Care Quality Commission

Maple Health UK Limited

Maple Cottage

Inspection report

5 Amber Court
Berechurch Hall Road
Colchester
Essex
CO2 9GE

Tel: 01206767117

Date of inspection visit:
22 November 2017

Date of publication:
04 January 2018

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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This comprehensive inspection took place on the 22 November 2017.

Maple Cottage is a residential care home that provides personal care and support for up to five people who have a learning disability and/or autistic spectrum disorder. People using the service live in a single house located within a residential community setting. People living in care homes receive accommodation and personal care and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection there were four people living at the service.

At the last inspection, the service was rated Good. At this inspection, we found the service remained Good.

A Registered Manager was in post. 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.

The registered manager had clear aims and objectives for the service. There was ongoing work to embed the values of providing personalised care, promoting independence, choice, rights and empowerment. We saw that the registered manager and staff put these values into practice.

This service was provided in line with the values that underpin the 'Registering the Right Support' and other best practice guidance. These values include supporting people with choice, promotion of independence and inclusion. People with learning disabilities and autism using the service are supported to live as ordinary a life as any other citizen.

People were treated with dignity and respect and staff interacted with people in a kind, caring and sensitive manner. Staff demonstrated a good knowledge of their roles and responsibilities in recognising abuse and safeguarding procedures with steps they should take to protect people.

The registered manager had a system in place to ensure appropriate recruitment checks had been carried out before staff started working at the service. There were sufficient numbers of skilled, trained and qualified staff on duty. Staff told us that they felt well supported in their role and we saw that staff had received regular supervision and training relevant to the roles they were employed to perform.

We found that detailed assessments had been carried out prior to admission to the service. Care plans had been developed around each individual's needs and preferences. We saw that there were comprehensive risk assessments in place and plans to guide staff in how the risks identified were to be managed and mitigated. People were supported with taking informed, every day risks and encouraged to take part in daily activities and outings. We saw that appropriate assessments had been carried out where people living at the

service were not able to make decisions for themselves, to help ensure their rights were protected.

People's medicines had been stored safely. There were clear personalised protocols in place to guide staff as to how people liked to take their medicines and identified allergies.

People were relaxed in the presence of staff. Where people lacked capacity to air their views verbally, staff supported people with opportunities to communicate through pictorial aids and visual prompts, appropriate for the individual. Relative's told us they were happy with the service provided and were able to raise concerns and there were systems in place to ensure people could be confident they would be listened to and appropriate action taken.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were offered choice. Where assessed as appropriate people were supported to develop their independence and gain life skills. People had access to a range of healthcare providers such as specialist learning disability support teams, speech and language therapists, their GP, dentists and opticians.

People had some opportunity to feedback on their experiences through monthly keyworker meetings and regular care reviews. Staff involved people in day to day decisions and the running of the service. Staff worked to create ways to involve people with limited verbal communication in day to day decisions and the running of the service.

Staff understood their roles and responsibilities and told us they were well supported by the management of the service. There was an open culture where people felt comfortable to air their views and, provide honest feedback. The registered manager was a visible presence in the service and carried out a number of quality and safety monitoring audits to help ensure the service was running effectively, keep people safe and to plan for improvement of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe.	**Good** ●
Is the service effective? The service remained effective.	**Good** ●
Is the service caring? The service remained caring.	**Good** ●
Is the service responsive? The service remained responsive.	**Good** ●
Is the service well-led? The service remained well led.	**Good** ●

CareQuality Commission

Maple Cottage

Detailed findings

Background to this inspection

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

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

One inspector and an expert-by-experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience had experience of providing support to people with a learning disability.

Prior to our inspection, we reviewed information available to us about the service, such as notifications that had been sent to us. A notification is information about important events, which the provider is required to send us by law.

Prior to our inspection, the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Because people using the service were not able to verbally express their views to us, we observed interactions between staff and people. We also contacted three relatives to ask for their views. We also spoke with stakeholders such as the local commissioning authority.

