Maples Care Home (Bexleyheath) Limited

Maples Care Home

Inspection report

29 Glynde Road
Bexleyheath
Kent
DA7 4EU

Tel: 02082986720

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This unannounced inspection took place on 11and 12 October 2017. At our last inspection of the home on 24, 26 January and 01 February 2017 we had found some areas for improvement with the way 'as required' medicines were managed and some care records and some risk assessments were not always accurate. We found staff did not always receive regular supervision to support them in their roles and improvements were needed to the provision of suitable activities to stimulate people and meet their needs for socialisation. The new manager had already drawn up an action plan that had identified all the areas for improvement we found and had started work on completing this plan at the time of the inspection.

Maples Care Home is a large nursing home which provides long term residential care and support, nursing care, dementia care and respite services for up to 75 older people. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. There were three separate units at Maples, with separate facilities. Two of the units specialise in providing care to people living with dementia. At the time of our inspection there were 66 people living at the home.

At this inspection on 11 and 12 October 2017, we found improvements had been made to all the areas previously identified but there was still room for improvement with the range and frequency of the activities provided to ensure people's individual needs were met. There were high levels of agency staff at this inspection and some people and some of their relatives told us this meant that their preferences and wishes in respect of their care were not always consistently met. However, the provider and registered manager had a robust induction for agency staff and had recruited a number of new staff who were due to start work in the near future. They told us they tried to use the same agency staff whenever possible.

There was a registered manager in place who had managed the home since October 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they were safe and well looked after. Staff were aware of the possible signs of abuse and neglect and what to do if they had a concern. The registered manager had reported any safeguarding concerns and the local authority said the home had worked with them in an open and transparent way. Risks to people were identified and guidance in place to reduce the risk of them occurring. Risks in relation to equipment and the premises were assessed and managed and there were plans to deal with emergencies. Medicines were safely managed.

We received some mixed feedback about staffing levels. We found from our observations there were sufficient numbers of staff to meet people's needs.

People told us staff were kind and caring. We saw people felt comfortable with staff and there was evidence of good relationships between most staff and people at the home. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. People's needs in relation to their disabilities, race, sexual orientation, religion and gender were recognised and supported appropriately. Staff told us they received sufficient training and support to know how to meet people's needs.

People's nutritional needs were met and a range of health professionals were available to support their health needs. People and their relatives told us they were treated with dignity and respect and that they were involved in their care planning. People's care plans were personalised accurate and reviewed regularly.

People's views were sought through regular residents and relatives meetings and surveys. Complaints were managed appropriately. Systems were in place to assess and monitor the quality of the service and to monitor risk and these operated effectively. The provider monitored the service through regular visits.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The home was safe.

People and their relatives told us they felt safe. Staff were clear about how to report any safeguarding concerns.

Medicines were managed safely. There were sufficient numbers of staff to meet people's needs. The home was reliant on a high number of agency staff at the inspection. However, a number of permanent staff had recently been recruited.

Risks to people including from equipment and the premises had been assessed and reviewed regularly to ensure people's individual needs were safely met. There were plans to manage emergencies.

Is the service effective?

Good

The home was effective.

Staff received suitable training and support. People's dietary and nutritional needs were met.

Staff sought consent before they provided support. Procedures were in place to act in accordance with the Mental Capacity Act 2005. Specific best interest decisions were recorded where needed.

People had access to a range of health care professionals when they needed.

Is the service caring?

Good

The home was caring.

People and their relatives told us staff were kind and caring. Staff knew people well and were aware of changes in their moods or routines

People told us their privacy and dignity was respected and we observed this to be the case.

People and their relatives told us they were involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

There had been improvements made to the availability of activities. However further improvements were needed to ensure that people's different needs for stimulation were met and their links with the community strengthened.

Improvements had been made to the care plans at the home and these were accurate and up to date. Some people and their relatives told us the high level of agency staff at the home meant that there was a lack of consistency about their needs always being responded to in line with their preferences.

Complaints were managed appropriately.

Is the service well-led?

