Care Expertise Group Limited

Maple Manor Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Maple Manor Nursing Home is registered to accommodate up to 16 people in one adapted building. People living at the service had a learning disability and or Autism or mental health needs. At the time of our inspection, 14 people were living at the service. Accommodation is provided over two floors and a stair chair lift is available.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. Staff levels had not consistently enabled people to receive care and treatment that maximised their choice, control and independence. People did not receive consistent person-centred care that promoted their dignity and human rights. Staff were task focussed and did not consistently uphold people's dignity. Improvements in communication and leadership was required to develop staff values, attitudes and behaviours.

Risks were not effectively or safely assessed, monitored or managed. Staff competency, understanding and skills in meeting people's individual care and treatment needs in relation to their mental health needed improving. Support plans varied in the level of detail and quality of guidance provided to staff and had not been consistently updated when changes occurred.

Staffing levels did not consistently meet people's individual assessed needs. Day time staffing levels fluctuated, meaning we were not sufficiently assured people were safe. Night staffing levels were not adequate to meet people's individual needs in an event they required to be evacuated safely. The provider took action to make improvements. Safe staff recruitment processes were used to ensure staff appointed were suitable.

Staff understood their role and responsibilities to protect people from discrimination and abuse but had not always reported concerns. Incidents were reviewed and analysed, but it was not clear how this informed the management of risks.

Leadership and communication were not fully effective, impacting on staff morale, team work and people not receiving positive outcomes. Systems and processes were in place to monitor the quality and safety of the service, but these had not been fully effective in identifying all shortfalls and areas that needed improving.

People received their prescribed medicines when required and the storage, management and monitoring of medicines followed best practice guidance.

Infection, prevention and control guidance was being followed at the time of the inspection. Cleaning had increased and Covid -19 risk assessments and plans were in place to support staff.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service under the provider's previous name of the service (Sycamore Lodge) was Good (published 3 November 2017).

Why we inspected
We received concerns in relation to staffing levels, the leadership of the service and how behaviours described as challenging were being met. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well-led sections of this full report. Following feedback with the provider about the inspection findings, they took some action to mitigate risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Maple Manor Nursing Home / Sycamore Lodge on our website at www.cqc.org.uk.

Enforcement
We have identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 Safe care and treatment and Regulation 17 Good governance.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always Safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always Well-led

Details are in our well-led findings below.

Maple Manor Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
One inspector and a Specialist Advisor, a qualified learning disability nurse and behavioural specialist completed a site visit. An assistant inspector made telephone calls and interviewed staff off site. On 3 November 2020 an Expert by Experience made telephone calls to relatives to seek their feedback. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Maple Manor Nursing Home is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced, and we checked the current Covid-19 status for people and staff in the service on arrival.

What we did

Before our inspection, we reviewed our information we held about the service. This included information received from local health and social care organisations and statutory notifications. A statutory notification is information about important events, which the provider is required to send us by law, such as allegations of abuse and serious injuries. We reviewed the last inspection report. The provider had not been required to complete a Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We gave the provider the opportunity to share information with us.

During the inspection, we spoke with two people who used the service. We also observed staff interacting with people. We spoke with the registered manager, deputy manager, five nurses, six care staff and the cook. We reviewed a range of records. This included in part, six people's care records. We looked at three staff files in relation to recruitment and a variety of records relating to the management of the service, including incident analysis.

After the inspection we continued to seek clarification from the provider to validate evidence found. This included but was not limited to the provider's current action plan, training data, policies and procedures and meeting records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection, this key question was rated as Good. At this inspection, this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Staff guidance and support about how to mitigate known risks associated with people's individual care and treatment needs were inconsistent in detail and not always up to date.

● Two people had complex mental health needs and known risks, in relation to behaviours that could put themselves and others at risk. Guidance for staff about how to mitigate these risks were limited. Staff confirmed they did not feel sufficiently trained, competent or supported to meet these needs. This put people at increased risk of harm.