During our inspection, we spoke with the registered manager and three members of staff. We reviewed care records for three people who used the service, reviewed three staff recruitment files, staff training records, meeting minutes and quality and safety monitoring audits.

Good

Is the service safe?

Our findings

People were safeguarded from the potential risk of harm to their health, welfare and safety.

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

Risk assessments were personalised to each individual and covered areas such as the risk of self harm, access to the community, the risk of absconding and medicines management. Behavioural management strategies had been developed which guided staff in steps they should take to keep people safe where they may become distressed and present a risk to themselves or others. The registered manager had produced risk management tools, which contained detailed information in easily accessible grab sheets, which would enable other agencies such as the police to have vital information, promptly in the event of a person absconding. This was in a format based on national guidance known as the 'Herbert Protocol'. This is a national scheme being introduced by safeguarding agencies, which encourages providers of care services to compile useful information, which could be used in the event of a vulnerable person going missing.

People received one to one support from staff. There were systems in place to monitor people's level of dependency and to assess the number of staff needed to provide people's care. On the day of our inspection, we saw that there was sufficient staff on duty to ensure people received the support they needed.

At our last inspection, we found the provider failed to evidence their decision making process and assessment of risk when employing people with previous convictions. At this inspection we found improvement. The registered manager explained risk management processes in place. A review of staff recruitment files and discussions with staff showed us that the registered provider had a system in place to ensure appropriate recruitment checks had been carried out before staff started working at the service. This included obtaining references from the most recent employer, carrying out enhanced disclosure and barring checks (DBS), checks on identification, and health.

One relative told us, "I have every confidence in them [staff]. They understand the risks of [relative] going out into the community and they support [relative] really well. I know they are happy there, they know [relative] well and know how to calm them when they become anxious."

Staff knew the people they supported well and ensured they were able to participate in personalised activities. We saw that people were provided with care promptly, when they needed it or on request. The registered manager told us they had two staff vacancies and this meant there was a need to use agency staff. They also told us that agency staff employed to cover for staff shortages were not allocated to support

people outside in the community on a one to one basis unsupervised. Whilst this could potentially impact on people having access to their personalised, community activities, staff rotas were organised in a way, which kept this disruption to a minimum.

Medicines were managed and administered safely. Staff responsible for the administration of people's medicines had received training in medicines management and their competency to administered people's medicines safely was regularly assessed.

People's medicines had been stored safely and effectively for the protection of people using the service. There were clear personalised protocols in place for staff to guide them when administering 'as and when required' medication such as pain relief. Guidance on each person's prescribed medication could be found in their care plan. This included information as to possible side effects of medicines, and alerted staff to any allergies.

We carried out an audit of stock against medication administration records (MAR). We found all items tallied with the records of administration. We saw from a review of records that the registered manager and the pharmacy provider carried out regular audits to check that people received their medicines as prescribed.
Appropriate monitoring and maintenance of the premises and equipment was on going. The environment was found to be clean and well maintained. Infection control measures were in place with cleaning schedules to reduce the risk of cross contamination. Regular checks had been completed to help ensure the service was well maintained and that people lived in a safe environment. We observed mobile electric heaters were in use whilst maintenance work was carried out to repair the central heating. We noted that there were no risk assessments in place to guide staff in steps they should take to keep people safe whilst these were in use. We discussed this with the registered manager. They promptly took action to produce a comprehensive risk assessment which they then made available to staff. A message was then recorded in the staff communication book, instructing staff to read and sign to evidence they had understood their responsibilities.

Incidents and accidents were monitored and analysed by the registered manager. Learning and actions for improvement following incidents were discussed at team meetings and with individual staff in supervision meetings when required. Where safeguarding incidents had been investigated, we noted the registered manager had produced action plans in response describing lessons learnt and action planned for improvement of the service.