Good

The service was well-led.

People, their relatives and staff told us the registered manager had an open approach to learning and they felt well supported. There was an emphasis on improvement and developing the service provided. Health and social care professionals confirmed this.

There were improvements across several aspects at the home. Systems were in place to assess and monitor the quality of the service and to monitor risk and these operated effectively.

People's views about the home were regularly sought and considered to drive improvements.

Maples Care Home

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 fresh rating for the service under the Care Act 2014.

This inspection took place on 11 and 12 October 2017 and was unannounced. On the first day the inspection team consisted of two inspectors and a specialist advisor in nursing. On the second day the inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we looked at the information we held about the service including any notifications they had sent us. A notification is information about important events that the provider is required to send us by law. We used information the provider sent us in the Provider Information Return. 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.

At the inspection we spoke with ten people living at the home and 11 family members. We spent time observing staff and people interacting and tracked that the care provided met their needs. During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us about their experiences of their care.

We spoke with seven care workers, three nurses, an agency nurse, a volunteer, two shift coordinator's, an activities coordinator, the administrators, the home's trainer, the maintenance person, the clinical lead, the deputy manager, the registered manager and the regional manager.

We looked at 11 care records of people at the home and five staff recruitment and training records. We spoke with two visiting health care professionals. We also looked at records related to the management of the service such as fire and maintenance checks and audits. Following the inspection we sought feedback from three other health and social care professionals.

Good

Is the service safe?

Our findings

At the last inspection in January 2017 we found some improvements were needed to the management of 'as required' medicines and made a recommendation in respect of this. At this inspection we found those improvements had been made and medicines were safely managed and administered throughout the home.

People told us they received their medicines as they had been prescribed. One person said, "There is no problem about that at all." The community pharmacist told us, "The care home has worked very hard to implement quite a number of initiatives aimed at improving both the quality of care and safety with respect to medication." We observed that staff were patient and considerate when giving medicines and did not rush people.

Medicine administration records were up to date and accurate and included information about people's preferences about how they wished their medicines to be administered. There were clear protocols in place to guide staff on the administration of medicines prescribed to be given 'only when needed'. This ensured there was a consistent approach and that these medicines were managed safely. Where people had their medicines administered covertly, this was managed appropriately with best interest assessments completed and pharmacist and GP advice was sought appropriately. Medicines were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. Controlled drugs were managed, stored and recorded correctly.

We had some mixed feedback about staffing levels at the home. Seven people and six relatives told us there were enough staff to meet people's needs at all times and they could get up when they wished and did not wait a long time to be supported. One person said, "I don't have to wait long. There are staff that come when I call for them." Another person told us "I ask them to get me up at 6.30am, which they do and they are very good." A relative told us, "There seem to be enough staff. When I come at meal times there are always staff helping people." Another relative said, "There are enough staff but it depends on the teams. You get good teams who know what they are doing and ones with lots of agency staff." Three people and three relatives told us they were not sure there was enough staff.

Staff we spoke with told us there were enough staff to meet people's needs but that they found it more difficult with some agency staff. However, one staff member commented that they thought there should be an extra staff member in the mornings on the ground floor as there were a number of people who liked to get up at the same time.

We observed the care provided on each floor of the home throughout our inspection. We saw there were enough staff on duty to support people's needs throughout the inspection. We checked the call bell response times during the weekend and on weekdays and night. We found call bells were answered promptly. We observed people were not waiting for long periods before being attended to and sufficient numbers of staff to support people to eat in a calm and relaxed way. We saw that the staffing levels were calculated depending on people's needs and dependency levels and reviewed frequently.

We discussed the comments made about staffing levels with the registered manager and operations manager. They told us they would monitor staffing levels on the ground floor in the mornings to confirm if they needed to change staffing levels. They had lost a number of staff in short space of time to go onto further training; this had necessitated the increased use of agency staff for a period while they recruited. We saw the provider and registered manager had taken action to recruit staff and interviews were being conducted during the inspection. They told us they had 13 new care staff waiting to start and employed a temporary head of care that with the deputy and clinical lead were supernumerary. This helped maintain standards of care in the day and at night.

