Maple Health UK Limited

Maple View

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This comprehensive inspection took place on the 08 and 22 November 2017 and was unannounced.

Maple View is a residential care home that provides personal care and support registered for up to five people with a sensory impairment, learning disability and/or autistic spectrum disorder. People using the service live in a purpose built bungalow, located within a residential community setting alongside four other individually registered services run by the same provider. On the day of our inspection there were five people living in the service

At the last inspection, the service was rated Good. At this inspection, we found deterioration in the overall governance of the service and so the overall rating is Requires Improvement.

The registered manager was also one of the organisation's directors and managed another nearby residential care service. A team leader supported them with the day to day management of the service. 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.

There were sufficient staff on duty at the time of our inspection. A safe recruitment process was followed to ensure that staff employed were suitable for the work they were employed to perform. However, training for permanently employed staff was not effective. The registered manager provided the majority of training but was not accredited to provide training in British Sign Language to Level one. We identified concerns about staff understanding of current good practice. Staff did not demonstrate knowledge of safe care and best practice in caring for people with sensory needs and those who may present with behaviour that may pose a risk to themselves and others.

Staff did not all receive appropriate training to understand the complex needs of people using the service. Behaviour, which may have impacted on others, was not always managed correctly with clear guidance for staff in responding safely and appropriately. The management of behaviours, which had a negative impact on others, was inadequate and placed people at risk of harm.

There was a lack of learning from incidents and events with action taken to improve safety as the provider's system for incident reporting and further analysis was ineffective.

Agency staff employed did not always have the skills, knowledge and relevant training to meet people's needs. We found that no check had been carried out which would assure the provider that staff employed from agencies had the skills, knowledge and experience to meet the needs of people who lived at Maple View.

Whilst we found there were safe systems for the management of people's medicines and prevention and control of infection, further work was needed to ensure robust fire evacuation procedures were in place. Fire safety checks had not been carried out at the regularity as required. We recommend the service follow good practice in the carrying out of fire drills so that these are used as a learning opportunity and to mitigate risks to people's safety and welfare.

People's care was not always planned in a manner that was responsive to their needs. People had care and support plans in place but these were not always updated, reviewed or reflective of their current needs. People were supported to access health services but staff had not always been provided with up to date relevant information for people living with complex, medical health care needs. Improvement was required to ensure that the full range of people's needs were being met.

The views of people were surveyed through monthly, through monthly one to one meetings with their keyworker. Relative and staff satisfaction surveys had been carried out. However, there was little evidence of any learning from this feedback or how responses received initiated any action plans for the continuous improvement of the service.

The registered manager did not operate effectively an accessible system for receiving and responding to complaints. People did not always have their complaints responded to in accordance with the provider's policy with any audit trail of actions in response. This meant people's concerns and complaints were not effectively listened to and used to improve the quality of care.

People were not supported by a service that had a good record management system. We found records management to be chaotic and poorly maintained.

People had enough to eat and drink with access to drinks and snacks. However, for people diagnosed with diabetes there was insufficient information to guide staff with and planning to meet their needs.

The governance framework for the service did not ensure that responsibilities were clear and that risks and regulatory requirements were understood and managed.

There were ineffective quality assurance mechanisms in place, with overall governance of the service, which would have identified the shortfalls we found at this inspection. There was a lack of learning from incidents and events with action taken to improve safety as the provider's system for incident reporting and further analysis was ineffective. This meant that risks to people and staff safety and welfare were on going. The failure to develop effective systems for management and governance of the service had left people at the potential risk of harm.

This inspection identified 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 this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

The management of behaviours, which had a negative impact on others, was poor and placed people at risk of harm.

The provider's system for incident reporting and further analysis was ineffective. There was a lack of learning from incidents and events with action taken to improve safety.

There were sufficient staff on duty at the time of our inspection. A safe recruitment process was followed to ensure that staff employed were to the service were suitable for the work they were employed to perform.