Good

Is the service effective?

Our findings

At this inspection, we found staff had the same level of skills, experience and support to enable them to effectively meet people's needs as we found at the previous inspection. People continued to have freedom of choice and were supported, where appropriate with their health and dietary needs.

Staff had been supported in the role for which they were employed to perform. Staff recently employed told us they had been supported with comprehensive induction training including support in working towards the Care Certificate. This is a nationally recognised, good practice induction for newly employed staff working within the care profession. New staff 'shadowed' more experienced staff to support them in getting to know the care and support needs of people and to gain confidence in their role.

Staff performance was monitored, and staff regularly competency assessed. For example, in medicines management, care delivery and their knowledge of current best practice. This was confirmed through discussions with staff and a review of records. Staff were positive about the management support they received and the training provided.

Training in 'positive protective intervention' was provided to staff to equip them with knowledge of safe de-escalation techniques when responding to behaviour that may challenge. This training was provided by another registered manager from another of the provider's registered services who was not an accredited trainer. The training was also not accredited in line with national best practice guidance. We discussed this with the registered manager and staff. We were not assured from their responses that this training equipped staff appropriately in responding to people with behaviour that may present as a risk to themselves and others. However, we saw from discussions with the registered manager and a review of records that the registered manager had consulted with specialist advisors in relation to the development of behavioural management plans for individuals using the service.

Staff told us and records we reviewed showed us that staff had been supported through regular one to one supervision sessions, staff meetings and annual appraisals. Minutes of staff meetings showed us that these sessions enabled staff to be involved in reviewing people's care and support needs, planning for improvement of the service and performance management.

CQC is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).The 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

following authorisations to deprive a person of their liberty were being met. At the time of our inspection, we found that they were meeting these conditions. DoLS applications had been submitted where relevant as required. We noted that one person had a DoLS in place whilst others were awaiting authorisation from the local authority. All staff had received training in understanding their roles and responsibilities with regards to the MCA and DoLS and the registered manager kept up to date with current practice.

People's capacity to make day to day to day decisions had been assessed to help ensure they received appropriate support. This showed that the service had up to date information about protecting people's rights and freedoms. Where possible, consent had been gained and people or their relatives and advocates had agreed to the service providing care and support. People were observed being offered choices during the day and this included decisions about their day to day care needs. All of the relative's we spoke with told us that the registered manager kept them updated with any relevant changes regarding the health and welfare of their family members. We also saw records of emails where the registered manager notified relatives of staff changes.

People were supported to maintain contact with people important to them. Staff supported people to telephone and use visual technology such as Skype to communicate with their family on a regular basis. This support was also recorded in people's care and support plan as 'important information to know about me'.

Staff supported people to make decisions and choices about their everyday lives. Assessments had been completed when people were thought to lack mental capacity to identify how their care could be provided in line with their wishes and preferences. When people lacked capacity, the provider had taken action to seek that the care, treatment and support, which people received, did not restrict their freedom and rights. These decisions were clearly documented with the reasons why and what these decisions covered including access to the community, medicines, nutritional needs, health care and medical appointments.

Staff had a good understanding of each individual person's nutritional needs, likes and dislikes. People's nutritional requirements had been assessed and their individual needs documented. This included risk assessments and a regular review of people's weight. We observed people were able to obtain snacks from the kitchen when they wanted.

People had been supported to maintain good health, had access to healthcare services, and enabled to receive ongoing support. The registered manager had systems and processes in place for monitoring people's health and welfare needs and to enable people a smooth transition between services. Each person had a health action plan in place to identify any health care needs and action needed to enable people to stay healthy. People also had hospital passports in place. The aim of a hospital passport is to assist people with learning disabilities in their transition to hospital. This would provide clinical staff with important information about the person, their health and communication needs.