Suitable recruitment checks were in place to reduce the risk of unsuitable staff. These included identity checks, proof of right to work, nursing qualifications where relevant, health checks and full employment histories were requested by the provider before staff started work. Checks were made on agency staff including their training and competence through an agency profile that was sent to the provider before they started work at the home.

People told us they felt safe and well looked after. One person told us "I do feel safe here. I can relax." A relative said "I know my relative is safe here." Another relative commented; "My [family member] is totally safe here. I can't speak highly enough of the home." We saw relaxed and warm interactions between staff and people at the service throughout the inspection. However, two people told us they had experienced problems at night with a small number of staff. One person told us "They come in and tell me to go back to sleep if I use the buzzer in the night." Another person said their concerns had been recently raised by staff with the manager and it had been dealt with promptly and effectively. We found robust and appropriate action had been taken in response to these concerns by the registered manager and provider to reduce the likelihood of this reoccurring. This included raising a safeguarding alert, disciplinary action, a number of night spot visits including one the night before the inspection and supervision with night staff.

Staff had the necessary knowledge and skills to ensure people were safe. They told us how they could recognise the various signs of abuse and knew how to report any concerns. They said there was an open culture in the home which encouraged them to report any concerns. Staff felt that if they raised concerns these would be dealt with to make sure people were protected. One staff member told us they put the safety of those who used the service, "Above and beyond all else." Another staff member told us where they had reported possible concerns the registered manager had acted promptly to address the issue. Staff were aware of which external agencies they could report concerns to under whistleblowing. The registered manager had raised safeguarding alerts appropriately with the local authority when needed. The local authority safeguarding team confirmed that the registered manager worked with them in an open and transparent way.

At the last inspection we had found a risk assessment tool in relation to choking was not always being accurately completed to ensure the level of risk was correctly identified. At this inspection we found improvements had been made. Risks in relation to choking were accurately assessed and detailed guidance provided to reduce risk. There was additional written information in people's rooms to guide unfamiliar staff about possible risks such as risk of choking.

Possible risks to people's health or welfare such as falls, skin integrity breakdown or weight loss were identified assessed and managed. Risks were assessed and documented in care plans to guide staff; actions to reduce these risks were well documented in people's care plans. For example, for one person whose skin was at risk of bruising easily, staff were provided with guidance to ensure their skin was kept clean, clear, moist and healthy. Care staff were also required to monitor the person's skin regularly and report any changes to the nurse in charge. There was guidance for staff to reduce the risk of damage to the person's

skin when moving or transferring them.

We tracked people's care to check that the risk assessments reflected people's current needs and were subject to regular review. For people at high risk of skin breakdown we saw they were supported with frequent changes of position and pressure relieving equipment. There were regular checks on people in their rooms and where people were assessed as unable to use a call bell. Risk assessments and guidance considered how to enhance people's independence and wishes in relation to their mobility as much as possible rather than restrict them.

The registered manager and staff demonstrated a good understanding and knowledge of each person's individual risks and actions taken to reduce them. Accidents and incidents were monitored by the registered manager to identify and check for control measures to reduce the risk of them reoccurring. For example we saw where due to the deterioration of their health, people's behaviour required a response, a range of actions had been identified by the registered manager within the home and referrals made to the GP and community mental health team.

There were plans to deal with any risks from emergencies. Staff had received regular fire training and knew how to respond in the event of a fire. They took part in regular fire drills and records showed that these included night staff. There was suitable evacuation equipment in place and personalised emergency evacuation plans for people were easily accessible in the event of an emergency. Staff knew what to do in response to a medical emergency and received first aid training which included cardio-pulmonary resuscitation. There was a business contingency plan for emergencies which included contact numbers for emergency services and gave detailed advice for a range of emergencies.

