

Beacon Place Limited Maple Leaf Lodge Care Home

Inspection report

37 Beacon Lane Grantham Lincolnshire NG31 9DN Date of inspection visit: 14 September 2021

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Tel: 01476590674

Ratings

Overall rating for this service

Inspected but not rated

Is the service safe?

Inspected but not rated

Summary of findings

Overall summary

Maple Leaf Lodge Care Home provides accommodation, personal or nursing care for up to 67 older people. At the time of our inspection visit there were 44 people using the service.

There were significant shortfalls in Infection Prevention and Control (IPC) risks and environmental safety processes. Areas of the home and equipment were unclean.

Accessibility to Personal Protective Equipment (PPE) and clinical waste bins was not adequate.

The provider had systems in place to monitor the quality of the service. However, these needed to be embedded and further developed to show the planned improvements could be sustained.

We were not assured that this service met good infection prevention and control guidelines.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Further information is in the detailed findings below.

Inspected but not rated



Maple Leaf Lodge 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.

As part of CQC's response to care homes with outbreaks of COVID-19, we are conducting reviews to ensure that the Infection Prevention and Control practice was safe and the service was compliant with IPC measures. This was a targeted inspection looking at the IPC practices the provider has in place.

This inspection took place on 14 September 2021 and was unannounced.

Is the service safe?

Our findings

S5 How well are people protected by the prevention and control of infection?

• Risk associated with people and staff contracting COVID-19 and the spread of infections had not been adequately identified and risks mitigated. A system was in place to mitigate risks from visitors entering the building, however, on arrival inspectors were greeted by staff with no masks on. Staff also failed to check adequate testing had taken place before visitors entered the building despite clear government guidelines being in place for care homes.

• We found Personal Protective Equipment (PPE) was not readily available to staff. Since the last inspection in June 2021 additional PPE stations had been added to the home, however, we found these were not always stocked with adequate PPE equipment meaning staff would have to source this from other areas of the home. Furthermore, when we spoke with the manager, she confirmed no one was allocated the role to replenish the stocks of PPE meaning accessibility was poor. Clinical waste bins were not easily accessible to staff meaning they had to travel through the home with soiled PPE to dispose of it correctly.

• Issues highlighted at the last inspection included the cleanliness of the home. We found on this inspection only minor improvement. Communal areas in the home, specifically areas that accommodates people with dementia who are unable to ensure their own safety, were unclean. We found embedded stains on furniture and carpets alongside significant amounts of food debris. Kitchenettes had damaged fridges which continued to be unfit for purpose, trolleys contained a mixture of dirty and clean equipment.

• Moving and handling equipment was found to be covered in stains and food splatters. We witnessed this equipment being used whilst on inspection without any cleaning taking place before or after use. Infection Prevention and Control (IPC) risks was increased due to the ongoing COVID-19 pandemic and the home currently being in outbreak. This put people at increased risk of infection due to a failure to ensure the cleanliness of the home and equipment.

• Systems and processes in place had failed to identify these risks found on inspection. We reviewed cleaning schedules in place and found they were either not completed or did not reference specific high-risk areas. A staff member confirmed where cleaning should take place during the night this had not happened for some time, further discussions with the manager also confirmed this.

• Records showed systems in place to monitor the quality of the service, however, IPC audits and governance processes had been ineffective in improving and monitoring the quality of the service. This was evidenced by the failure to address issues raised at the last inspection regarding infection control concerns. The providers failure to ensure these audits were effective and embedded into working practices, this significantly restricted the providers ability to identify risks and address shortfalls, exposing people to the risk of avoidable harm.

• We discussed the areas of concerns within IPC and environmental safety with the provider. The provider responded to the concerns identified with an action plan, which gave us assurance the provider was committed to driving improvement in the service.

The provider's failure to monitor and mitigate a wide range of IPC risks placed people at risk of avoidable harm and was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 12 HSCA RA Regulations 2014 Safe care and treatment
	The provider failed to monitor and mitigate a wide range of IPC risks, which placed people at risk of avoidable harm and was a continued breach of Regulation 12.