Mappleton House Care Homes Limited

Mappleton House

Inspection report

9B Chestnut Grove
Mapperley Park
Nottingham
Nottinghamshire
NG3 5AD

Tel: 01159623714
Website: www.rushcliffecare.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected the service on 6 July 2016. The inspection was unannounced. Mappleton House provides accommodation for up to 11 people with a learning disability. People are accommodated in one of two houses or a bungalow on the same grounds. On the first day of our inspection there were three people using the service.

We carried out an unannounced comprehensive inspection of this service on 10 and 12 May 2016 . After that inspection we received concerns in relation to the provider not taking action to protect people from harm and a lack of appropriate leadership, resulting in the service being unsafe. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Mappleton House on our website at www.cqc.org.uk"

The service did not have a registered manager in place at the time of our inspection and has not had one since June 2015. 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.

Although people were supported by staff who knew how to recognise abuse, action was still not always taken to protect people from the risk of harm. People were still at risk in relation to how they were supported and from risks from the environment. Staff were not deployed appropriately in the service to ensure people were supported safely.

People were supported by staff who did not have the knowledge and skills to provide safe and appropriate care and support. People who lacked the capacity to make certain decisions were still. not protected under the Mental Capacity Act 2005.

There was still a lack of appropriate governance and risk management framework and this resulted in us finding ongoing breaches in regulation and negative outcomes for people who used the service.

The overall rating for this service is 'Inadequate' and therefore remains in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of

preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Action was still not always taken to protect people from the risk of harm and people were still placed at risk in relation to how they were supported and from risks from the environment.

Staff were not appropriately deployed in the service to provide care and support to people when they needed it.

People received their medicines as prescribed and medicines were managed safely.

Is the service effective?

Inadequate

The service was not effective.

People who lacked the capacity to make certain decisions were still not always protected under the Mental Capacity Act 2005.

People were supported by staff who were not suitably trained and supported to meet their varying needs.

Is the service well-led?

Inadequate

The service was not well led.

There was still a lack of appropriate governance and risk management framework and this resulted in us finding ongoing breaches in regulation and negative outcomes for people who used the service.

Mappleton House

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Mappleton House on 6 July 2016. This inspection was done in response to concerns raised by the Nottingham City Council and to check that improvements to meet legal requirements planned by the provider after our 10 and 12 May 2016 inspection had been made. The team inspected the service against three of the five questions we ask about services: is the service safe, effective and well led. The inspection team consisted of two inspectors.

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

Some people who used the service had limited verbal communication and so we relied on observations to gain their experience of using the service. We spoke with four members of support staff and the compliance manager. We looked at the care records of three people who used the service and their medicines records. We also looked at range of records relating to the running of the service such as maintenance records and auditing systems.

Inadequate

Is the service safe?

Our findings

During our inspection in May 2016 we found there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that incidents were not being acted on appropriately and were not always shared with the local authorities safeguarding adults' team. We told the provider they needed to make improvements in relation to this.

During this inspection we looked to see if improvements had been made and we found they had not. Although people were supported by staff who recognised the signs of potential abuse and how to escalate concerns within and outside of the service, they had failed to do so when incidents occurred. Information about people being at risk of harm or abuse was still not always shared with the local authority when it should be. This meant that action was not taken to ensure people were protected from the risk of harm.

At our last inspection we found incidents which should have been shared with the local authority had not been. Prior to this visit we were again informed of incidents which should have been shared with the local authority by the provider had not been. Previously we had found referrals had been made by external professionals rather than the provider and again we found external professionals had made the referrals. During our visit we found other examples of information which should have been shared with the local authority but had not been.

There were eight body maps where staff had recorded that people had sustained an injury from an unknown cause. These injuries had not been reported to the management team and no action had been taken to investigate the cause of the injuries, or consideration given to referring these to the local authority safeguarding adults' team. There were also two incidents which had been reported to the management team who had failed to share this information with the local authority safeguarding adults' team.