Equipment at the home was routinely serviced and maintained which helped reduce risks to people. There was a maintenance book for staff to record any identified equipment issues, areas identified were promptly dealt with. Equipment such as bed rails and hoists were checked frequently to ensure they were in good working order. There were regular checks on the safety of the premises such as hot water, radiator and window restrictor checks. A new fire risk assessment had been completed recently and actions identified had been completed or were in progress. Actions identified from a legionella risk assessment had also been completed. This reduced any possible risks from the premises.

Good

Is the service effective?

Our findings

At the last inspection in January 2017 we found some improvements were needed to ensure staff training and supervision was up to date. At this inspection we found these improvements had been made.

People told us that the permanent staff were competent. One person remarked; "The staff are definitely well trained." Care staff told us they received a wide range of relevant and person centred training which was a mixture of online sessions and face to face training with practical sessions. We confirmed from the home's trainer and records that staff training was up to date. A care worker told us, "Training here is of a very good quality – it has to be to do this sort of job properly." A nurse commented, "The training here is the best I have had." Another care worker commented "I feel I really got the message about the importance of infection control from the training delivered."

New staff told us they had received a robust induction before delivering care to people. This included training and shadowing a more experienced member of staff for two weeks before they were deemed competent to independently support people who used the service. One staff member said, "I felt confident at the end of this induction and shadowing period." We saw there was an induction record kept to ensure staff had been observed to have the skills to work unsupervised. Staff told us they were able to request additional training and asked about this during supervision. The home was a pilot site for a urinary tract infection training programme so that the staff have enhanced knowledge on what to look for and how to respond. Training was provided for nurses on a range of clinical skills such as catheterisation and venepuncture.

Agency staff were given an induction before they started to work at the home and we saw these covered areas such as fire safety and the recording system. Agency staff told us the induction was thorough and that they had been given enough information to help them in their roles.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the last inspection in January 2017 we had found some improvement was needed to the recording of some best interest decisions. At this inspection we found decision specific best interest assessments were completed, appropriately, to ensure people's rights were protected, where they may lack capacity to

understand. Applications for authorisations for DoLS were made appropriately and the home completed regular monitoring forms required and ensured that any conditions required of the under the DoLS were met.

People told us that their consent was sought before staff offered them support. Throughout our inspection we observed staff asking for people's consent before providing them with care and support with for example mobilising or joining activities.

Staff told us they had been provided with training in MCA and DoLS and were clear about people's rights to make decisions. One care worker said, "I will always ask them, giving them choices and also respecting their wishes." They were also able to tell us how a person who had capacity had a right to make decisions which might be viewed as poor decisions.

At the last inspection in January 2017 we had found some room for improvement with the meal time experience. People had given us mixed feedback about the food. At this inspection we found improvements had been made and most people and their relatives were complimentary about the food provided. One person said, "The meals I have had have been quite nice." Another person remarked, "The food is good and there is plenty." A relative told us, "The food is very good; especially the roast dinners." Another relative told us, "The food is better. Not perfect but better." People and their relatives confirmed their views about the food had been sought and there was a comments book to record any issues for catering staff. A separate company managed the catering. The registered manager told us they spoke with the catering staff on a daily basis to try to ensure people's preferences and needs were met.

People's nutritional needs were met. People's dietary requirement and any support they may need during meal times were recorded in their care plans. For example people's ability to use cutlery or if they could eat independently. People's care records also included food that they liked and those they disliked. Catering staff had an up to date list of people's dietary needs and told us they were kept regularly updated.

People's weight was monitored weekly to identify any concerns and provide the appropriate care and support where required. If needed referrals to a dietician or speech and language therapist were made. If required people's food and fluid intake was monitored by staff to reduce risks of further deterioration.

We observed the meal times and saw they were a relaxed experience on each floor. Staff interacted with those who were seated in the dining room and the food served was hot and fresh. We observed people who could not eat or drink on their own were supported to eat sufficient amounts for their wellbeing in a calm and unrushed way either in the dining room or in their own rooms.