Staff worked together with other organisations to deliver effective care, support and treatment. The registered manager described to us how they were in the process of preparing for a planned admission of a person due to move into the service the following week. They described how they had worked together with the person's social worker, occupational therapists, their relatives and hospital staff to ensure a planned, smooth transition. This included the allocation of two staff who had been visiting the person in hospital twice weekly to build relationship with them and planned visits to the service.

Daily records recorded contact with health care professionals. Referrals had been made to healthcare professionals when needed and this showed us that staff responded in a timely manner to people's needs

and supported people to maintain good health.

Good

Is the service caring?

Our findings

People were treated with kindness, respect and compassion. They were provided with emotional support when needed. We observed apparent bonds between staff and people who used the service. There were physical and verbal reassurance provided when needed such as, hand holding, patting on the back, touching on the arm, encouragement, 'well done, that's brilliant'.

One relative told us, "[relative] is really happy there. They are doing really well. We could not be happier with the care and support they receive. Another told us, "They are helping [relative] in so many ways, they manage [relative] really well. The staff are kind and so understanding of their needs."

We saw that staff interacted with people in a calm and considerate way. Where people expressed anxiety staff provided reassurance with plenty of explanation to help calm the person. Staff were also observed to be regularly affirming, reassuring and praising people whenever they achieved a task they were performing. This impacted positively on their sense of wellbeing.

One member of staff who was also a keyworker described how they supported people to maintain contact with their relatives. "It's so important that we help people to keep in contact with family. [Person they were keyworker to] must not miss the weekly calls or skype conversations with their family or this would really distress them. [Person] likes to hear their voices and they contact him at arranged times every week. It is so good to see how happy this makes them feel."

One relative told us, "I can always keep in touch with [relative] staff always help [relative] call me, and we visit when we can, there is very good liaison and staff call me often including about the good stuff too which is nice." Another told us, "The staff are lovely they involve [relative] in things and help them make choices, their quality of life is much improved and they are always looking to improve things further."

People received personalised care from staff who knew them well. We saw that staff worked to ensure that where possible people had been involved in decisions about their care and how they lived their daily lives. Staff had a good understanding of people's non-verbal communication and responded to them appropriately. Staff described to us and care plans confirmed how they identified people's needs and preferences through non-verbal cues.

We saw that people with limited verbal communication skills were supported to express their needs, wishes and preferences through a variety of communication tools such as; objects of reference and the 'Picture Exchange Communication System' (PECS). This enabled people with to communicate using objects, pictures and symbols.

One relative told us, "They help people cope with change very well. I have not seen them before but they use social stories here to explain things to people. Like if a family member is going on holiday they prepare them for that the week before it happens which is great, and they are doing one about the new resident moving in. they are very good at reassurance and at reassuring families too."

People's bedrooms were personalised and contained photographs, artwork and personal items, which reflected people's individuality and personalities. Staff respected people's private space, for example waiting for a response from people before entering their room.

People were supported with their needs in a timely manner and their privacy and dignity was maintained. It was evident that the staff were there for the people they cared for and wanted to make a difference to their lives.

Good

Is the service responsive?

Our findings

At this inspection, we found people continued to receive responsive care, which was personalised according to their assessed needs and preferences and met their needs.

People's needs were assessed prior to their admission to the service, and these assessments were used to develop their care plans. Care plans were personalised and covered different aspects of people's health, welfare and safety needs and provided staff with guidance as to how people preferred to have those needs met.

Staff supported people according to their assessed needs and preferences. People received the support and assistance they needed and staff were aware of how each person wanted their care to be provided. Care plans were regularly reviewed and reflected people's current care and support needs. Care plans contained personalised information about each person including their physical, psychological, social and emotional needs. Staff told us that they worked closely with people and their relative's to find out their personal preferences and how they liked their care to be provided.

During our observations, it was evident that the staff knew the people they supported well and were able to establish their needs and preferences. They were also seen encouraging people to be as independent as possible through enabling and empowering them to complete tasks and take part in chosen activities. For example, in food preparation, shopping and the planning of their weekly activities.

