

St. Matthews Limited

# Maple Leaf House

## Inspection report





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### Ratings

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

# Summary of findings

## Overall summary

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 14 people living at the home.

The home had a manager but they were not registered with us and had only been in position for three weeks. After our visit we were informed that this person had left their employment at the service and a new manager had been appointed. They were due to commence their employment shortly. 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.

At the last comprehensive inspection this provider was placed into special measures by the CQC. This inspection found that there was enough improvement overall to take the provider out of special measures.

At our previous inspection on 8 and 14 October 2015, the provider was not meeting the required standards. We identified four breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to improve staff training, the arrangements for safeguarding people and to improve the management of risks. This included risks associated with medicine management. The provider was also required to develop systems and processes to check and improve the quality and safety of the care and service people received. The provider sent us an action plan which stated action would be taken to ensure the required improvements were implemented by no later than January 2016.

During this inspection we checked whether improvements had been made. We found sufficient action had been taken in response to two out of the four breaches in regulations. Further improvements and action was needed to address the breach in Regulation 12 related to how people's medicines were managed. Also Regulation 17 related to having systems and processes that were effective in improving the service. You can see what action we told the provider to take at the back of the full version of the report. The provider was continuing to work to ensure on-going improvements were maintained.

Medicines were not managed effectively because staff were not working to a clear policy and procedure that demonstrated safe practice. The provider was asked to take immediate action following the first day of our inspection to ensure this was addressed. The provider responded by undertaking some initial actions to improve safety of medicine storage, however, further work was required to ensure safe medicine management in the home.

The provider had implemented quality monitoring systems and processes to assess if people were receiving a quality service and to determine if staff felt the home was operating effectively. Whilst people and staff

were positive in many of their comments about the home, there were areas identified for improvement that had not been sufficiently actioned. We also found audit processes were not always accurately completed to ensure they were effective in identifying areas for improvement.

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 central record and they had not always been responded to in writing to demonstrate the action taken in response to them. Discussions with staff and people suggested sometimes complaints were addressed satisfactorily, but at other times they were not always resolved to people's satisfaction.

People we spoke with were positive about the home and we saw they were relaxed and content around staff to help them feel safe. Relatives of people living at the home felt their family members were well looked after and safe at the home. Staff had a good understanding of people's needs and the risks associated with their care. However, information about risks was not always sufficiently detailed in care plans to ensure there was a consistent approach by staff in managing them to keep people safe from harm.

Staff had completed training to help them manage people's behaviours that were challenging. Staff told us the training had helped them to understand better how to manage people's behaviours. They told us people were calmer and more relaxed in the home. Staff received ongoing training to help them further develop their skills to support people's needs safely and effectively. This had resulted in a reduction in accidents and incidents at the home.

The provider had sought support from the Local Authority to ensure they were meeting their legal responsibilities under the Deprivation of Liberty Safeguards. This was to ensure people were not subject to restrictions in how they lived their lives without these being authorised. Applications had been completed to seek authorisation for restrictions placed on people in order to meet their needs and keep them safe.

There were sufficient numbers of staff to meet people's needs and staff felt there were sufficient staff available most of the time. New staff went through recruitment checks to ensure their suitability prior to working with people in the home.

Staff supported people to undertake social activities of their choice when possible. However, information in care plans did not always support staff in delivering person centred care because it was not sufficiently detailed with information such as people's daily preferences and past histories.

People had a choice of meals and most comments were positive about the food provided. People were prompted or assisted to eat where this support was needed.

## 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.

Medicine management was not consistently safe. Risks to people's health and safety were assessed and staff knew about risks associated with people's care. Ongoing actions were being undertaken to improve information about risks in care plans. There were sufficient numbers of staff to meet people's needs.

**Requires Improvement** ●

### Is the service effective?

The service was not consistently effective.

Staff completed ongoing training to improve their skills and knowledge to ensure people's needs were met effectively and consistently. This included the development of skills in meeting people's physical nursing needs. People were offered choices of meals and mostly enjoyed the food provided. People were supported to eat meals when needed. People's mental capacity had been assessed and work was ongoing to ensure people were not inappropriately deprived of their liberties or placed at risk of improper treatment.

**Requires Improvement** ●

### Is the service caring?

The service was caring.

People and relatives were positive in their comments about the staff. Staff were caring in their approach and interacted well with people. People responded positively to staff interactions and told us staff were caring towards them. Staff ensured people's privacy and dignity was maintained.

**Good** ●

### Is the service responsive?

The service was not consistently responsive.

Staff aimed to provide care to people in accordance with their wishes and preferences. Information about people's hobbies, interests and mental health needs was not consistently clear in care records to support staff in delivering person centred care. However people told us they enjoyed the social activities

**Requires Improvement** ●

provided and were supported to maintain some independence. People felt they could approach staff with any concerns, but records of complaints did not consistently show they had been managed and resolved effectively.

### **Is the service well-led?**

The service was not well led.

Systems and processes were subject to ongoing action to drive improvement within the home. Arrangements to ensure the home had a registered manager were ongoing. The provider had developed quality assurance procedures to monitor the ongoing quality of care and services but these were not always fully effective. People and staff were positive overall about their experiences of the home.