The failure to act on and report matters regarding people's safety gave us serious concerns. The provider had been made aware of these issues following our inspection in May 2016, but they had failed to implement effective systems to ensure people were protected from harm.

This was an ongoing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection in May 2016 we found there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that people were not being supported in a safe way. They were being given food which was not safe to eat, being placed at risk of scalding and other risks associated with the environment. We told the provider they needed to take action to eradicate these risks.

People were still being placed at risk of eating food which was not safe to eat. We saw there was out of date, high risk food such as egg pies, in the fridge which were either out of date or had no date of opening on them to inform staff they were still safe for people to eat.

Temperatures of hot water outlets were tested monthly to ensure they did not exceed the recommended safe level of 44 °C. However we saw the hot water from a tap in a toilet in Chestnut House had not been tested since we last inspected. On the day we visited we tested the water from this tap and it was 64 °C. All three people who had unrestricted access to this hot water supply had been assessed as being at high risk of scalding themselves. The compliance manager told us the door to this toilet should be kept locked to protect people from the risk of scalding; however the door was left unlocked throughout the course of our visit.

The failure to prevent people being exposed to avoidable risks gave us serious concerns. The provider had been made aware of issues about food storage and water temperature issues following our inspection in May 2016, but they had failed to take the required steps to protect people from these risks.

This was an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection in May 2016 we found there was a breach of Regulation 18 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. We found that staff were not deployed in such a way as to ensure people received the support they should. Some people had been assessed as needing one to one support from staff and this had been funded by the local authority. We found staff did not understand the meaning of one to one support and people who required one to one support were not receiving this when they should be. We told the provider they needed to make improvements in relation to this following the inspection.

During this visit we saw people were still not receiving appropriate care and support when they needed it, and one to one support was still not being given as intended. There were only three people using the service on the day we visited and in the morning there were three members of staff on duty to support them. One of these people were supposed to be within staff sight at all times during the times they were awake due to the risks to themselves and to others. We had concerns at our inspection in May 2016 that this person was not always being given this one to one support and our observations on this visit showed this person was still not receiving one to one support as intended which placed them and others at risk of harm.

The person had a risk assessment in place which stated they were unable to manage personal safety and unable to recognise potential threats or dangers. The assessment stated that the person needed to be constantly monitored by staff to ensure their safety at all times and that one to one support was in place to implement this. On this visit we saw this person in another person's bedroom without any supervision from staff. Additionally records showed the person had sustained some injuries from an unknown cause, which would indicate the person was not in the line of sight of staff when the injuries were sustained. Staff we spoke with told us the person was safe to be in certain areas of the service alone at times, which showed staff still did not understand the directions of the one to one support to ensure the person's safety.

This was an ongoing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had been assessed as not being safe to administer their own medicines and so relied on staff to do this for them. We looked at how medicines were managed and we found that people were being given their medicines when they should. However we saw that medicines were not always being stored safely. We saw that the temperature of the room in which the medicines were stored had exceeded the safe recommended temperature on 12 separate days in June 2016 and there was nothing recorded to show what action had been taken to address this, or to check if the medicines were still safe to administer.

During this visit we found that some improvements had been made to the safety of the environment. Legionella testing had been re-instated and there were regular checks being made to ensure people were protected from this risk. We saw staff were also carrying out frequent testing of the fire systems to ensure they were effective.

Inadequate

Is the service effective?

Our findings

During our inspection in May 2016 we found there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that people were not being supported with decision making and were not protected under the Mental Capacity Act 2005 (MCA). We told the provider they needed to make improvements in relation to this.

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.

We found that people were still not being supported with decision making and the MCA was not implemented appropriately. There were some MCA assessments in the three care plans we looked at, but some of these still lacked any real meaning because there was no evidence of how people's capacity had been tested, such as using different communication methods. Additionally there was a lack of evidence of a best interest's decision.

