day. We could not see the risks of this happening again were being appropriately assessed and managed. Records indicated this person had slipped "underneath the belt" on their wheelchair to the floor. The belt was described as "quite loose". We noted the person "slipped again" from a chair 15 minutes later.

One incident described in the accident and incident records demonstrated how both the safety of a person and staff had been compromised. This was because a person obstructed the lift with their walking stick and would not move when staff needed to use it. Staff attempted to remove the stick from the person and this resulted in them being hit. The walking stick which the person required for their mobility was then taken off them. This placed the staff at risk of harm due to the way the incident had been managed and potentially placed the person at risk of falls.

When we spoke with staff and observed them working, it was evident they were not fully aware of risks associated with people's care. For example, risks associated with poor nutrition, people's behaviours and risks associated with health conditions such as diabetes and the use of catheters. We saw one staff member giving a person a drink from a spouted beaker as opposed to slowly on a spoon as advised by a health professional. This potentially put the person at risk of choking.

A staff member we spoke with told us the instruction of how to give fluids had changed but this was not evident from the person's nutritional records. We noted from this person's care records they had lost 11kg over a three month period which was a significant amount of weight. This

suggested the person was not receiving a sufficient amount of food to maintain their weight. There was no risk assessment which identified the risks this presented to the person and to advise staff on what actions they should take to prevent the person from losing more weight which could impact on their health.

One person who had diabetes required their blood sugar to be monitored each day to make sure it was not too low or too high which could result in their ill health. Records indicated the person's blood sugar levels were not stable due to the person's eating habits. Their blood sugar levels were not being monitored each day to manage this risk.

Care plans lacked information to support staff in managing risks to keep people safe. For example, one person had a care plan relating to falls dated July 2015. This stated the person was unable to mobilise independently and needed staff support to help them transfer to their wheelchair or bed. There was no information about what mobility aids should be used. The manager confirmed this information was missing from the care file and advised that the nursing staff were being asked to update the care plans. We observed one person who could mobilise but was at risk of falls, was alone in the garden. They were bending down pulling out plants and we were concerned they could fall. Staff were not observing this person at the time although they knew the person was in the garden. It was only when we noticed this happening that a staff member called the person back into the lounge. We could not be confident that risks associated with people falling were being effectively managed.

There was one registered general nurse (RGN) in addition to Registered Mental Nurses (RMN's) employed at the home to attend to people's nursing needs. We found nursing staff did not have the skills to safely manage people's physical nursing needs such as attending to wounds. This was being done by visiting district nurses. When we spoke with the RMN's we found their responses to our questions around risks associated with people's physical healthcare needs were vague. We noted one person's wound dressing had come off and there was no information about what actions staff should take in those circumstances. We saw a second person had open wounds on their leg with no dressing on them. We were told the dressing would not be replaced until the district nurse visited the following day. There was a potential risk of these wounds deteriorating further due to the lack of clear management plans in place.

We found that medicines were not always managed effectively. One person had refused their medicines since September 2015 and it was not apparent the risks associated with the person not taking their medicines had been fully assessed. Some people had been prescribed medicine which was not always administered to them. For example, one person was prescribed a medicine to be taken each day but this had not been taken for two days and there was no explanation why not. There were some cases where the code "0" had been recorded on the medicine administration record (MAR). We were told this meant "other" but there was no explanation of what "other" meant. It was therefore not clear if the person had received their medicine or not. Some people had not been given the medicine they needed to manage their health conditions because it was out of stock. One of these people had been prescribed a medicine to help them sleep at night. On one of the nights it had not been given, they have been very unsettled. Sometimes there were gaps on the MAR and we could not tell if the person had received the medicine they had been prescribed.

Medicines were stored securely. On the day of our visit the medicine room was of an acceptable temperature to ensure medication was kept in accordance with manufacturer's instructions and remained effective. However, there were no temperature recording documents to monitor the temperature of the room and fridge on an ongoing basis. This meant we could not be sure these remained within the recommended guidelines to maintain the effectiveness of medicines. The nurse we spoke with did not know who monitored the temperatures but said they would use the air conditioning unit if the room got too hot.

This was a breach of Regulation 12 HSCA (Regulated Activities) Regulations 2014 (Part 3) Safe Care and Treatment.