There were safe medicines management systems in place and prevention and control of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff including agency staff were not provided with appropriate levels of training to enable them to carry out their duties effectively and meet people's assessed needs.

People were supported to access health services but staff had not always been provided with up to date relevant information for people with diagnosed with complex, medical health needs.

There were ineffective systems in place which would support staff to communicate the needs of people when being transferred to other services, such as admission to hospital.

People were supported to eat and drink sufficient amounts to maintain their health.

Staff were trained in understanding their roles and responsibilities with regards to the MCA 2005. The need to obtain consent was understood by staff.

Is the service caring?

Requires Improvement

The service was not consistently caring.

While staff were caring and respectful people did not always have their needs met in a personalised way.

The views of people were surveyed through monthly in one to one meetings with their keyworker. However, there was little evidence of any learning from feedback or how responses received initiated any action plans for the continuous improvement of the service.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had care and support plans in place but these were not always updated, reviewed or reflective of their current health, welfare and safety needs.

There was a failure to recognise the need to log complaints and evidence outcomes with actions taken.

Is the service well-led?

Requires Improvement

The service was not well led.

There were ineffective systems and process in place to enable the registered provider to identify where the quality and the safety of the service was being compromised.

The governance framework did not ensure that responsibilities were clear and that risks and regulatory requirements were understood and managed.

People were not supported by a service that had a good record management system. We found records management to be chaotic and poorly maintained.

Maple View

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on the 08 and 22 November 2017 and was unannounced.

One inspector and an expert-by-experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience had experience of providing support to people with a learning disability.
Prior to our inspection we received some information of concern. In response, we looked at how the service protected people from the risk of harm. The local safeguarding authority also notified us of incidents, which were being investigated under local safeguarding procedures.

Prior to our inspection the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also looked at safeguarding concerns reported to us prior to our inspection. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect.

During our inspection, we spoke with two people who used the service. Because some people using the service did not have capacity to answer our questions, we observed interactions between staff and people. We also contacted three relatives to ask for their views.

During our inspection, we spoke with the registered manager, the team leader, two agency staff, three senior support workers and two support workers. We reviewed care records for three people who used the service, reviewed three staff recruitment files, staffing rotas, staff training records, meeting minutes, medicines management, quality and safety monitoring audits.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection, we received information of concern about the management of incidents and the lack of action taken to mitigate people from the risk of physical and emotional harm.

Some people using the service had complex needs, which impacted negatively upon others, which could have resulted in harm to staff or other people if not managed correctly. The management of these behaviours is a specialised area and requires staff who have developed understanding of how to recognise triggers and support people safely and proactively to mitigate the risk of harm.

When asked if people felt safe living at the service, one person told us, "If things kick off with one person, I am kept in my room with a member of staff to keep me safe. But that's not good, I'm not a child. Most of the time its fine and I can wander around as I wish. It's all very flat here with no stairs so I can be more independent. I am happy here, I love the place to bits. We've had problems with some behaviour. Everybody [staff] have done the best they can, but it's not easy with no sight, as I can't tell what's going to happen. If you can't see anything and someone comes up to you and grabs your hair it's scary."

Records we reviewed and discussions with the registered manager and staff showed us that there had been number of incidents, which had caused people who lived in the service to experience distress and ongoing anxiety. There had incidents when staff had needed to intervene to prevent people experiencing harm or distress.

The provider had in place a 'Restraint and Physical Intervention' policy with procedural guidance for staff, which contained conflicting inaccurate information. This policy had a date stating when it had been reviewed, in March 2017 but information it contained was long outdated and incorrect. For example, the policy referred staff to care homes regulations no longer relevant. It also guided staff to refer any concerns they might have to the Care Quality Commission's (CQC) predecessor organisation.

Physical intervention training was provided by the registered manager for all staff across the provider's registered locations. This course included some theory and practice with instructions for staff in the use of breakaway techniques and one escorting manoeuvre. The registered manager told us they had put this training together using information obtained from the internet and confirmed this training was not provided by any accredited trainer or accredited training material. We also noted from a review of the staff training matrix that not all staff had received this training.