**Requires Improvement** 

# 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 25 February 2016 and 1 March 2016 and was unannounced.

We reviewed the information we held about the home. We looked at information received about the home and the statutory notifications the registered 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 local authority commissioners who funded the care for some people at the home. They told us they had identified areas for improvement and they were working with the provider in relation to these.

The inspection was carried out by two inspectors, a specialist advisor with experience of people with mental health needs and a pharmacist over a two day period. We spoke with two people who lived at the home, five relatives, seven care staff, four nurses, a cook and a visiting health professional. We also spoke with the manager, a business development manager and a member of staff responsible for delivering training.

We observed staff interactions with people and the support they delivered in the communal areas of the home.

We looked at the care records in detail of three people to see how their support was planned and delivered but also viewed care records of a further five people to check what information was available to staff. We looked at other records such as medication records, recruitment files, complaints records and quality assurance records including staff meeting notes.

# Is the service safe?

## Our findings

During our last inspection in October 2015 we found medicines were not managed safely and we could not be confident people always received their medicines as prescribed. This was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 – Safe Care and Treatment.

Following our last inspection, the provider sent us an action plan outlining how they would make the necessary improvements. We were told by a nurse at the inspection they were completing daily audit checks in regards to medicine management and were working with the Clinical Commissioning Group (CCG) in addressing the required actions to make improvements.

On 14 December 2015 an assessment was undertaken by the 'Medicine Management Care Homes Team' from the CCG. Their assessment detailed what action the provider needed to take to improve medicine management. At this inspection visit we found insufficient action had been taken to address risk and the issues of concern that had been identified by us and the CCG.

On the first day of our inspection we found medicines were not consistently stored securely or safely. This was because the medication storage room door was unlocked. Within the storage room we found the medicine refrigerator and a medicine cabinet containing people's prescribed medicines were also unlocked. There was a risk of unauthorised access to the medication storage room and the medicines stored there. We alerted our concerns to the provider who responded by advising a new lock would be fitted to the door the following day. On the second day of our inspection we found the door had a new more secure lock fitted which automatically locked when the door was closed. This meant medicines were secure.

We found no clear system of medicine storage in the medicine trolley. There were multiple containers of the same medicines prescribed for people open and in use. For example, one person had a blister pack (a system where medicines are stored in pockets on a card and pushed out when needed) of a prescribed medicine available in one basket. We also found a second basket with a box of the same medicine labelled for the person. When we opened the second box, this was filled with a combination of two types of the medicine. This meant there was a potential risk of a medicine error. A nurse told us, "It is still a mess. We are trying. I know it could be better."

Medicines that should have been removed from the medicine trolley remained available. For example, we found a bottle of liquid medicine that had been discontinued by the doctor as well as dirty and contaminated inhalers. This was unsafe practice and increased the risk of harm to people. This was because there was the potential for the discontinued medicine to be given in error. The dirty contaminated inhalers posed a risk of infection particularly if inhaled.

Controlled drug medicines that required special and secure storage were not stored in a cabinet that met the regulations for the secure storage of controlled drugs. However, we noted that by the second day of our inspection, the provider had replaced this with a cabinet confirmed as suitable for the secure storage of controlled drugs.

Temperature records for the room temperature and the medicine refrigerator were not consistently completed every day. This was important to ensure medicines were stored within a safe temperature range so they remained effective.

We looked at the Medicine Administration Record (MAR) charts for ten people. The receipt of people's medicines from the supplying pharmacy was not recorded. The quantities of medicines carried forward from the old MAR chart to the new MAR chart were not always recorded. We also found the amount of medicine available did not always match the records of receipt or administration. This made it very difficult to check that people had been given their medicines. On the day of the inspection we found that the amount of medicine available did not always match the records of receipt or administration and we could not be assured that people were being given their prescribed medicines. A lack of accurate records meant that any delivery errors could not be identified by us or the provider.

The MAR charts did not document all of people's prescribed medicines. Medicines prescribed as 'when required' were not written onto the MAR charts. They were documented on separate charts which were not easy to locate due to the filing system in the MAR chart folder. This meant there was a risk these would not be checked regularly to ensure these medicines were given safely and consistently. Some people did not have their 'when required' medicines in stock. For example, two people had inhalers to help with shortness of breath. Both people did not have an inhaler available if they needed one which put them at risk. A nurse told us they would ask the doctor for a prescription to obtain the inhalers. We spoke with people about medicines prescribed "when required" to ask if they received them when they needed them. One person told us, "When I want my medication for pain I just need to ask." Another person told us they had to ask a nurse several times before they received their pain relief, but stated, "I do get my routine medication with no problems."

Supporting information for staff to safely administer medicines was not available. For example, there was no information documented on MAR charts to inform staff which eyes prescribed eye preparations should be used for. There were people who had been prescribed a medicine to be given 'when necessary' or 'as required' for agitation. Procedures were not available to inform staff under what specific circumstances the medicine could be given. This information was important for staff who may not be familiar with a person so they understood in what circumstances it should be used. We also found that when the medicine had been given, the reason for giving it was not always clearly documented. This information was important to ensure a consistent approach by staff in supporting people with mental health needs.

When people were prescribed a medicine patch for pain relief, records were not always clear where the patch had been applied. This is considered good practice so staff can ensure they place a new patch on a different area of the body. We were told by the nurse this was normally recorded despite us finding this was not the case at the inspection.