Medicine administration records (MARs) were kept for each person at the home. MARs contained a photograph of each person so the nurse could check each person's identity before giving them their medicine. Where medicines were prescribed to be given at mealtimes, the medication rounds were organised to accommodate this.

One of the nurses told us they had experienced problems in obtaining some people's medicines. As a result they were looking at ways to improve the systems and processes

Inadequate

Is the service safe?

used for managing medicines. The manager told us they were being supported by the local clinical commissioning group to improve systems and processes in relation to medicine management.

We were told by the manager that she aimed to have nine care staff on duty plus a nurse to support people's needs. Duty rotas showed these numbers were not always achieved. For example, we noted that in August 2015 there were no nursing staff indicated on the night rota for two days and on one day there was only four care staff rostered to work during the day. The manager stated that there would have been additional staff working on these days, but was not able to confirm which staff due to records not being sufficiently clear. We could therefore not confirm there were always sufficient numbers of staff on duty. Staff told us sometimes there was one nurse on duty and sometimes two and did not raise concerns with us regarding staff numbers. When we arrived on the first day of our inspection there were only seven care staff working at the home plus a nurse and management staff. Care staff told us there were six people who needed one to one staff supervision. This meant care staff were limited in what support they could offer to those people who were not on one to one supervision. In response, the nurse in charge arranged for two additional agency care staff to work at the home so there were sufficient staff numbers to support people. This showed that action had been taken to address the low numbers on the day of our visit.

Suitable recruitment processes were in place to ensure staff were of good character and were safe to work with people. The manager told us that new staff members were not able to work at the home until all their recruitment checks such as references and police checks had been completed. Staff files viewed confirmed recruitment checks had been completed before staff had started work at the home.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA ensures the rights of people who lack mental capacity are protected when making particular decisions. The MCA and DoLS require providers to submit applications to a supervisory body for authority to deprive a person of their liberty. This is to help make sure people get the care and treatment they need in the least restrictive way. The manager understood their responsibilities under the MCA and DoLS but in some cases referrals had not been made when they should have been.

People at Maple Leaf House had complex mental health conditions, some of which included dementia. There had been no mental capacity assessments completed to determine the level of capacity that people had to make decisions. The manager accepted this was something that needed to be done so it was clear what support people may need to make decisions relating to their care.

One staff member told us they could recall an incident when "restraint" was used to address a person's behaviours and prevent any injuries. Accident and incident records contained two references to the use of restraint in response to people's behaviours. This suggested staff were not responding to people's needs in an appropriate and safe manner. One staff member told us they found it difficult to understand what was acceptable and what was not when using intervention to prevent people and themselves from coming to harm. We found that staff had not completed training in managing challenging behaviours and intervention techniques to help them understand fully what was acceptable practice to keep them and others safe. The manager told us it was not the policy of the home to use restraint practices. They stated they felt staff were not using the term 'restraint' correctly when describing incidents in the home. The manager said staff training would be planned to help staff better understand how to respond to people's behaviours.

When we looked at the accident and incident records we found the nursing staff had not recognised potential abuse incidents so that they could be followed up and any risks to people's health and safety managed.

DoLS applications had been made to restrict people leaving the home independently. However, there were other restrictions being placed on people's care where applications had not been made. For example, there were instructions from an occupational therapist in one person's care plan for the lounge area to be clear of other people before they were allowed to use it. This was restricting them from social interaction with others. It was recorded that this action was to safeguard others from this person's behaviour but we could not see this decision had been fully assessed with other health professionals involved in the person's care to ensure this was in the person's best interests. There was also an entry in this same person's care file from an occupational therapist stating that if they ate an "adequate" meal they could be "rewarded" by being given the choice to re-enter their bedroom after lunch. This suggested if the person did not eat an adequate amount they would be prevented from going into their bedroom. The manager stated that she thought this information must have come with them from their previous home. This meant the manager had not explored whether this was currently in the person's best interests although they commented this was not something they found acceptable.

Another person's movements were being restricted due to the use of bedrails and it was not clear why these were being used. The manager told us there were concerns the person may try to get out of bed and fall. The risks associated with the use of the bedrails had not been assessed to determine if their use was in the person's best interests. We observed this person had a member of staff with them to provide one to one supervision which meant the risk of this happening was reduced. The manager stated she would reassess this need.