Each person had a health action plan and daily observation and shift handover records were maintained. These provided information about each individual and ensured staff, were kept up to date at each shift. Newly employed staff told us they had been given time to read each person's care records, which they said, provided them with sufficient information for them to meet people's needs.

It was evident that staff planned with people what they wanted to do and enabled them to have choice with their daily routines. We observed people supported by staff on a one to one basis to access the community, going out for walks, shopping, social clubs and educational opportunities.

Relative's confirmed that staff supported people with a range of personalised activities appropriate for the needs of the individual. One relative told us, "They encourage [relative] and they have learnt so much. They really understand that [relative] has to be occupied all the time, and having one to one support, which they provide means they can do that. I used to have difficulty getting [relative] to do things, but they now live a full life, go to the gym and out and about."

When asked if they were involved in planning their relative's care where appropriate to do so relative's told us, "I am totally involved, they are extremely approachable and friendly. They email me about any changes and invite us to care reviews." Another said, "They really involve [person using service] with things, and I know we can always discuss things as a family with the manager. I feel very involved. They are very good with their interventions to support [relative] with any changes and they know [relative] likes their own space

and staff know and respect that."

The registered manager had effective systems in place for people to use if they had concerns or wanted to complain formally if they wished to do so. People were provided with regular reviews of their care. This system enabled people's care to be reviewed and any concerns to be discussed. Issues raised which required action had been recorded into action plans with a description of actions taken.

Annual satisfaction surveys had been sent to staff and relatives. Responses received had been analysed and action plans put in place in response.

Good

Is the service well-led?

Our findings

At this inspection, we found the service continued to be well led.

The service had a registered manager who had clear aims and objectives with vision for the service. They also managed another of the provider's services locally, within the same housing complex.

There was ongoing work to embed the values of providing personalised care, promoting independence, choice, rights and empowerment. We saw that the registered manager and staff put these values into practice. From observations and discussions with staff it was clear that staff were passionate about providing quality, personalised care.

It was apparent from our discussions with stakeholders and a review of records that the registered manager understood their responsibilities in reporting incidents to the relevant authorities.

Our observations and feedback from staff showed us that the registered manager had an open leadership style and that the service had a positive, enabling culture. Staff told us they were involved in developing the service through support with one to one supervision meetings, regular team meetings where they were listened to and they felt valued.

Staff were confident and understood their roles and responsibilities in supporting people to live a full, independent a life as possible. One member of staff told us, "I love it here. It is not like coming to work. It is a home from home. I get great satisfaction from working with the people living here. We work well as a team and pull together well." Another told us, "It's a really lovely place. The manager is totally approachable and can't do enough for you. We have a very good team."

The registered manager was organised and had a number of systems in place to show they aimed to regularly monitor and involve their staff in the planning and delivery of quality care. Records reviewed showed us that the registered manager carried out a range of regular audits to assess the quality of the service and to plan for continuous improvement.

We noted that recent policies reviewed, staff had been informed and were engaged in reviewing these and signing to say they had read and understood them.
There were systems in place to gain people and their relative's views about the service and involve them in decision making where possible. Examples of this included monthly keyworker meetings and care reviews. Relative's told us they were regularly updated as to changes in the health and welfare of their relatives and notified of changes within the staff team. One relative told us, "The manager is great, always accessible, keeps us informed of anything we need to know. They and they staff always make us feel welcome to visit at any time."

In their PIR, when asked, what improvements they planned to introduce in the next 12 months that will

make your service better led, the registered manager told us had a clear vision and had identified areas of improvement. They told us that they planned to make improvements to training and were planning to introduce , 'Training feedback sheets will be implemented so that the quality of the training being delivered to our staff can be monitored. It will also help us identify whether each staff member found the training suitable/beneficial or whether they need the training delivered to them in a different format/way dependent on their individual needs.'