Information on MAR charts was not always clearly documented. We noted that the names of some medicines recorded on the MAR chart did not match the name on the medicine container. This was because there was a difference between the 'generic' medicine name and the 'brand' medicine name. The names of medicines had not been noted or changed on the MAR chart to prevent confusion to staff when administering the medicines. One person had two different containers of the same medicine with different directions on each container which did not match the directions on the MAR chart. Also, when changes were made to people's medicine, the changes on the MAR chart were not clearly recorded which meant there was an increased risk of an error. We also noted that one person had been prescribed an external preparation to be applied twice a day, however the MAR chart stated once a day.



On the first day of our inspection we observed two members of staff give people their lunchtime medicines in a way that did not follow safe practice. This was because the nurse remained with the medicine trolley in the medicine storage room whilst a senior care staff member took the medicine to the person. The nurse signed for the administration of the medicine without seeing the person take it. When we asked this nurse how they knew that the medicine had been given to the correct person we were told this was standard practice and that staff "trusted each other". We questioned this and asked to see the provider's medicine policy. The policy available in the home was out of date. One nurse told us they had never been shown or seen a medicine policy. This meant staff had no clear guidance on safe medicine management. The provider was informed about our concerns related to medicine management and by the second day of our inspection provided us with an updated medicine policy dated December 2015. We were advised this had been provided to all staff and the practice of using a second member of staff to deliver medicine had stopped. On the second day of our inspection we observed a nurse took the trolley to people to administer medicines and only signed the MAR once they had observed the medicine taken which was in accordance with safe practice.

Both management staff and the nurses did not have sight of the original electronic prescriptions for people. This meant they could not check what had been ordered and prescribed for people to ensure that the correct amounts of medicine were delivered. We were informed that arrangements were being made with the GP practice to ensure this happened.

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

During our last inspection in October 2015 we found people were not always protected from abuse and harm. Staff did not always recognise incidents of potential abuse which meant they were not always reported to us. As a result of this we were unable to check that risks relating to incidents were being sufficiently managed. There were numerous occasions when people's behaviours had become challenging towards staff and sometimes other people. Some of these incidents had not been managed well and compromised the health and safety of both people and staff. Risks associated with people's care were not identified and acted upon.

Following our last inspection, the provider sent us an action plan outlining how they would make the necessary improvements. This included reviewing all information held within care plan files related to risks associated with people's care and ensuring processes to manage these risks were implemented.

Many of the people who lived at Maple Leaf House had complex mental health needs as well as physical health care needs. This meant we were limited in what we could discuss with them about their experiences within the home. Relatives we spoke with told us they felt people were safe because improvements had been made. This included having a new manager in post which they felt had resulted in changes for the better, however, shortly after our visit the manager left their employment and a new manager was appointed.

Risks associated with people's behaviours were being managed through close staff supervision. This included some people having a staff member allocated to them on a one to one basis to ensure their health and safety needs were met. Relatives felt people were safe because of this close supervision. One relative told us, "I do feel that [person] is (safe). [Person's] behaviour changes from day to day and at the start I was concerned... They watch [person] all of the time now they have to be watched a lot." Another said, "Yes (safe) because they always have someone with him and watching him." We observed staff were present in the communal areas at all times. A staff member told us, "Whatever task we do is for two hours. I am on

observations from 7.30am to 9.30am then somebody else will come and do observations and I will do something else." This helped staff to focus their time more effectively in getting to know people and how to manage their care safely.

We noted that the number of accidents and incidents linked to people's behaviours that were challenging had reduced since our last inspection. Most of the time we saw that people were relaxed and comfortable in their environment. People usually responded positively to staff interactions which indicated they felt reassured and safe. One person told us, "I feel very safe, staff make me feel safe."

Staff were able to tell us about some of the triggers that resulted in people's behaviours escalating and what they did to ensure this was managed or minimised. They also understood their responsibility to report any concerns they had regarding people's behaviours. One staff member told us, "You do know the signs. You know when to go to [person] if they need comfort or you know when to give them a bit of space until they have calmed down." Another said, "Basically we know the clients. We know how to react. After that we need to document the incident, inform the nurse about the gravity of the situation and inform the night staff." They went on to say that folders were available in the nurse's office to record information about people's behaviours. This was so they could share information with health professionals if needed.

We found that whilst there had been some improvements to the management of risks to keep people safe, there remained some areas of risk that required further attention. This included ensuring care records reflected areas of risk and how staff should manage them. Although staff were aware of risks associated with people's care, these were not always clearly recorded in sufficient detail within care plans and risk assessments so it was clear what actions staff needed to take to minimise them. For example, one person was known to present with specific behaviours towards staff that could be difficult to manage. There was no risk assessment around this person's behaviours so it was clear to staff what they needed to do to minimise or manage these behaviours to keep both them and the person safe.

During our inspection there were sufficient numbers of staff available to support people's needs. Relatives we spoke with also felt there were sufficient numbers of staff available, although one relative felt at times the nurses seemed "overworked". When we asked staff if there were enough of them to meet people's needs, they felt there were sufficient numbers available most of the time. Comments included, "I would say 90% of the time. There are days when you get the odd staff phoning in and not being able to come in. It is better than it was" and "With this staff level we are alright, we don't have any problems." One member of nursing staff told us there was usually one nurse on duty each day. This meant that when they were completing a medicine round and completing records, this limited their times to manage the physical nursing needs of people. The manager told us they were available in the home on a full time basis to help support nursing staff if needed. However, we subsequently were advised this manager was leaving the home. The management team remaining was therefore confirmed as the deputy manager, a lead nurse and the business development manager. We were advised this management team would support the home until the new manager started.