Staff were not clear in their understanding of DoLS and how this impacted on people. Staff told us they had not completed training to help them understand this. A member of the management team who was present at the home during our inspection told us, "The service is relatively new and we are extending our training."

This was a breach of Regulation 13 HSCA (Regulated Activities) Regulations 2014 (Part 3) Safeguarding service users from abuse and improper treatment.

The person who organised the training at the home told us that all staff completed an induction programme. They stated that staff who had previous experience of working in a care setting completed a one week induction

programme, those who had not, completed a two week induction programme. Following this training staff were then given shifts to work on the rota. They told us induction training typically comprised of training such as health and safety, safeguarding people and moving and handling people. Staff confirmed this training took place by watching a series of DVDs.

Care staff told us as part of their induction to the home they had worked alongside more senior and experienced staff so they could observe them working and learn from them. One care staff member told us, "I was watching them (other staff) supporting residents, toileting them and was helping as well." They went on to say they observed other staff feeding people and "picked things up as I went along." Another stated, "The seniors were very good because they knew it would take longer to get to know some residents."

Care staff told us the training they had completed was helpful but felt they needed more training linked to the needs of people to be able to meet people's needs more effectively. Two care staff members we spoke with told us, "We find it difficult to work with people with dementia and engage with them. We have had no training regarding people with dementia who cannot communicate and how we could support them." Both felt the training provided could be improved overall to support them better in meeting people's needs. We observed that sometimes staff did not always speak or engage with those people who had difficulties communicating.

We found that training was not always being effectively implemented into practice. For example, one person with an infection was being kept in their room. When we asked the nursing staff why this was they did not know and stated this was what they had been told to do. A health professional told us there was no requirement for the person to be isolated and cared for only in their room. This showed there was a lack of understanding of infection control and how to support people with infections.

We asked a health professional about the skills of staff at the home to determine if they felt these were sufficient. They stated there were areas in regards to meeting people's physical nursing needs that could be improved. We found the physical nursing needs of people were usually being attended to by external nurses or visiting healthcare professionals as opposed to nurses within the home.

We looked to see how a person's urinary catheter was managed and saw they had been admitted to hospital because their catheter was not draining properly. The hospital had identified the person was dehydrated and requested support from community nurses to explore alternative ways of managing the person's catheter when they were discharged back to the home. This suggested the person's needs had not been effectively met at the home. We found there was no catheter care plan in the person's care file to inform staff how this should be managed. We saw the last hospital admission for this person was because their catheter bag was not draining and had been blocked. The manager told us on the second day of our visit that the provider had arranged for both care staff and nurses to be registered for further training in catheter care.

We found that the lack of training linked to people's needs impacted on how care was provided. For example, during our inspection we heard a person shouting in the corridor who was very agitated. We observed them shouting at a nurse because they wanted to go outside to have a cigarette. The person had run out of cigarettes and so another staff member had left the premises to buy some. The person was becoming more agitated and began shouting threats to other staff that were close by. The nurse offered the person some medicine which they refused. Another nurse suggested taking the person outside to wait for the other member of staff but this option was not given to the person. The person was eventually escorted to another part of the home to be given their medicine. We discussed with the manager how this situation was managed. The manager agreed this had been handled poorly and that other methods could have been used to reduce the person's agitation. The manager stated that sometimes staff were not always confident to use alternative options available to them such as, in this case, escorting the person to the shops to buy their own cigarettes. The manager stated this was an area where further training was needed.

In a behaviour care plan for one person it stated there should be group activities and the person should be stimulated and staff trained in 'pamova' (prevention and management of violence and aggression) techniques. This manager confirmed this training had not been provided to support staff in managing the person's care.

Care staff told us that competency checks were sometimes carried out by the nurses to make sure they were

supporting people appropriately. For example, one care staff member told us, "When I first started, I fed [person] standing up and was told to sit down or kneel." This was so they were more respectful to the person and they could assist them to eat more easily. We asked the manager about nurse competency checks. They confirmed these were done but we found the checks were not comprehensive enough. For example, one nurse had been identified as not managing medicines safely. The manager confirmed no action had been taken regarding this nurse to ensure areas where they needed to improve were addressed. During our inspection we identified there continued to be medicine errors made but there was no staff audit process to identify poor practice so this could be promptly acted upon.