For example one person had a MCA in place for 'dressing' and the assessment concluded the person did not have the capacity to make decisions about getting dressed or dressing themselves. However there was nothing recorded to show how this had been assessed to see if the person had the capacity to make that decision. There was a care plan in place for this person which stated the person was able to choose their clothes and could independently manage to dress themselves in some items of clothing. This contradicted the decision in the MCA assessment and the person was not being supported with their independence as described in their care plan.

The compliance manager told us prior to our visit that a tracking system had been implemented to monitor the progress of DoLS applications so that there was a clarity about who had an application made for a DoLS and if they had been authorised. However on the day we visited the tracking system was not yet completed and there was still a lack of knowledge by staff about if any of the three people who used the service had a DoLS authorised. One member of staff told us they thought one of the people had a DoLS in place but was unsure. Another member of staff told us they thought applications had been made but were unsure if any DoLS had been granted for any of the three people. This meant staff may not be supporting people in the least restrictive way.

This was an ongoing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected the service in May 2016 we had concerns about staff not being given the training and supervision they needed to give them the skills they required to support people safely. During this inspection we were unable to assess if staff had been given any further training or supervision since our previous inspection as the records were unavailable on the day we inspected. However staff we spoke with told us they had not been given any further training since our visit in May 2016.

Inadequate

Is the service well-led?

Our findings

Nottingham City Council inspected the service in 2015 and reported significant concerns. The provider submitted an action plan to tackle these concerns, which was closely monitored. The Nottingham City Council told us that improvements to the service were slow, and they instigated a multi-agency process to work with the service. Regular meetings were held to address poor care standards which the Care Quality Commission attended. The Care Quality Commission worked closely with the Nottingham City Council and Mappleton House to enable the provider an opportunity to make changes to their practice and to hold them to account for required improvements. However, these improvements were not evidenced by the Nottingham City Council and they issued a contract suspension in March 2016.

When we inspected the service in May 2016 we found the systems in place to monitor the service and to identify and make improvements were ineffective and this had led to multiple breaches in regulation and negative outcomes for people who used the service. We found the provider was in breach of regulation 17 and we told them they must improve.

The Care Quality Commission continued to work in partnership with the Nottingham City Council to monitor the identified risks to people who used the service and actions that the provider was taking to address this. As a result of the on-going concerns from all agencies involved, Nottingham City Council served the provider with a final 90 days' notice to improve on the understanding that if improvements were not evidenced a termination of contract would be issued. A further multi-agency meeting was held where no improvements were noted. The provider then informed Nottingham City Council that they intended to end the contract and people who used the service would need to move out within 90 days, this was followed by a termination of the contract by Nottingham City Council.

Following the inspection in May 2016 the Nottingham City Council informed the provider they had to make improvements to the service or a termination of contract would be considered. The provider then informed Nottingham City Council that they intended to close the service and people who used the service would need to move out within 90 days. However the Nottingham City Council continued to receive serious concerns about the service and they started to move people out of the service much quicker than intended. On the day we visited there were three people remaining in the service and there were plans for these three people to move out by the end of the week.

There was no registered manager in place at the time of our inspection in May 2016 nor during this visit. Since the last registered manager left the service in June 2015 there had been a lack of consistent management in the service. An acting manager had commenced employment and then left, followed by another acting manager who had also stopped working in the service. A further acting manager had commenced working at the service two weeks prior to our inspection. There had not been a handover of the service and any issues which needed monitoring to ensure consistent care delivery. This had led to the quality of the service deteriorating and people were being placed at risk of receiving inappropriate or unsafe care and support. Relatives and staff we spoke with in May 2016 told us that changes in management and a

high turnover in the staff team had had a negative impact on the service their relations received.