Staff knew how to recognise signs of possible abuse and understood their responsibilities to report any concerns to their manager so they could be appropriately acted upon. One staff member told us, "Every resident needs to be cared for properly and I would have no problem reporting concerns." Staff felt that improvements implemented by the management team had helped them to work differently to ensure people were kept safe. This had included increased support by the management team on a day to day basis. One staff member told us, "Yes, you try and make it as safe as possible. Generally the residents seem more relaxed. Just the way we are with them because we have more confidence. We are confident because we have got support from our seniors, the nurses and the manager. We are more aware of where residents are."

They went on to say, "It is calmer – it is better if the patients are happy and the staff are happy."

Recruitment checks were carried out when employing new staff to ensure their suitability to work with people in the home. Staff told us that both written references and 'police' checks were obtained by the manager before they started work at the home.

Personal Emergency Evacuation Plans (PEEP's) were available for each person which included an assessment of their needs and how they would need to be supported in the event of an emergency situation such as a fire. Staff had received training in fire awareness, evacuation procedures and fire drills so they were clear on their responsibilities in keeping people and themselves safe. We noted that staff were required to observe people when they smoked cigarettes to ensure the risks associated with smoking were appropriately managed. We saw this happened.

A fire risk assessment had been completed in December 2015 to identify any potential fire risk areas in the home and the actions required to minimise these. We noted that some of the actions required to comply with this had not been carried out consistently. For example weekly fire alarm checks had not always been completed. Monthly emergency lighting checks had not been completed for January 2016 but had been for December 2015 and February 2016. There was no evidence that any fire drills had taken place.

## Is the service effective?

### Our findings

During our inspection in October 2015 we found there were insufficient arrangements to ensure staff completed the training they needed to carry out their duties to meet people's needs safely and effectively. We found references to restraint being used when people had behaviours that challenged staff and others. When we spoke with staff they were not always confident they were responding to people's behaviours in the safest and most appropriate way. This was a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 – Staffing.

Following our October inspection, the provider sent us an action plan stating that all staff would be provided with training on safeguarding people so they knew how to recognise incidents requiring action and those that needed to be reported to us. The provider also said they would carry out a training audit of all staff and implement training around "core" subjects to help staff meet people's needs effectively. The provider told us they would arrange for staff to receive training in how to respond to people's behaviours.

Staff told us they had attended training to help them work more effectively with people who had behaviours that were challenging. Relatives we spoke with during this inspection told us they felt confident staff managed people's behaviours that challenged well. One relative told us, "They deal really well with [person] when [person] loses it sometimes (person) can get aggressive." Another told us, "They know what to do when [person] is agitated. [Person] can lash out at you. They have all got to know [person] now. Staff are all used to [person]."

Staff told us they felt the training they had undertaken since our last inspection had helped to support them better to carry out their roles. One staff member told us, "We have had the challenging behaviours one, the two day one – PAMOVA (Prevention, Assessment & Management Of Violence & Aggression). I have done react to red (relating to preventing skin breakdown), equality and diversity, nutrition, dignity and accidents and falls." PAMOVA training programmes help staff to develop their skills in de-escalation of behaviours and provide breakaway training and restrictive physical intervention training. One staff member told us, "An outside company came in, it was two days on techniques to manage behaviours. A lot of theory and then practical. There is a lot you can do without having to physically restrain someone. It is important so when something happens you know what to do."

We asked staff if the training had given them more confidence. One staff member told us, "I do, I had PAMOVA training and that kind of explained and showed us what to do in those sorts of situations." Another staff member told us, "However much you know someone, if they are having a moment you are anxious, but the training is helping and you do what you can for the person as much as you are able. If you can't, there is always a senior or someone who knows the person better than you. Whereas before you might have thought, I'm not managing this very well, you know there is always somebody to ask. Sometimes you may not have done anything wrong, but it may just take another person to understand the resident at that time." We saw that staff had put their learning into practice. For example, we observed one person hit out at a member of staff. The staff member stepped back out of reach and continued to talk to the person calmly, quietly and reassuringly. This helped to prevent the person's behaviours from escalating further.

Staff confirmed they received an induction to the home when they started which had included induction training. One new staff member told us they had worked alongside more experienced staff for three days before being allocated shifts on the staff rota. They told us this had enabled them to understand their role and what was expected of them. The business development manager told us that all staff were being supported with ongoing training to ensure they could support people's needs effectively. Staff we spoke with confirmed they were attending regular training. One staff member told us, "Things have definitely changed. When I first started I didn't do much training, I have done quite a bit now."

The person who organised training at the home had arranged training for staff in diabetes and management of catheters which were linked to people's physical care needs at the home. They told us staff competencies in regards to the management of the catheters were to be tested by the person delivering the training to ensure they did this safely. They told us staff could approach the trainer if they had any problems or needed assistance.

We saw that some competency checks had been completed to confirm staff had learned from their training. However, this was not routinely carried out to ensure training provided was resulting in effective learning by staff. This was an area for further development.