● Whilst staff were due to receive additional training to meet one person's known behavioural needs and risks, this should have been provided pre admission. The person had been at the service four weeks. This person's care record also showed staff were using the person's previous placements support plan and risk assessment documentation. This put the person at risk of not receiving care and treatment reflective of their current care needs.

● Whilst behavioural support plans recorded triggers to people's behaviours, there was a lack of staff guidance of what proactive strategies should be used to reduce behaviours from occurring and escalating. Reactive strategies also lacked detailed guidance for staff.

● One person's care record stated the person had a 'Do not attempt resuscitation'. However, the registered manager told us this was incorrect. This assessment was dated March 2020. This put the person at risk of receiving incorrect care and treatment.

● The personal emergency evacuation file used to store people's evacuation plans were not up to date. This information was kept in reception to inform staff and the fire and rescue service of people's support needs. Two people's evacuation plans were missing. This put people at increased risk of their support needs not being known in the event they needed to evacuate the building.

Poor risk assessment of people's individual needs and health and safety, and a lack of mitigating actions placed people at risk of harm. This was a Breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Health and safety checks were completed on the environment, equipment and premises.

Staffing and recruitment

● Staffing levels were not consistently safe in meeting people's individual care and treatment dependency needs. Night staffing levels did not provide sufficient assurances people would be safely evacuated in the event of an emergency. This put people at risk of harm.

● On the whole, relatives told us they believed staffing levels were appropriate to meet their family

member's needs. One relative believed night staffing levels needed to increase, due to their family member having an increase in falls. This person's night time funding had been reduced by commissioners, the provider was using assistive technology to monitor their mobility needs. People told us staff were available when they needed support.

● The staff rota showed, and staff confirmed, daytime staffing levels fluctuated. Staffing levels were not consistently maintained at the levels required to meet people's individual needs and safety. This impacted on people receiving positive outcomes and their safety compromised.

● Following our inspection and feedback, the provider took immediate action to mitigate these risks. Night staffing levels were increased, and the provider assured us the staff rota would be reviewed to ensure correct staffing levels were consistently maintained.

● Safe recruitment processes were used to ensure only staff suitable for their role were employed at the service.

Systems and processes to safeguard people from the risk of abuse

● Safeguarding procedures were not consistently used by staff to report concerns or risks. Staff were found to be aware of their role and responsibility to protect people from discrimination and abuse. However, staff had not always raised safeguarding concerns direct to the registered manager or followed the internal whistle blower policy and procedure. This increased the risk of people not being effectively protected.

● People who used the service told us they felt safe living at the service. Feedback from relatives was mixed. Some concerns were raised about how a person had sustained some injuries. At the time of the inspection, the local authority was investigating these. Positive comments included, "They've [staff] worked miracles, [relation] seems really settled, it's wonderful, it's took a load off my mind."

● The registered manager followed the local multi agency safeguarding procedures. This included reporting safeguarding incidents and any suspicion of abuse to the local authority safeguarding team and the Care Quality Commission.

Preventing and controlling infection

● At the time of the inspection, the provider was adhering to best practice guidance in relation to Covid-19. Whilst we saw staff using PPE as required, staff reported they had not used a face mask until very recently. This meant Public Health England guidance had not been consistently followed during the pandemic and put people at greater risk of Covid-19.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong

● The provider had a process to record, report, monitor and analyse incidents and these were reviewed monthly. Action such as referrals to external health care professionals were made if required. However, it was not clear how this information was used to review risk management in relation to people's behavioural needs and support. Staff consistently raised concerns about meeting some people's behavioural needs and told us there was a lack of guidance and support.

● Lessons were learnt when things went wrong. An example of this was the implementation of guidance for staff when providing people with hot drinks to reduce the risk of injury.

Using medicines safely

● Medicines were managed safely. Staff had access to a medicines policy and procedure and staff responsible for the administration of medicines had completed medicines management and administration training.

● Procedures for ordering, storing and returning unused medicines followed best practice guidance. Recommendations made in 2019, following the local clinical commissioning group medicines audit had been completed.