Following recent safeguarding concerns in relation to the care and support of one person, the local authority, Behavioural Advisory team had provided advice and support to guide the registered manager in implementing a positive behaviour support plan. However, we noted that only four staff had signed to say they had read and understood this plan. Agency staff told us they had not been provided with access to this plan and had not been made aware of the risks it described, potential triggers and action they should take to mitigate the risk of harm to the people they supported, themselves and others.

Checks of agency staff employed to cover for shortages of staff were not carried out to ensure they were competent to work at the service. The registered manager could not confirm if agency staff had received training in the application of positive support plans, the associated use of physical interventions to manage behaviours, which may challenge and supporting people with sensory impairment. This meant people and staff were exposed to the risk of harm.

There was little evidence of learning from events or action taken to improve safety as the provider's system for incident reporting and further analysis was ineffective. Discussions with staff and the registered manager showed us that recent incidents where aggression shown by some people had meant that, some form of physical intervention had been used. A review of care plans, risk assessments and incident reports showed us that there was a lack of effective monitoring of incidents with insufficient information to provide analysis and agreed actions with guidance for staff. For example, the provider's policy stated staff should use Antecedent Behavioural Charts (ABC) charts to record and monitor incidents of behaviour, which may present as a challenge and put others at risk. The aim of using an ABC chart is to better understand what the behaviour of the person is communicating or the event that occurred before the behaviour was exhibited. This information also enables the provider to put in place a plan to guide staff in mitigating and responding to incidents. We found there was a lack of monitoring using the ABC forms to aid analysis. Incidents report forms were rarely signed as seen by the registered manager and did not always provide a record of actions taken in response. We saw that in response to one incident staff had recorded, 'they [person using the service] should not be here we cannot meet their needs'. This meant that risks to people's welfare and safety had not been appropriately monitored and managed with actions to keep people to stay safe.

This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they understood what steps they should take to identify and protect people from the risk of abuse. Records reviewed showed us that staff had received training in safeguarding adults from the risk of abuse. The registered manager and staff were able to explain the process for reporting any abuse and who their concerns could be raised with, including the local safeguarding authority. Staff told us they were aware of how to find the provider's whistleblowing policy. This is a policy, which guides staff in how to report concerns about poor practice within their organisation and to local safeguarding authorities.

On the two days of our inspection, there was sufficient staff on duty to ensure they received the support they needed. Staff knew the people they supported well and ensured they were supported to participate in personalised activities. We observed people were provided with care promptly when they needed it or on request. The registered manager, staff and people who used the service told us there had been a recent high turnover of staff, which had resulted in a high dependency on the use of agency staff in the last year.

A review of staff recruitment files and discussions with staff showed us that the registered provider had a system in place to ensure appropriate recruitment checks had been carried out before staff started working at the service.

People's medicines were stored and managed appropriately, although the corresponding information in care plans was not always up to date. Medicines had been stored safely and effectively for the protection of people using the service. There were clear personalised protocols in place for staff to guide them when administering 'as and when required' medication such as pain relief. Guidance on each person's prescribed medication could be found in their care plan and this included information as to possible side effects, also alerting them to any allergies.

We carried out an audit of medicines stock against medication administration records (MAR). We found three items of medicines, which did not have any record of amounts received or carried forward on the MAR records. This meant we could not carry out an audit of stock for these medicines. All other stock audited, tallied with records maintained. We discussed the shortfall with the registered manager who took immediate action to rectify this.

Staff responsible for the administration of people's medicines had received training in medicines management and were regularly competency assessed. .

One person told us, "I know all about my medicines and it's always the correct two people giving them out. If you ask for anything they do it immediately."

Infection control measures were in place with cleaning schedules to reduce the risk of cross contamination. Regular checks had been completed to help ensure the service was well maintained and that people lived in a safe environment.