A health professional we spoke with was complimentary of the care staff and how they supported people. They told us they had confidence in some of the nursing staff, but there were times when nurses were not carrying out basic nursing tasks. We found that information was not available to the GP to assist them when they visited the home to see people. For example, sometimes basic checks such as weight, blood pressure, temperature and urine testing were not completed to support the GP. There had been one person who required end of life care due to their failing health. We learned that staff had required increased support and advice at this time as they were not confident in delivering and supporting end of life care. Nurse skills were discussed with the manager who gave assurances these issues were being addressed on an ongoing basis. We saw forms had been implemented to prompt nursing staff to record baseline checks for the GP when they visited.

During our last inspection in October 2015, staff were not clear in their understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) to protect people from potential abuse. This was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 – Safeguarding service users from abuse and improper treatment. The provider told us staff would be provided with training to help their understanding of the MCA and DoLS.

During this inspection we found some training had been provided to staff but there were ongoing improvements needed to ensure people were protected from potential abuse.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The nursing staff and manager told us there were people at Maple Leaf who lived with dementia or mental health problems which meant they did not have capacity to make specific decisions about their care and

treatment. There were other people that either had mental capacity or fluctuating mental capacity. Mental capacity assessments had been completed for each person to identify if they had capacity to make decisions independently. One staff member told us, "We try and work in the best interests of the resident."

The provider had sought support from the Local Authority to ensure they were meeting their legal responsibilities under the Deprivation of Liberty Safeguards. We saw applications had been completed to seek authorisation for restrictions placed on people in order to meet their needs and keep them safe. However, there were restrictions implemented in regards to people's care that we could not see had been agreed such as the use of bed rails when people were in bed. The best interests decision around these restrictions was not always demonstrated. For example, there was no evidence of meeting notes where the decision had been discussed despite the manager telling us the use of bedrails had been agreed with the person's family and other interested parties. This meant we could not be confident decisions had been appropriately agreed with family members and health professionals to demonstrate they had been made in the person's best interest. The manager told us improvements were ongoing in regards to this. For example, they told us a best interest decision meeting had been arranged with the family of one person who did not have capacity to discuss whether a medical intervention for a diagnosed health condition would be in the person's best interests. This demonstrated action was being progressed to ensure decisions were made appropriately.

When speaking with staff, we found they were aware of the MCA and had completed some training to help them understand the MCA and DoLS. Staff understood the importance of obtaining people's consent before delivering care. One staff member told us, "I think they have capacity, with some it depends on the stage of their dementia or their mental health problems. They can choose between one thing and another thing, that is why it is our duty of care to offer them choices." However, we found staff were not able to tell us about restrictions to people's care that would require a formal DoLS application to be made. Most staff we spoke with were also unclear in their responses when we asked them about DoLS under the MCA. One staff member told us their training had consisted of a "PowerPoint" presentation but felt they needed more training. They told us "No I don't feel confident with it. I know capacity can change on a whim." Another staff member told us, "DoLS is to keep people safe." However, they were not able elaborate on this further suggesting they did not fully understand this.

The provider's business development manager acknowledged that staff would benefit from further support and training to help them have a greater understanding in regards to MCA and DoLS and how this impacted on people. They told us that arrangements were in progress for this to happen and they had employed a new staff member to specifically organise and deliver training to staff. During our inspection we spoke with a DoLS assessor who was visiting the home. They explained how they had been providing support to the manager in regards to their understanding of MCA and DoLS. This demonstrated action was in progress to help ensure people were protected from decisions being made against their wishes.

Staff told us they had regular one to one supervision meetings with their manager where they talked about any concerns they had and any areas for their development. One staff member told us, "I recently had one with the manager. We discuss any issues, improvements, anything that can make us better in our role." Records of supervision meetings showed these had increased throughout the months of December and January 2016 to help ensure staff were being supported in their roles with any training and development needs. However, we could not see that any supervision meetings had taken place in February 2016 and some staff had no supervision meetings recorded at all. The business development manager told us there was a supervision plan to ensure all staff regularly completed supervision meetings with their manager and this would be regularly checked.

We spent a period of time observing mealtimes to see if this was a positive experience for people. Some people chose to eat in the lounge or in their room but generally people ate their meals in the dining room. The lunchtime experience was relaxed and people were offered choices so they had what they wanted to eat and drink. People told us they enjoyed the meals provided. Comments included, "It's good food, and they give me a choice" and "The food is brilliant." Another stated, "The food is really good here and I can ask for food when I am hungry."

At lunchtime people who needed specialist diets such as pureed or liquidised meals were provided with them. Staff were available to offer encouragement or assistance where needed. For example, they asked people if they wanted their food cutting up. One person who was assisted to eat was not rushed and the staff member waited for each spoonful to be swallowed before offering another. One person who repeatedly refused to eat was encouraged several times. We noted during breakfast that when one person would not eat their breakfast they were offered an alternative choice by the cook which they accepted and ate.

We looked at the nutritional assessment for one person and saw the instruction, "Staff should offer him high fibre foods such as green leafy vegetables and wholegrain." However, through discussions with the person's relative, we established they did not like green vegetables. As these were frequently put on the person's plate, they would not eat their meal. Through discussions with staff we found that people were not involved in menu planning to ensure the food they were provided with was in accordance with their likes and preferences. The cook was aware of some likes and dislikes that had been reported to them through staff, but agreed that involving people in this way could help to improve their mealtime experience.