This was a breach of Regulation 18 (2) (a) (Regulated Activities) Regulations 2014 (Part 3) Staffing

Staff told us they had supervision meetings every three months where they talked about how they were feeling, if they were enjoying their role and if they needed any support. Staff were completing training on an ongoing basis. One staff member told they had completed all of the essential training with the exception of moving and handling training which they needed to complete.

Most people told us they liked the food and were given a choice of meals each day. One person told us the meals had improved from when they first came to the home but the choices were not always varied. However, they told us they had not made any specific requests for something different. Another person told us the food was "Alright".

We spent a period of time observing in the dining room to see what the lunchtime experience was like. The meals we saw looked appetising. Most people ate in the dining room so they had an opportunity to mix socially with other people. There were some people in the home that needed assistance to eat. A staff member who supported one person to eat did not rush them and enabled the person to eat at a pace suited to them to ensure their mealtime experience was a positive one.

Sometimes requests for specialist support were not always made in a timely manner by the service. For example, there was one person who required foot care, but a referral for chiropody support had not been made in a timely manner. This had resulted in the person developing foot problems that needed prompt attention. On the first day of our inspection we noted one person would not open their eyes and the person was unable to communicate their needs. At this time, the person had not seen the GP and had not been referred to an optician to rule out any infection or concerns. We identified that this person had not opened their eyes for some time. On the second day of our inspection the manager confirmed the GP had seen the person's eyes and no concerns regarding an infection had been found.

Requires improvement

Is the service caring?

Our findings

People and relatives we spoke with were generally positive in their comments of the staff. One told us, "Very good. They are very nice." Another stated, "Nice, lovely staff, very helpful and very kind." A staff member we spoke with told us, " People who do work here are genuinely caring."

We observed the communal areas of the home to see how people were cared for by staff. Staff were caring in their approach but communication with people was mostly when they offered support or were completing a care task. We found that staff did not always know about people's health needs and daily routines or about their past histories so they could hold meaningful conversations with them. One person told us, "Sometimes I need to talk to people, I want to express myself, just chat." They explained they had limited opportunities to talk with staff.

Staff were caring when people became anxious. When this happened staff spoke with people in a calm manner to help prevent their anxiety levels increasing. For example, one person offered to show us their room. We shared the lift with them and a care staff member but the person became anxious and began to shout they did not like the lift. The care staff member offered words of reassurance which helped to calm the person so they could continue to show us their room. When a person was anxious in their room because of building work noise in the home, a care staff member moved them to a quieter lounge and sat beside them to try and reduce their anxiety. The staff member stroked the person's arm and offered words of reassurance which had a calming effect. We saw one staff member had good communication skills with a person they were supporting who had limited speech. The person responded positively to the care and attention given by the staff member. A health professional we spoke with told us, "Whenever I go the carers are fantastic, really caring, respectful with patients. They are wonderful."

There were some less caring staff interactions seen during lunch. For example, changing a person's disposable clothing protector twice with no communication. Different staff moving the person's wheelchair away from the dining table to take them to the lift but then leaving them in this position until they returned later. Staff asked the person questions such as "Are you ready to go?" but did not wait for a response before walked away. This was not respectful to the person and would not have made them feel valued as a person.

We observed a second staff member not being respectful to a person in the dining room who was speaking and singing to themselves as they ate their lunch. A care staff member asked the person, "Are you ready love (to be moved from the dining room)?" but walked away as the person was speaking. The staff member returned with a tissue to wipe the table and said, "You made a little mess here love." When the staff member asked the person if they were ready to go they replied "No." Again this staff member walked out of the room as the person was answering them.

When we walked around the home we saw there were external doors from each of the lounges to access the garden area. We noticed that these doors were regularly used by staff to access other areas of the home which meant cold air entered the lounge areas every time the doors were opened. In one lounge we saw a door was left open to enable one person who was in the garden to return to the lounge in their own time. This left people in the lounge sitting in a draft. We were told there had been a complaint made about one person being left in a draft in this lounge due to them being prone to chest infections. We saw the person had a blanket around them to keep them warm. A staff member told us the manager had put a sign instructing staff not to leave the door open. Despite this, it was apparent the notice was being ignored. We raised this issue with the provider at the end of our inspection with a view to the practice of staff regularly using lounge doors to access other parts of the building to be reviewed.