People told us they had access to appropriate health advice when needed. One person said, "I see the GP here when I need to and I've seen the optician too." Another person told us, "If you want a GP they put it in the book and he comes and sees me." We saw that the home referred people to health and social care professionals such as GPs, chiropodist, community mental health teams and care coordinators where needed, people's care to ensure their needs were met. Advice from health professionals was recorded in people's care plans. The home's electronic record system produced an information pack for hospitals that was ready at all times and contained important information to assist hospital staff where needed. Health professionals told us the staff at the home worked well with them. One professional commented on the positive way the staff at the home worked with them in relation to one person's complex needs.

Good

Is the service caring?

Our findings

People told us staff were kind and caring. One person said, "The staff are lovely I get on pretty well with them .They know me well and we have a laugh." Another person stated, "We have some good carers. They are kind." A relative commented told us, "Staff are lovely;" Another relative remarked; "Some of the carers are excellent, I couldn't fault them. Some agency are excellent too." A third relative stated, "The care is really good here. It's like five star hotel compared to where [my family member] was." We saw that the home had received several cards from relatives thanking them for the care provided.

The atmosphere in the home was friendly and relaxed. We observed interactions between people and staff were kind and caring. Staff members were observed on all floors to be sensitive and responsive to people's individual needs and offered support and reassurance in an unobtrusive manner. Interactions demonstrated that permanent staff knew people and their family members well. For example, calling people by their preferred name. We observed staff coming on duty greeted those who used the service warmly and asked how they had been since they were last seen. A care worker told us, "It is so important to develop a relationship; it is all about gaining people's trust." People's life history was included in their care plan. The life histories included where people were born, where they lived most of their life, their occupation, marital status, names of their children and grandchildren, their religious preferences and any achievements they had attained in life. This provided care staff with information to help them engage with people better.

People and their relatives confirmed that people's privacy and dignity were maintained and that personal care was provided behind closed doors. One person told us, "They are very good. They do knock on the door before they come in." Health professionals also confirmed they observed staff knocked on people's doors before they entered. We observed that when people were supported to mobilise using equipment staff ensured their dignity was protected through the use of additional covers if needed.

Staff told us of ways they maintained and promoted privacy and dignity such as knocking on people's doors before entering, closing the curtains and shutting the doors before providing personal care, covering parts of the body not being washed with a towel and not exposing people's nudity and treating them the way they would want to be treated when they got older. During our inspection we observed people being supported out of the communal areas into the privacy of their room to receive personal care. We observed people were encouraged to do as much as they could independently. One staff member said "Encouraging people to be as independent as possible, no matter how tiny the task might be, is so important for our resident's well-being."

People's needs with regards to their disability, race, religion, sexual orientation and gender were clearly documented in their care plans. Staff supported people to meet their identified needs and wishes for example in respect of referrals for more specialised equipment for those unable to use a wheelchair safely to join people in the lounge and dining areas. People's spiritual needs were addressed through visits from spiritual representatives for those who expressed an interest. The activities coordinator told us they had offered a dementia awareness session to relatives to help them gain an understanding about dementia.

People were supported to maintain relationships with their family and friends. People's care records showed that their relatives were involved in their care and were invited to the resident of the day meeting to contribute to the review of the care plan. Relatives told us they were able to visit at any time and found staff welcoming and kind. They confirmed they were involved in making decisions about their relative's care and treatment needs where this was appropriate and that they were kept informed about changes to their family member's needs. One relative said, "They are every good like that. They always let me know."

People were supported with end of life care where required. Where people do not wish to be resuscitated we found Do Not Attempt Cardiopulmonary Resuscitation (DNAR) forms completed and signed by the people using the service their relatives, where appropriate, staff (clinical care coordinator) and their GP to ensure their end of life care wishes were respected. The home told us they had developed a good working relationship with the local hospice and they had provided training for staff on end of life care. Anticipatory management plans were in place where needed to ensure people had access to sufficient pain relief if their condition deteriorated.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in January 2017 we found some improvement was needed to ensure care plans consistently reflected people's current care needs. At this inspection we found improvements had been made. Care plans were up to date and reflected people's current needs. The provider had introduced an electronic care plan system which staff were able to update as they completed their tasks which helped to maintain its accuracy.