The cook told us that if they knew someone was losing weight, they fortified foods by adding extra calories such as cream and milk powder to help people put on weight to maintain their health. They also made available high calorie foods such as full fat yoghurts and milk. However, there was no clear system of communication between the cook and staff so that when people were not eating well this was known throughout the staff group so they could provide consistent support to addressing a person's weight loss. This was discussed with the business development manager so that communication systems across the home could be improved.

## Is the service caring?

### Our findings

People and relatives we spoke with were positive in their comments about the staff. When we asked them if staff were caring they told us, "The staff are definitely caring people" and "They care for me well; they help me when I need to do things." One relative told us "Yes (caring) the way they talk to them (people). Not just [person] but the way they deal with the others." Another stated, "Staff are wonderful and caring."

One staff member explained how giving people their time when they needed it helped to keep people calm and content and how this often influenced how they were for the rest of the day. They gave an example of this with one person. They told us, "First thing this morning I could spend more time with [person] and not rush. How she is in the morning sets her up for the rest of the day." Another staff member told us, "The residents seem more relaxed. Whether it is because they are getting a nice mix of staff. Some of us are better with some residents which is natural."

We saw that staff were very vigilant in observing people to make sure their needs were attended to and their anxiety levels were not increased. We observed the caring approach of a staff member who went to attend to a person who was in bed. They explained everything they were going to do so the person knew what to expect. They stated, "[Person] we need to make you more comfortable. We need to slide you a bit more up on the bed, is that okay? I'm just going to move your pillow up a bit. Can I take this blanket please?"

When staff carried out care interventions such as hoisting a person they were reassuring and caring in their approach. We observed that when staff assisted one person with a hoist they talked calmly to the person to tell them what they were about to do and offered reassurance throughout the whole process. This helped the person to feel relaxed and calm.

Where one person was not able to communicate verbally we saw the person had been provided with a communication board which was used by the person and staff. This helped ensure the person was involved in making decisions to make sure their needs were met in a way they preferred.

When talking to people staff always knelt down to be respectful and communicate with people on the same level. Staff constantly offered physical reassurance to people by stroking or holding people's hands. When one person was asleep staff stroked their arm gently to wake them up without startling them. Staff spoke with people calmly and kept their voices at the same level to help people feel reassured. We observed that staff acknowledged people when they entered a room to help them feel valued. For example, one staff member said "Good morning [person]. You are looking very smart today. How are you feeling this morning?"

We saw that staff encouraged people to make choices about their daily lives such as what they would like to do during the day, where they would like to sit and what they would like to eat and drink. Some people became anxious if their requests were not met in a timely way such as being given a cigarette when they wanted one. Staff managed these situations well and always attempted to meet requests in a timely way to prevent people's behaviours from escalating.



People felt staff were respectful and that their privacy and dignity was respected most of the time. One person told us, "The majority of the time staff respect my dignity and privacy, however there are occasions when staff walk into my room without knocking." Another said, "Staff are nice, polite and nothing is a problem." We observed that people's dignity was respected. For example, when a care staff member walked with someone they noticed the person's trouser leg was rucked up. They bent down and straightened the trouser leg. When one person lifted up their top and exposed their stomach a care staff member went straight over and straightened their top. One care worker noticed a person's nose was running and got them a tissue and said, "I'm just going to wipe your nose." We noticed that some people in their rooms on the ground floor could be seen from the pathway running alongside the home. One person in these rooms was at risk of their privacy and dignity being compromised. We discussed this with the business development manager who agreed to look at how best the person's privacy could be maintained without restricting their view.

During our last inspection we noted that some areas of the home had an unpleasant odour which compromised people's dignity and enjoyment of their environment. We did not identify any unpleasant odours during this inspection.

Families and friends told us they were able to visit at any time and people were supported to maintain relationships with people who were important to them.

## Is the service responsive?

### Our findings

People spoke positively about living at the home and relatives felt that people's needs were being met. Comments included, "I couldn't fault the care [person] is getting. [Person] is unpredictable because they have Alzheimer's and they are really able to handle [person]." And, "They look after [person] very well and take [person] out when they want."

We saw a record of a compliment received by the home which demonstrated the person's needs were being met. This stated, "Every day the wonderful staff take care of his every need and look after him in, what appears to be, exactly how his family would if we had him at home. They have each got to know him personally and know all the things he likes and dislikes to make his day better. He is always clean, tidy, shaved and groomed to perfection."

We observed that people were involved in decisions about their daily care and staff respected decisions they made where this was appropriate. For example, when care staff assisted a person to the lounge they went to get a footstool to elevate the person's leg. The person shouted, "I don't want that." The staff member responded by saying "That's alright" and did not pressurise the person to use the stool. However, when another staff member walked in, the person asked for the foot stool and it was put in place to support their leg. The person asked for a cup of tea and staff responded they would get this right away.

Those people who had difficulty communicating were not excluded from social interactions and experiences. Staff communicated with some people by using gestures such as "thumbs up" to confirm if the person was happy with the care intervention they were about to carry out.

There was evidence of some person centred planning where people were supported with positive risk taking to maximise their independence. For example, in accessing the community independently where this was deemed appropriate. Staff supported people to do as much for themselves as they could to maintain their independence. We saw when one person wanted to alter their position in their chair, staff gave them step by step instructions such as "Put your hands there, help yourself and move backwards" so they could do this independently but safely.