Further work was needed to ensure fire safety checks were carried out as required. For example, fire equipment checks had not been carried out in line with the provider's policy. Records of fire drills did not provide information about the drills to show they were carried out regularly and effectively. For example, how long each drill took, any observations about how people reacted or general learning points to improve evacuation processes.

We recommend the service follow good practice in the carrying out of fire drills so that these are used as a learning opportunity and to mitigate risks to people's safety and welfare.

Requires Improvement

Is the service effective?

Our findings

Staff including agency staff employed did not always have the skills, knowledge and relevant training to meet people's needs. Further work was required to ensure staff had the skills, knowledge and experience they needed to deliver safe and effective care and perform the roles for which they were employed.

One person told us, "I feel safe here inside and when I go out but only if I have staff trained to guide a blind person, lots of them can do that but the agency staff haven't got a clue, and I don't like to be held. I have refused agency staff like the one supposed to be working with me today because they have not been trained in guiding a blind person. I don't feel confident with them." Another person told us, "I am fed up with them allocating agency staff to me who have not been trained to support me or anyone else who is blind."

All five of the people using the service were either registered blind or lived with a hearing impairment. People living with severe hearing impairment required support from staff who had been trained to communicate with people using British Sign Language (BSL). Staff told us, "It is hard work if you are working with someone who has not been BSL trained. We noted from a review of the staff training matrix that not all staff had been provided with this training. We spoke with two agency staff working at the service. They both told us they had not been trained in BSL and neither had they received any training in providing support to people who were registered blind.

We reviewed the provider's agency staff induction profile. We found that no check had been carried out which would assure the provider that staff employed from agencies had the skills, knowledge and experience to meet the needs of people who lived at Maple View.

The registered manager told us that they personally provided the majority of training to staff across all of the provider's services. The training delivered by the registered manager included; Positive Proactive Intervention (PPI), training to equip staff with knowledge of safe de-escalation techniques and sensory awareness training. They also told us they had not obtained any teacher training qualification or accreditation to deliver training in these subjects and the training they provided in (BSL) to Level one where accreditation would be required.

All other training such as health and safety, emergency treatments, medicines management and safeguarding had been delivered via an external training organisation.

Staff told us they received supervision support occasionally but this was not always planned and provided on a regular basis as per the provider's policy.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to access health services but staff had not always been provided with up to date relevant information for people with diagnosed with complex, medical health needs.

People told us they had access to healthcare services to receive ongoing healthcare support. We observed staff supporting people to attend hospital and GP appointments. One person told us, "I've got a bus pass and can go to the hospital whenever I need to. When I go to a doctor or hospital consultant, I always go with staff I like and am comfortable with. I will refuse to go with agency staff because they don't know how to support people you are blind." Another told us, "'I go to the local doctor's surgery, it's nice. I don't like my own doctor as I don't understand him but he has given me some cream today to put on and I am on other medication which helps."

People had care and support plans in place but these were not always updated or reviewed to reflect their current health, welfare and safety needs. We found vital, important information described in pre-admission assessment records provided by placing commissioners. This information had not always been included in the person's plan of care. For example, important information about people's complex health care needs and identified risks to their welfare and safety. Where people had accessed the service on a short term, temporary basis there was insufficient review of their care.

We found records in relation to people's healthcare needs were chaotic and not everyone had a health action plan in place. Staff did not always have access to the information required to guide them in meeting the needs of people with multiple health conditions. For example, those diagnosed with diabetes, heart conditions and those with a previous history of cancer. There was a lack of care planning to guide staff in meeting the needs of people registered blind and those with significant hearing impairment.

The provider did not have clear systems and processes for referring people to external services, for example, when they required emergency admission to hospital. There was a lack of information available to access in the event of an emergency or when transferring the care of people to other services. This put people at risk of not having their healthcare and communication needs met.