Care plans were personalised to people's needs and wishes and gave staff information about the help people needed, including how and when they liked to be supported. The care plan covered all areas of people's care and support needs as well as people's likes and dislikes. For example the food they would like to eat, or, their favourite football club, or music and any recreational activity such as gardening that they enjoyed. The care plans also included information on things people could do for themselves and those that they needed support with and the level of support required. For example, we saw that one person needed full assistance with personal care; however, they were able and encouraged to eat independently. Each care plan was reviewed regularly and easy to access. The daily care records we looked at showed the care delivery was in line with the care and treatment which had been planned for people. A staff member told us, "It [the care plan] should reflect all the support and care we offer to the resident. It should also be developed in conjunction with the person and their relatives and really listening to what they say."

Care plans clearly identified for staff how one aspect of a person's care could have an impact on another area. For example one person's care plan regarding their safe mobility was linked to their nutrition risk assessment and their risk score for skin integrity. Their nutrition care plan reflected the importance of dietary control as a means of improving both mobility and skin condition. This helped to guide staff members to consider all possible risk factors. The operations manager told us they were working to enable relatives to access their family member's care record securely.

Staff understood people's needs and cared for them in a way that met their needs. However, three people told us that because of the high level of agency staff currently at the home sometimes their preferences about their personal care and support were not always followed. One person told us, "It's the smaller things but they matter. Some staff are good and others not so good at responding." Relatives also commented this was the case. One relative said, "It just depends who is on. With some agency staff, they could not have time to read all the care plans and know my relative's individual likes and dislikes." Examples given included not always being supported to get up at their preferred time or staff not being aware of the order of their routines. We saw that there were at a glance sheets in some people's rooms to enable unfamiliar staff to understand people's preferences but these were not available consistently across the home to help guide unfamiliar staff and this required improvement to ensure information about people's preferences was readily available to unfamiliar staff..

At the last inspection we had found improvements were needed to ensure people's needs for stimulation and socialisation were met. At this inspection we found there had been some improvements. There were four activities coordinators who provided activities throughout the week. We received some positive

comments about the activities at the home. One person said, "The activities here have improved, there is more going on now." There was an activities programme which we saw provided activities on each floor of the home and a range of external entertainment such as therapy dogs. During the inspection we saw people engaged in a variety of activities such as biscuit decorating, games and there was a musical entertainer.

However, we found activities still required improvement to ensure they were more person centred and that people who were nursed in their rooms were provided with regular opportunities to engage with people and take part in an activity they enjoyed.

Three people who spent time in their rooms told us they did not often see the activities coordinators. One person told us, "Sometimes an activity person comes to my room but that is unusual experience." Two other people told us they did not enjoy the range of activities on offer. One person said, "I am not all that thrilled on the activities here." Some people expressed an interest in being in the garden more often and taking part in outings. One person said "I have been here about three months and only twice been outside. Once to see the classic cars and once with a carer." A relative told us that activities were not very person centred in their view, "My family member loves to do crossword puzzles and is very good at them; they need support and a little prompting and I have been telling [the activities coordinator] this for months. I have never known this to happen which makes me sad for my [family member]." Two people told us the activities programme was in too small a print to read easily. We found there was no difference between the range of activities provided despite the difference in needs of people on each floor and that there were periods of the day when there were no organised activities. People's life experiences and preferences were not taken into account in the planning of activities.

We discussed our findings with the provider and registered manager who told us they were aware that activities needed further development and had provided training for activities staff. The provider ran meetings for activities coordinators across the company to try and improve the range of activities on offer. They had recently met with the activity coordinators and were working to address this issue. We will check on the progress with this at our next inspection.