Despite the breaches of regulation we found in May 2016 the provider had failed to implement effective systems to monitor, assess and improve the support people who used the service received. We saw that all audits in the service had stopped following our inspection in May 2016 and the compliance manager told us this was because the priority was ensuring people were moved safely from the service. Whilst we acknowledge that the moves of people was a priority, this meant there were no systems in place to monitor the quality and safety of the service to ensure people still living at Mappleton House were receiving safe care. We found that people were not in receipt of safe and appropriate care and a lack of systems for monitoring the service meant this had gone undetected and therefore unresolved.

A lack of appropriate governance and risk management framework had resulted in us continuing to find ongoing breaches in regulation and negative outcomes for people who used the service. There was still a lack of effective systems in place to monitor how incidents and accidents were acted on and this had led to people being placed at risk of harm and receiving care and support that was not safe.

Prior to our inspection in July 2016 Nottingham City Council told us they had concerns about a lack of management presence on a daily basis in the service. We discussed this with the compliance manager and they told us that a manager was always present during the day apart from one day when a manager had gone shopping for groceries for the service. However, two members of staff told us that there was not always a manager present at the weekends and that they had to rely on support from senior support workers. When we arrived at Mappleton House for this visit at 9am we found the manager was absent and there was no management cover on site until later that day. We also saw records of two incidents on two separate days where staff had recorded there were no managers present in the service. During a time of instability it would be vital for staff to have leadership in the service and our evidence would indicate this was not always the case.

There was still a lack of learning from incidents in the service and a lack of analysis to assess if information from incidents needed to be shared with the local authority. We saw that the manager had investigated some incidents and referred these to the local authority where needed. However there were some incidents and unexplained injuries which had not been acted on. This meant there was no oversight of what was happening in the service and a lack of learning from the incidents to try and prevent similar incidents from occurring again. This showed that despite the provider's attempts to put systems in place to investigate injuries and protect people from harm, the systems were not effective and did not provide an overview of what was happening in the service and therefore service users were exposed to harm.

Three of the staff we spoke with told us they felt let down by senior managers and didn't feel they had been treated fairly. Two members of staff told us the new manager was helpful and supportive but that the manager was not being supported by higher management. Three staff told us they felt they had not been given information about the future of the service in a timely way and felt senior managers had not been open and transparent with them.

When we inspected the service in May 2016 we found that records kept were disorganised, inaccessible and not completed appropriately. We found this still to be the case on this visit. Records were locked away and the manager, who was absent on the day, was the only person who held a key to access the records. This meant records relating to the running of the service were not easily accessible. We found records were still not being completed as intended. For example, there were records for staff to complete each day to show they had checked food stock in the fridge to ensure food was within its sell by date. These records were frequently still not being completed. We again found food which was not safe for people to eat in the fridge.

Despite the provider knowing about this issue the systems in place to monitor the quality and safety had not been effective in improving this.

The last time we visited we found that daily handover forms were not always being completed to ensure staff arriving on each shift would have an overview of how people were and if there was any information they should know. When we visited this time we found the handover forms had been taken out of the service and replaced with a communications log. However staff told us they had not been completing the communication log for some time and the last completed record we could find was on 18 June 2016. This meant that there was no system in place for staff to hand over important information about people to the next shift.

We saw records which showed that staff had been given the policies and procedures of the service in relation to safeguarding and how to manage one to one support. However it was clear from our inspection that systems to monitor and supervise staff had not been effective in ensuring staff followed these policies.

This was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was failing to ensure people received safe care and treatment. Regulation 12 (1)(2)(a)(b)(d)

The enforcement action we took:

We cancelled the registration of the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider was failing to ensure service users were protected from harm or the risk of harm. Regulation 13 (1)(2)(3)

The enforcement action we took:

We cancelled the registration of the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was failing to effectively assess and monitor the quality of the service in order to identify and make improvements. Regulation 17(1)(2)(a)(b)(c)(e)

The enforcement action we took:

We cancelled the registration of the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was failing to ensure that there were enough skilled and experienced staff deployed in the service. Regulation 18(1)

The enforcement action we took:

We cancelled the registration of the provider