We found there were no 'hospital passports' in place as is common good practice in services provided for people with a learning disability. The aim of a hospital passport is to assist people with learning disabilities in their transition to hospital. This would provide clinical staff with important information about the person, their health and communication needs. We discussed this with the registered manager who told us, "We do not need to provide this I would send staff with the person." The National Institute for Clinical Excellence (NICE) guidance for care homes states, 'Health and social care providers should develop a care plan with adults who have identified social care needs and who are at risk of being admitted to hospital. This written information should include the person's care plan, communication needs and contingency planning for all aspects of the person's life. If they are admitted to hospital this would enable clinical staff to refer to this plan and meet people's needs'.

The registered manager told us that one person had recently absconded from the service and was found later having turned up at a local police station. We noted that that since this incident their care plan had not been updated with any risk assessment or protocol to guide staff in steps they should take to mitigate and respond to a repeat incident.

This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's dietary needs were identified as part of their care plan. One person told us, "They are pretty good to me about my meals, I get plenty of hot drinks, and I have my chicken and roast potatoes when I don't like what everyone else has. We choose the sort of things we like and it's not bad."

People had enough to eat and drink. We observed people had access to the kitchen and encouraged to express their preferred choice of food and help with the preparation of meals. We observed during lunch each person, regardless of the level of disability, was fully engaged in expressing their likes and dislikes with their choice of meal. For people diagnosed with diabetes there was insufficient information with guidance for staff and planning to meet their needs.

People lived in a purpose built bungalow with rooms decorated and personalised to reflect their personalities.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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).

Only three out of ten staff had been provided with training in understanding their roles and legal responsibilities in relation to the MCA and DoLS. This meant that not all staff had been supported to understand the requirements about obtaining consent and the steps they should take to protect people's human rights and ensure compliance with the law.

The registered manager told us there was no one currently using the service subject to a DoLS. The review of care records showed us that some best interest decision making had taken place; however, there was a lack of information contained in care plans and risk assessments in relation to these decisions.

Requires Improvement

Is the service caring?

Our findings

Everyone we spoke with including relatives were positive about the caring nature of the staff towards the people they supported. One person told us, "I am very, very comfortable with my keyworker. I go out with so many but she is the one I like to go out with. We chat and I can talk to her about most things. However, they [registered manager] really do need to explain to new staff and especially to those agency staff that I've lost my sight, not my mind. They are not always properly informed or trained. This is not very caring of me is it?" Another told us, "It's just a lovely home really, better than the home I came from. The staff are nice, they have agency staff and I don't like change but our staff are nice."'

One relative told us, "I am really pleased with the care. They always update me. [Relative] is encouraged to go out and [relative] is a new person, they used to be a recluse but loves it here." Another told us, "The staff are kind. My voice is heard and if I have any concerns it's easy to contact them [staff]".

We spent time with people in the communal areas and observed there to be a relaxed and caring atmosphere. People were comfortable and happy around staff and there was laughter between them as they chatted. We saw that staff encouraged people to express their views and listened with interest and patience to their responses. People who expressed any form of anxiety were attended to with patience, lots of reassurance and kindness.

All staff had received training in relation to equality and diversity, which had been provided by the registered manager. Whilst care plans were detailed with regards to people's personal care including morning and bedtime routines we found a lack of information, which would describe how support would be provided to meet people's diverse needs. For example, what was important to the person in relation to their life history, spirituality, their cultural background, hopes and aspirations. There was a lack of information to evidence people had been involved in planning how support would be provided to maintain their personal relationships and express their sexuality. We discussed our findings with the registered manager who told us this information was not something they had considered including in their assessment of people's needs unless the person receiving care and support requested this to be included. We were not assured that people's views had been gathered and as such opportunities provided for people to express what was important to them.

The views of people were surveyed through monthly, one to one meetings with their keyworker. Relative and staff satisfaction surveys had been carried out. However, there was limited evidence of any learning from this feedback or how responses received initiated any action plans for the continuous improvement of the service.