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. People and relatives had some involvement in care planning although some people told us they had not seen their care plan and were not aware of what was in it. We asked staff if they had time to read care plans so they knew about people's needs. One staff member told us, "Yes, and we are told we have to read the care plans and if you need time to read them, just to ask." Another told us, "I do in my own time and they do a care plan meeting on a Thursday. One of the nurses will take us through stuff, anything you need to know. I do find it useful." During our last inspection we found that care plans lacked information to help staff in delivering care that met people's needs. Since our last inspection, care plans had been reviewed and contained more information to support staff in delivering care that was responsive to people's individual needs.

Staff were able to describe people's needs but we found when people's needs changed, staff were not always aware of the changes. For example, one staff member knew about a wound on a person's foot, but were not aware of a wound on another person's foot. This meant we could not be confident that staff were always informed about people's needs in a timely way to ensure those needs were consistently met.

When we looked at the care files, specific information about people's care needs was sometimes difficult to find or was not accurate. For example, in one person's file there was a body chart that identified they had a wound to their leg in February 2016. There was no follow up information to show if this had healed or a skin care plan if the person had any wounds to show how they should be managed. We asked to see mental health care plans for people and of six care files viewed, only one had a mental health care plan to support staff in supporting people's mental health needs. One care plan contained information about the triggers that caused the person to be anxious which could cause them to present with behaviours that challenged them and others. The actions staff needed to take to reduce or minimise these triggers were not sufficiently detailed to support staff and ensure a consistent approach. However staff observed had a good understanding of how to support people at these times.

One care plan contained a "Manual handling strategy" that was dated February 2016. This stated the person required "minimal assistance" when moving in bed and was able to turn in bed independently. However, we observed two staff members moved the person in bed using a slide sheet. The records did not accurately reflect how the person needed to be supported. This meant that the person may not always receive the support they need.

A nurse told us that one person was hoping to leave the home to live more independently in new accommodation. When we viewed this person's file, there were no clear objectives and goals for the person to help support them in achieving this. We also did not identify from staff there were clear goals in place to support the person with the transition into more independent living.

Information about people's background and social preferences had improved within some care files to help support staff in delivering person centred care, but the collection of this information was ongoing. People had access to social activities including some social outings of their choice. Staff had some knowledge of people's hobbies and interests and supported people with these where possible. For example, one person had an interest in horses and staff had arranged a visit to a farm. A relative told us, "They talk to me about [person's] interests and what they like and things .... I know they try to take [person] out quite regularly I have seen photographs of [person] around Maple Leaf."

We saw photographs around the home of people smiling and participating in activities arranged at the home indicating they had enjoyed them. A notice board on the units confirmed what social activities were planned each day. One person was due to celebrate a special birthday and the cook had arranged for them to have a birthday cake. Staff told us they had supported the person to spend time with their family to celebrate their birthday.

People and relatives that we spoke with said that the new manager in post was approachable and they would feel comfortable to raise any concerns they had with them. One commented, "I would go to the manager. Yes, I feel they would sort any problems out." Relatives were able to give examples of concerns they had raised with the manager and the actions they had taken to resolve these. In some cases this was making more specialist equipment available to support their family member's needs. A professional visitor told us that in addition to the manager they were also able to approach the deputy manager with any concerns who they felt confident would address them.

There was a complaints procedure available at the home for people to follow if they had any concerns. However, we found the procedure was not being followed consistently in managing complaints received. The complaints register did not contain all of the complaints that had been received by the home. The business development manager located copies of letters of complaints received following our last inspection that had not been entered onto the register as required. Some of the complaints had not been responded to in writing to demonstrate they had been sufficiently investigated and actioned. However, we were told that the manager had verbally responded to some of these. In some cases it was not clear from records that the person who had made the complaint was satisfied with the outcome of the investigation and actions taken. The business development manager told us that action would be taken to address these issues.

# Is the service well-led?

## Our findings

At the time of our last inspection in October 2015 the provider was in breach of Regulation 17 HSCA (Regulation Activities) Regulations 2014 (Part 3) Good Governance. The provider did not have suitable systems and processes to monitor and improve the quality and safety of services provided. There were also insufficient systems to manage risks related to the health, safety and welfare of people and records were not always sufficiently detailed and accurate to support safe and appropriate care.

Following our inspection in October 2015, we met with the provider and others of their management team who would be undertaking the improvements at Maple Leaf House. They provided us with an action plan telling us how they would improve. We carried out this inspection to ensure sufficient action had been taken to make these improvements.

At this inspection we found that overall improvements had been made and outcomes for people who lived at the home had improved. However these were ongoing and needed to be sustained. Quality monitoring systems had been devised and implemented. Work had commenced on improving the provider's policies and procedures such as medicines, complaints management and audit systems. Audit checks had been introduced to monitor any falls, accidents and incidents. We noted that work was ongoing to improve care plans to ensure they were person centred so that the care planned and delivered was in accordance with people's preferences.