● Staff had the required information about people's individual needs in relation to their prescribed medicines. This included the safe administration of medicines prescribed 'as required' such as for pain relief or anxiety.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection, this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider's systems and processes had not been fully effective in identifying and taking action to mitigate risks, improve safety, and deliver consistent high standards of care and treatment.
- The provider had failed to consistently monitor and maintain staffing levels required to meet people's individual dependency needs and safety. This put people at risk of harm and achieving positive outcomes.
- The fire safety file that contained personal emergency evacuation plans (PEEP) had not been audited to check information was up to date and available. Two people did not have a PEEP. This put them at greater risk in the event they required support to evacuate the building.
- Staff competency, skills and experience had not been effectively monitored. Staff repeatedly told us they did not feel sufficiently confident and trained to meet people's mental health care and treatment needs. This put people at risk of receiving care from staff insufficiently equipped to meet their individual care needs and impacted on them achieving positive outcomes.
- Support plans and risk assessments had not been adequately monitored and checked, to ensure guidance for staff was sufficiently detailed and up to date. This put people at risk of receiving inconsistent and unsafe care and treatment.
- The provider had failed to ensure national guidance in relation to Covid-19 had been consistently followed during the current pandemic. This put people at increased risk of harm.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The staff culture and leadership of the service was not consistently positive. A reoccurring theme raised by staff was how communication systems and processes were ineffective. This had resulted in staff morale being low. This had a negative impact on the quality of care provided.
- People did not consistently receive care and treatment that was inclusive and empowering. Staff were observed to be task focussed in the delivery of care. People received limited or no opportunities to engage in activities or stimulation. There was a lack of recovery planning to support people with their mental health needs, including a lack of effective discharge planning to support people to return to the community.
- One person was observed to be supported to get ready to attend a health appointment. Support was provided by several staff and the person was observed to be reluctant to engage. The environment was loud and chaotic, and this had a negative impact on the person. Support was rushed and unplanned.
- People did not receive a positive meal time experience. Two people were observed to receive support

from staff with their meal. However, one staff member was observed to frequently leave a person to do other tasks. Another staff member supporting a person, was observed to ask a staff member to take over as the person was not responding well to them. Neither staff gave an explanation to the person when they left them. This showed a lack of dignity and respect.

The systems and processes used to monitor the quality and safety of the service provided was ineffective. This is a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● External professionals provided some support and guidance to the staff in how to meet people's care and treatment needs. However, the management team had not always effectively communicated recommendations or advised staff of some of the decision-making processes. This resulted in staff feeling confused and unconfident in the delivery of care and treatment. This had a negative impact on people achieving positive outcomes.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● People who used the service told us they knew who the registered manager was, and how they would raise any concerns with them or staff. On the whole, relatives were positive about the communication they had with staff. However, relatives told us changes such as a new registered manager being appointed had not been communicated. A relative said about communication, "It's as good as it could be, staff phone on a regular basis, although they are busy of late, I don't hear directly from [relations] named keyworker now." We saw the provider had shared information about the appointment of the new registered manager via a newsletter in 2019.

● Relatives told us they had not had to make a formal complaint, but when any issues had been raised, the management team had been responsive.

● The provider was meeting their registration regulatory requirements in informing CQC of notifiable incidents as required by law to enable monitoring of the service. The provider's inspection ratings were displayed as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People who used the service, relatives, external professionals and staff received opportunities to share their experience about the service provided. This included an annual quality assurance survey, feedback received was analysed and action was taken to make improvements. The 2019 survey showed improvements had been identified in relation to the environment and a refurbishment plan had commenced.

● Staff received ongoing training, supervision and appraisal meetings to review their work and development. Staff meetings and daily handover meetings were also used to share information.

● Compliments had been received from some external health care professionals about the care and treatment provided to people.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to effectively assess and mitigate risk put people at increased risk of harm. Regulation 12 (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to have effective systems or processes to assess, monitor and improve quality and safety impacted on people's health, safety and welfare. Regulation 17 (2) (a) (b) (c)