People told us they were treated with dignity and that staff respected their privacy. One person told us, "I can choose to be alone if I want in my room and when I want. I get up when I want and go to bed when I want." Where people expressed a preference for a specific gender to support them with their personal care this was respected and staffing arranged to meet this need. However, staff told us that some people's wants and needs had been excluded or dismissed. For example, one person dominated a communal room whilst

others felt excluded from these spaces. In addition, arrangements where one person living at the service was expected to go out with staff when other people's relatives visited.

Requires Improvement

Is the service responsive?

Our findings

People's care was not always planned in a manner that was responsive to their needs. The pre-admission assessment process was not always robust to prevent inappropriate admissions to the service which put people at risk of not having their needs met and placed others at risk.

One relative told us, "They are taking in people who are not compatible with one another. The staff don't always have the experience to deal with aggressive behaviour and this leaves people. We are not happy that [relative] is at risk." Another told us, "One person is putting other people at risk and another constantly makes inappropriate, derogatory remarks about others who are deaf."

Staff told us, "There are people here who are not compatible with each other and this leads to regular conflict. One person came here as an emergency admission and this has not been reviewed properly and we cannot meet their needs."

Care plans were not always organised, easy to read, updated and reviewed. This meant they did not always accurately reflect people's current health, welfare and safety needs and guidance for the support they required from staff.

Care reviews including those required to take place with the commissioning authorities had not been undertaken at the regularity required. For example, one person who had been living in the service for over two years and who had been placed as a short term emergency placement had not had their care reviewed for over two years. Information in their pre-admission assessment provided prior to the person's placement was not always transferred to people's plan of care. For example, information in relation to their complex health care needs. This meant that staff did not always have access to the information they required to meet people's assessed health, welfare and safety needs and mitigate the risk of harm.

In relation to the care review of another person, the registered manager told us, "An in house review of their care had taken place, six months previously." We asked to review a copy of this review. They told us there was no record of this, as "it had not yet been typed up."

This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not operate effectively an accessible system for identifying receiving, handling and responding to complaints. People did not always have their complaints responded to in accordance with the provider's policy.

Prior to our inspection, we received information of concern regarding the lack of response to people and their relative's concerns and complaints.

One relative told us, "I have tried to complain. I have asked staff how I raise a formal complaint and they did

not know. We have not always been informed of incidents." However, another relative told us, "My voice is heard and if I have had any concerns it's easy to contact them and they respond as you would expect them to."

When people were asked who they would communicate, any concerns or complaints to they told us, "I would go to the team leader. They listen and they explain things to you without rushing off." Another person told us, "I bottle things up, I don't talk to people for ages but if I need to talk I always talk to the team leader, he explain things really well and checks that you understand. If you ask the other one [registered manager] she says things once and if she doesn't like what you say she just stops and disappears."

We asked to review the registered manager's log of any complaints made to the provider. We found only one complaint had been logged. However, we had been made aware of other complaints received within the last three months prior to our inspection, which had not been logged. The complaints log did not contain any audit trail with timescales for response and any actions taken in response to resolve the one logged complaint.

When asked staff were unable to tell us how to support people or their relatives to formally log their concerns or complaints or where these should be logged. They told us, "We would tell the team leader." We were therefore not assured that people's concerns and complaints and been listened and responded to improve the quality of care provided.

This demonstrated a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported with one to one community activities according to their individual needs. One relative told us, "They [relative] are always out and about doing what they like to do best." Another relative told us, "I am really please. Everything they do they can, they always update me. [Relative] is encouraged to go out and is a new person. [Relative] used to be a recluse but loves it here and is more confident going out and about."

People who used the service told us that staff had a good knowledge of their personal interests and supported them to go out and involve them in community activities. On person told us, "I like to go out into town and stop for coffee, I like that." Another said, "I go out when I want to, but can stay on my own when I choose to. I like my own company."

Requires Improvement

Is the service well-led?