The care staff we spoke with were able to tell us some information about how people preferred their care and support to be given. They also explained how they maintained people's independence. For example, by encouraging people to make choices about their daily lives. We saw this sometimes happened. Staff enabled people to make daily life choices such as where they would like to sit, what they would like to eat and drink and they supported people to different areas around the home at their request. One person told us they independent with their care and

Requires improvement

Is the service caring?

frequently went out to places of their choice. Most family members we spoke with told us they felt staff were approachable and caring towards their relative. One commented, "The care assistants are very attentive."

There were times when people were treated with dignity and respect and times when they were not. We observed a care intervention with one person that was not respectful. The person was sleepy in their wheelchair and was approached by a staff member who pulled the foot pedals into position and placed the person's feet on them with no communication. They pulled the blanket off the person without asking or telling them they were going to do this and folded the blanket up and put it on a chair. The person stirred as if uncomfortable with this as they had the blanket on to keep them warm. The staff member then wheeled the person to the dining room with no conversation.

We saw there was a board in the main office which listed people by name and their care needs beside it. This contained personal information which could be seen from people looking into the office from the glass windows. This did not respect people's privacy and dignity. The board had a sliding facility and when pulled to one side hid the information on the board. However this was not always done.

We also noticed in a number of areas around the home there was a strong unpleasant odour which was not dignified for people or pleasant for people to experience. We were told there were problems with some people urinating inappropriately. It was not evident this was being managed effectively to ensure people lived in a clean and pleasant environment.

Families and friends were able to visit at any time and people were supported to maintain relationships with people who were important to them. One person told us they went to visit their family and this was arranged with staff support from the home. A family member who was unable to visit the home told us, "They phone me to tell me to go and visit if I need to. They tell me they do everything for [person]." Another stated, "We phone up and they put [person] on the phone, everything is fine like that."

Requires improvement

Is the service responsive?

Our findings

People we spoke with felt their needs were being met. One person told us, "You can't pull staff up, when I press the buzzer they come." We asked people if they were involved in planning their care or if they had seen their care plan. One person told us, "I asked to see it (care plan) but nothing came of it, [staff member] said they needed to see me personally when they find some time." They told us this had not happened as yet. However the person told us they were happy living at the home. It was evident from speaking with another person that they were involved in planning their care. They told us how they made visits to their family with staff, although this did not always happen as often as they would like.

Most relatives we spoke with felt that staff were responsive to their family member's needs and demonstrated a good knowledge and understanding of the support they required. One relative told us, "They do know what [person] needs are. I am satisfied with the care they give." However there was one relative who did not feel the needs of their family member were being met effectively. We were able to confirm through discussions with staff and viewing care records that there were elements of this person's care that had not been met effectively. We discussed our concerns with the manager to enable these to be followed up.

People's needs had been assessed prior to them moving into the home to enable care plans to be developed in accordance with their needs. There was an occupational therapist employed at the home to help assess people's needs and support staff in developing plans of care. However, care plans we looked at lacked information about people's needs. For example, they lacked detail in identifying triggers and warning signs to help staff recognise early signs of behavioural issues or deterioration in people's health and well-being. This meant staff did not always have clear guidance to follow when delivering support and care. They also lacked detail about people's personal interests and their preferences in regards to their daily routines. We could not see that people and relatives had always been involved in developing care plans. This meant care plans did not always support staff in delivering person centred care.

In some cases care plans for specific needs had not been developed. For example, one person did not have a care plan detailing how their personal care needs were to be met by staff. This was particularly important for this person as they had behaviours that challenged staff so staff needed to know how to manage their personal care without causing them to become anxious. We saw there was a care plan that had been developed by the Coventry and Warwickshire Partnership Trust (CWPT) when the person was in hospital which gave advice on "preventative measures" to help reduce the risk of the person becoming frustrated and agitated that could lead to their behaviours escalating. This information included potential triggers to their inappropriate behaviour. None of this information had been incorporated into a care plan to be used by staff to support them in meeting the persons needs when delivering care. The manager was not aware the information from the CWPT was in the care file.

When we spoke with staff about people's care they sometimes gave conflicting responses or could not give answers which suggested they were not always aware of what was written in care plans. We asked staff if they read care plans so that they knew about people's care needs. One staff member told us, "I think you do if you get time but you are not allocated time to look at them." We asked the staff member when they had last looked at a care plan and they responded, "A month ago, maybe six weeks" which suggested they were not using care plans to make sure they delivered care in accordance with people's needs and preferences.