We found there had been some improvement in communication systems across the home but new systems for effective communication were still being embedded. This was because it was clear that the management team's roles and delegated responsibilities were continuing to be established. For example, we found we had to approach different members of the management team to find out the information we needed to establish whether the home was being effectively managed. We acknowledged the recent new addition of staff including a new manager and new nurses had impacted on this. However, we found staff had a clearer understanding of their responsibilities within the home and what was expected of them. We saw there had been monthly staff meetings where communication had been discussed to help improve this. Staff were reminded that this was 'key issue' that needed to be improved. Staff told us they had attended a team meeting where they had shared information amongst themselves about what was happening at the home and what their responsibilities were. This was to help ensure a consistent approach to meeting people's needs. One staff member told us, "We have had a team meeting and discussed the residents, the care plans, the new management structure, their responsibilities, the senior's responsibilities and our responsibilities. It was all about responsibilities."

During our last inspection in October 2015 we found accidents and incidents were not always being reported to us as required. The manager told us that accidents and incident records were being checked to make sure any necessary actions had been taken in response to them. An 'Incident monitoring tool' was now used to identify potential accidents and incidents that would need to be reported to us. However, when we looked at this we found that although a number of accidents and incidents had been reported to us, there were incidents that should have been reported to us that had not been. For example, there were 11

"physical attack patient to patient" incidents recorded on the monitoring form between October and December 2015. However, only one of these potential abuse incidents had been reported to us in accordance with the required notification reporting process. This was an issue we identified for action at our last inspection. We also noted that the monitoring form showed there were no medication errors recorded. However, we identified during our inspection that the processes and systems to check effective medicine management were not effective or sufficient to make sure any medicine errors would be identified.

Systems for managing medicines remained unsafe and we noted that the provider's new medicine policy had been delayed in being implemented. Medicine management was identified as an area needing improvement at our previous inspection in October 2015. There was no clear system for managing medicines that was consistent. Medicine audits had not been effective in identifying errors and ensuring suitable actions were taken to prevent them happening again. The provider told us they were committed to ensuring the necessary improvements were made. Following the first day of our inspection when we communicated some immediate areas needing attention, the provider had responded to these so they were addressed by the second day. This demonstrated this commitment. They told us they would continue to work with the clinical commissioning team and pharmacy to ensure improvements happened. They would also continue with increased monitoring to identify any medicine errors or concerns.

Quality monitoring systems included a survey that people living at the home had been asked to complete about their experiences of the home. This had been completed in November 2015. Responses seen were positive in a number of areas including their privacy and dignity needs being met, and the social activities provided. People indicated they were happy in the home. There were less positive responses in regards to people being involved in the development of their care plan and feeling their dietary needs were being met. Our inspection visit indicated that some action had been taken to address these areas. However, people were not involved in menu planning to ensure the meals provided on an ongoing basis were of their choice. We had also found people were not aware of their care plans to confirm their involvement in developing them. People that we had spoken with could not recall seeing the outcome of the survey so they knew what actions had been taken to address the issues raised.

We identified during our inspection that the rating awarded to the home following our last inspection was not displayed. This was raised with the business development manager who advised this would be immediately addressed. We subsequently received confirmation that our inspection report showing the rating had been placed on display in the reception area of the home.

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

The home continues not to have a registered manager in post. Since our last inspection the home had employed a new manager. They had been in post for three weeks at the time of our inspection. People and relatives we spoke with told us they had noticed improvements in the management of the home. They told us, "At first it was ok and then it went down. Since the new manager has started it has been much better." And, "This new lady [manager] came on she is wonderful she is absolutely wonderful. She is putting things in place that were not there before and I think she is going to do wonders." However shortly after this inspection the provider told us the manager had left their employment and a further manager had been appointed. In the interim staff are able to approach the new deputy manager, the business development manager or the new lead nurse for support.

Staff were complimentary of the new manager for the period of time they were in post they felt managed

situations well that required their support. Staff felt that improvements had been made to the home and this was partly because they felt more supported by the management team in carrying out their role. One staff member told us, "We are listened to more. If you say you have concerns about someone, they will listen to you. Morale is better. Staff seem to be supportive of each other. You know who you can ask for support." Another staff member told us, "I think it is a lot better with new management and good staff. There is a good relationship with the management. Any problems you can go to them."

There had been changes to the nursing staff at the home and care staff and relatives felt the new nurse team had helped in making improvements at the home. One staff member told us, "They have had a few changes with the nurses and introduced a new nurse. They have come down and covered breaks. If you have problems you can give them a shout and they will always come down." We asked this person if the standard of care had improved. They told us, "It has definitely gone up. At the beginning it was a struggle. Now we are improving daily, especially since the management changed. The quality of care was always here, but it opened our eyes that we had a lack of communication."

The provider had implemented a staff survey in October 2015 so they could determine staff views of their experiences of working at the home. There were mostly positive responses about the training, supervision and management support staff had received. There were some negative responses in regards to staff not feeling appreciated for the "hard work and effort" they put in to the home and about their concerns being taken seriously. At the time of this inspection staff told us that some improvements had been made in relation to this and most staff spoke positively about working at the home.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 17 HSCA RA Regulations 2014 Good governance  Systems and processes to monitor and improve the quality of services provided and to manage people's health, safety and welfare were not fully effective. This included records not always being sufficiently detailed and accurate to support safe and appropriate care. Regulation 17 (2) HSCA (RA) Regulations 2014



This section is primarily information for the provider

## Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  The risks associated with medicine management were not being identified resulting in medicines not being safely managed. Regulation 12 (2) (f) (g) HSCA (Regulated Activities) Regulations 2014 (Part 3)

**The enforcement action we took:**

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