Our findings

The governance framework for the service did not ensure that responsibilities were clear and that risks and regulatory requirements were understood and managed.

There was a registered manager who managed both Maple View and one other of the provider's services locally. The registered manager was also one of the organisation's directors. The registered manager told us they were present in the service for two to three days per week. The team leader took responsibility for the day to day management of the service when the registered manager was not present.

Prior to our inspection, we asked the registered manager, what improvements do you plan to introduce in the next 12 months that will make your service better led, and how will these be introduced? Their only response was, 'I will continue with my own personal development as this will filter down through the staff team.'

We found there were ineffective systems and process in place to enable the registered provider to identify where the quality and the safety of the service was being compromised. We found that there was a lack of effective provider and registered manager overall governance which would have identified the shortfalls we found at this inspection. For example, a lack of effective oversight in the auditing of care records, risk management, staff training, the monitoring of incidents and the update and review of policies and procedures in line with current regulations and good practice requirements.

People were not supported by a service that had a good record management system. We found records management to be poorly maintained and chaotic. For example, the recording of complaints, care plans, care reviews, staff training, and staff meeting minutes produced with action plans for follow up and review.

The registered provider did not operate effectively an accessible system for identifying receiving, handling and responding to complaints. People did not always have their complaints responded to in accordance with the provider's policy.

The registered provider was failing to respond quickly to the risks people and staff faced. This meant that risks to people and staff safety and welfare were on going. The failure to develop effective systems for management and governance of the service had left people at the potential risk of harm.

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

Staff told us that the registered manager was approachable but not always present as they shared their time between the two services for which they were registered. They told us their main point of contact was often the team leader who was present and managed the service on a day-to-day basis.

Staff told us there were regular staff meetings. However, the last recorded meeting minutes of these

meetings was February 2017. We discussed with the registered manager and team leader the regularity of access for staff to share their views. They told us they did not have a system to ensure planning for regular staff meetings to take place. They also showed us some handwritten minutes from a recent staff meeting, which took place in October 2017. We saw that a range of subjects was covered including confidentiality, the use of personal mobile phones whilst working and discussions as to the care and support of people.

Staff told us that one to one supervision meetings were ad hoc and annual appraisals were not always provided in a timely way. This meant that staff did not always have the planned opportunities to discuss their training and development needs. However, the majority of the staff were positive about the support they received from the team leader who they said, "Is supportive of everyone", "Calm and approachable" and "Nothing is too much trouble."

Staff told us that there was an on call duty manager system in place to enable them to access advice and support out of hours from within the group of manager's across the provider's services.

Everyone we spoke with expressed their confidence in the team leader and complimented their approachability. People told us, "The team leader is very approachable and always willing to help. He knows us very well." Another said, "When I am upset I would always go to the team leader and not the manager who is not always here. The team leader is the more approachable one."

Relatives told us, "We have always found the team leader to be the calm and approachable one and listens to you." And "We are kept updated and he keeps us informed and we are very happy the care they give to [relative]" However, another relative told us, "You only find out when you arrive that some incident or other has happened. I have complained but they have not handled that very well."

We asked people who used the service what improvements they saw were needed to improve how the service was managed. They told us, "If I was the manager I would make sure there was continuity of staff, and ensure that staff are appreciated more by the hierarchy. Staff change too much in this place, there's been lots of change. Staff often get into trouble, you need to tell people off in private not in front of others. I'd change that." Another told us, "'I wouldn't have any or as much agency staff and only employ staff who are trained to support people who are blind. I would just have the same staff who know you well."

Staff told us, "The manager has lots of good ideas but they don't always get put into practice and followed through." Another said, "I have worked elsewhere and can see this place needs some organising, it's a bit all over the place. I hope I can be of some help with organising things."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had failed to provide person-centred care that met people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to provide care in a safe way that mitigated the risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person had failed to operate an effective system for the handling of complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality of the service provided

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had failed to provide appropriate support, training and supervision to enable staff to carry out their duties.