People had access to social activities and some went on social outings in accordance with their wishes. One person told us, "I go out on a one to one (with staff) to town to buy clothes, I go out in a taxi." Another stated, "We are having a Halloween do, there are trips to the local pub and people go out on trips to the parks." A relative told us how their family member at the home was supported by staff on outside visits to places of their choice on a regular basis. During our inspection we saw some people participated in a group craft activity with staff which they seemed to enjoy. However people with limited communication who were unable to move around the home independently were sat for long periods in the lounges or bedrooms with little or no stimulation. Staff sometimes found it difficult to find effective ways to communicate with them and this was hindered by the lack of information in care plans about people's past interests and hobbies. Staff could not rely on information in care plans when planning activities and when providing social stimulation that was of interest to people. A staff member we spoke with told us "We don't

Requires improvement

Is the service responsive?

know enough about their background so it is only about getting to know when you are on shift." However, we found time was not always taken to find out about people's interests to ensure their social care needs were met. For example, a relative we spoke with told us, "Before [person] retired they liked music. " They went on to say what type of music and pointed to a CD player in the person's room which they had bought for them. They stated it "was never on".

A staff member told us that they used a 'communication board' so they could communicate with one person. However during our discussions with people we were told this board was rarely used and the person who used this needed more social stimulation.

One person's social activities care plan contained no personalised information to reflect their interests. The care plan stated, "Maple Leaf offers therapeutic activity with designated activity workers, ward staff, occupational therapy and any other agency that may be provided. The aim of activity is to provide distraction aid concentration and assess communication skills and generally add to the overall mental health assessment of your stay at Maple Leaf." We asked a staff member if therapeutic activities always took place for those people who had been identified as needing them. They confirmed this was not happening which meant people's mental health needs may not be met consistently.

People and relatives we spoke with said the manager was approachable and they would feel comfortable to raise any issues of concern with them. One person told us, "I have no complaints at all, very obliging." We found complaints had not always been effectively managed but processes had been developed to enable this to happen. When we viewed the complaints folder there were two complaints that had been recorded that had been made by a person who lived at the home. These were linked to the management of medicines and the food provided. We saw a written reply had been provided to one of the complaints which had been made in September 2015. The manager told us she had resolved the second complaint which was made in October but had not responded to the person as yet. We spoke with the person who told us they were satisfied with the actions taken by the manager and their complaint had resulted in an improvement in the food provided. This demonstrated lessons had been learned.

We identified through our discussions with people, relatives and health professionals that some complaints made had not been recorded in the complaint log to demonstrate they were being investigated and taken seriously. The manager told us they had not been recorded because she had only recently developed the complaints log. This meant we could not obtain a clear picture of the number of complaints received, how they had been addressed and if they had all been responded to. The manager told us she would ensure all complaints were logged to demonstrate this.

Inadequate

Is the service well-led?

Our findings

This was the first inspection carried out of this service by us. The home did not have a registered manager in post but action had commenced for the registration process to be completed. The manager told us they had recently returned to the home after a long period of agreed absence. During her absence the provider had made arrangements for another manager to manage the home to help ensure this did not impact on people's care.

We found there was no effective process to check people had care plans which were accurate and which supported staff to meet their needs. Sometimes care plans were not developed where it was identified there was a need for one. For example, in the notes of two person's care records dated May 2015 and July 2015 there were instructions for care plans to be developed in regards to 'pressure ulcers'. These had not been created. There was also a care record dated June 2015 that indicated a person needed a nutritional care plan due to their eating difficulties. This had not been created. This meant there was a risk people's needs may not be met. The manager told us they had identified care plan files were lacking in information and training had already been organised to support staff in improving them. On the second day of our inspection, the nurses told us they had been asked to update the care plans.

Communication systems in the home were not effective. When we asked staff about people's needs they were sometimes vague in their answers or did not know the answers to our questions. For example, we noted that one person's foot care had been addressed and they had bandages on their toes. We asked staff who had attended to the person's feet so that we could be confident this had been done by a health professional. Both nursing staff and care staff did not know but made assumptions as to who this may have been. The manager told us that staff handover meetings took place at the beginning of each shift but some staff recorded these and some did not. This meant staff could not rely on this method of communication to identify changes in people's needs.