People and their relatives knew how to complain if they needed to and were confident any problems would be dealt with. Most people and their relatives told us they had not needed to complain. One relative said, "I have not needed to complain at all, if I did I am sure the manager would deal with it quickly". There was a complaints procedure in place. We checked the records and found complaints had been responded to in line with the policy and most complaints had been resolved. Complaints were reviewed to identify any common themes for learning. Health and social care professionals told us the registered manager had an open approach to identifying any concerns. We saw any learning was communicated to staff at the daily 10 at 11 meetings or to wider staff groups in meetings. "They do take things on board when you raise them."

Good

Is the service well-led?

Our findings

People and their relatives gave us positive feedback about the registered manager and the senior team at the home. One person said, "The manager is often around. You can talk to her." Another person remarked, "We know the manager she often walks around. She is very good and easy to talk to." A relative said, "There is continuous improvement on going. I always feel very welcomed by the carers and residents." Another relative commented, I can't speak highly enough of the home and would recommend it to anyone. The manager is available and the staff are friendly and really care about people here."

Staff told us that the registered manager and management team were very visible. One person said, "The registered manager and the other managers are very visible. They are on the floor several times a day and there is always a senior manager on duty at the weekend; it makes us feel like we are all in this together." Another staff member remarked, "It is good that the management team come onto the floor; they have an understanding of our pressures and gives me a chance to demonstrate that I am doing a good job." Staff commented they thought the manager promoted a culture that put people's needs first. One staff member said, "The registered manager has done a great job; she is very firm but fair and follows protocol." Another staff member commented; "There is a good culture here; we all pull together." Health professionals gave positive feedback about the leadership at the home. A health professional remarked; "We have all found the manager very co-operative, competent and committed to making Maples the best care home that she can."

The majority of staff told us they felt involved and listened to. One care staff said, "The managers are great and very supportive." Another staff member commented, "The managers' are very open…their door is always open for me." However, two staff members commented that they thought communication could be improved. The registered manager told us that they had not held a whole staff meeting recently but had organised a number of smaller meetings and the provider had organised a series of meetings for staff who wanted to attend to raise any issues or concerns. A full staff meeting had been booked for early November. The registered manager had introduced a scheme to make compliment cards for staff available for visitors to complete if they wished. We saw a number of these had been completed and were displayed in the reception area to highlight where staff had contributed to improving outcomes for people.

There were a series of meetings to help monitor risks, aid communication amongst the staff group and improve the quality of care provided. These included a daily meeting that focused on any risk issues and plans for the resident of the day. Clinical risk meetings were held weekly to consider complex health needs and risks as well as new admissions to the home. An electronic log was maintained to monitor possible risk indicators such as falls, accidents and incidents and clinical care. Staff took part in regular handover meetings to ensure any changes in people's care and support needs or health were communicated across the care staff. The registered manager held meetings with the lead persons of each department. Health and safety meetings and nurse and senior care worker meetings were also held. We saw these were used to share learning and identify issues. For example the health and safety meetings discussed a poor response to a fire drill and we saw steps were being taken to address this with staff through additional training. Improved completion of accident and incident records was discussed at the nurses' meeting.

We found where changes had been introduced such as the new electronic care plan staff had been provided with support to understand and use the new system. Staff told us they liked the new care plans and had received lots of training on the use of the electronic care plans. We spoke with a new agency nurse to on one day of the inspection and they told us they had been shown how to use the electronic system and found it easy to use. The registered manager and provider told us there were some small issues with the use of the recording system that they were trying to resolve and had recently carried out refresher training with staff to ensure everyone had the knowledge and skills to use it properly.

There was a system of audits to monitor the quality of the service and identify any learning or action needed to rectify an issue. These included areas such as medicines, care plans, recruitment and training and health and safety audits. The provider also conducted their own audits and we saw that a visit earlier in the year had identified that staff supervision frequency needed addressing. We found steps had been taken to resolve this issue. The provider and registered manger told us they were looking to develop champion roles once they had sufficient permanent staff to develop staff practice in areas such as dementia and end of life care.

People's views about the service were sought through regular relative and resident meetings and a survey. We saw from minutes of the meetings that catering staff attended and discussions included the electronic care plans, recruitment updates, activities and catering. Surveys were being sent out at the time of the inspection.