We found there were no effective systems in place to drive improvement within the home. This included the completion of quality checks and audits. There had been no audit of the accident and incident records to determine whether there were any emerging patterns or trends of concern. Information within these records detailed potential abuse and restraint which the manager had not identified or explored due to the lack of audit processes in place. We brought these to the attention of the local safeguarding team.

The manager had not fully understood their legal responsibility to notify us of serious incidents and accidents that affected people. We found examples of these that had not been reported to us as required.

The system for monitoring people's weight was not effective. One person had lost a significant amount of weight which had not been identified and acted upon in a timely manner. The manager told us information on people's weights was kept on their individual files. This meant it would have been difficult to identify concerns relating to people's weight at a glance so they could be effectively acted upon if needed.

Quality assurance systems were not sufficient. People and their relatives told us they had not been given the opportunity to complete satisfaction surveys or attend meetings with management or staff at the home to offer their opinions of the service. This was so the provider could identify what the service was doing well and what they needed to improve upon. One person we spoke with told us, "This is the first time I have been asked for my opinion."

We received mixed opinions from people and relatives about their experiences of the home which suggested there were areas that needed improvement. Comments included, "[Person] seems to be settled and everything seems to be alright." "Things are just not right …one day when we visited last week they were all in bed in the day time." "Some people have not got capacity, some are very disabled and a couple could benefit from more attention."

Staff meetings did not regularly take place across all levels to enable them to be kept updated in regards to issues related to the running of the home as well as offer their opinions and be involved in decisions.

The provider had not ensured there were suitably skilled and trained nurses to provide meet people's physical nursing needs effectively. This had resulted in some reliance on visiting district nurses to provide this care. When we asked the manager why district nurses were called to the home for nursing support they told us "because this is where the home is lacking in experience."

Inadequate

Is the service well-led?

Processes to record complaints had not been managed effectively and a complaints log had only recently been developed. This meant there had not been an effective system to monitor and learn lessons from complaints made to help prevent the same concerns arising. Conversations with people, relatives and health professionals demonstrated their concerns had not always been managed in a timely manner.

The provider did not have systems and processes to ensure that they were meeting the requirements of the Health and Social Care Act 2008.

Staff were overall positive about working at the home but some felt further training was needed. We found that training had not been effectively managed to ensure staff had the skills they needed to undertake their role. When we asked one staff member about their views of the care being provided they told us, "I suppose when we are fully staffed it is good. I think it is getting the right staff, properly trained. A lot have complex needs."

The manager told us about actions she had planned or implemented to help make improvements across the home. This included regular staff meetings to discuss care plans and setting up audit processes to monitor the service. At the time of our inspection the manager had only just implemented a system to review all accident and the incident forms. This was so they could monitor them for any concerns. They also told us they had expected the nurses to monitor them but it was clear the nurses were not fully aware of the manager's expectations for them to do this.

The provider has responsibility to ensure the manager and staff carry out their responsibilities safely and effectively to meet the CQC regulations. We were aware the provider had taken some action to ensure this happened by organising a monthly internal audit of the service by a representative of the company. A copy of the audit reports seen detailed the actions required of the manager. However we could not see actions were always carried out in a timely manner and clear records were not always kept of progress made to ensure this did not impact on the care and services people received.

This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) regulations 2014 (Part 3) Good Governance

People knew who the manager was and one person told us, "I have spoken with [manager] on occasions." People and their relatives felt the manager was approachable. We saw that when people approached the manager she took the time to speak with them or support them with their needs.

The provider and manager told us they were working with the local authority and clinical commissioning groups to bring about improvements to the home. The provider told us they were committed to ensuring improvements were made and would be taking the necessary actions to make sure these happened.

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 Risks associated with people's care were not effectively assessed and managed to ensure people received safe care. Staff providing care did not always have the skills needed to deliver care and treatment to people in a safe way. Medicines were not being safely managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and process for protecting people from abuse and improper treatment were not effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes to monitor and improve the quality and safety of services provided, and to manage risks related to the health, safety and welfare of people, were not effective. This included records not always being sufficiently detailed and accurate to support safe and appropriate care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff had not received sufficient training to enable them to carry out their duties safely and effectively to meet people's care and treatment needs.