

Burlington Care (Yorkshire) Limited

Maple Court

Inspection report

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Date of inspection visit:
22 November 2021

Date of publication:
13 January 2022

Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Maple Court is residential care home providing personal and nursing care to up to 64 people aged 65 and over, some of whom may be living with dementia. At the time of the inspection, 39 people were using the service.

The home has two floors. The ground floor provides accommodation for people requiring residential care, and the first floor provides accommodation for people living with dementia. At the time of this inspection, Maple Court were no longer providing nursing care.

People's experience of using this service and what we found

People told us they felt safe and received kind and compassionate care. Staff responded to people's needs in a timely manner and knew how to respond and report any safeguarding concerns.

Safe recruitment processes were followed, and although there had been recent challenges with recruitment, progress was being made.

Medicines had been stored, administered and recorded in line with best practice guidance. Effective infection prevention and control measures were in place to reduce the risk of spreading infections. Covid-19 guidance was being followed.

Risks to people had been assessed and recorded. Mitigation was in place where possible.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Effective governance systems to monitor the quality and safety of the service was in place. Senior management visited the service on a regular basis to provide support and ensure they had effective oversight of the quality and safety of the service provided.

People, relative and staff views were listened to and acted upon. Clear action plans were in place where any shortfalls were found.

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

Rating at last inspection

The last rating for this service was good (published 3 June 2019).

Why we inspected

The inspection was prompted in part due to concerns received about staffing levels and the level of care people were receiving. A decision was made for us to inspect and examine those risks.

We found no evidence during this inspection that people were at risk of harm from this concern. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Maple Court on our website at www.cqc.org.uk.

Follow up

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

Details are in our well-led findings below.

Maple Court

Detailed findings

Background to this inspection

The inspection

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

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

Inspection team

The inspection was conducted by one inspector. An Expert-by-Experience made calls to people who used the service and relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Maple Court is a 'care home'. People in care homes receive accommodation 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.

The service did not have a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. An interim manager was in post, but they were not registered with CQC. They are referred to as 'the manager' throughout this report.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with two people who used the service about their experience of the care provided. We also contacted five people who used the service and four relatives via telephone. We spoke with five members of staff including the area manager, interim manager, administrator and two care staff. We contacted a further three staff via telephone after the inspection site visit.

We reviewed a range of records. This included six people's care records and multiple medicine records. We also looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at meeting minutes, audits and documentation relating to monitoring people's health.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Systems and processes were in place and followed to keep people safe.
- Where any concerns had been identified appropriate processes had been followed to ensure this was reported.
- People told us they felt safe. Comments included, "I've been given help and I've got my confidence back. I'm happy here" and "Yes, I've been poorly. I'd fallen and I'm not safe on my own. I feel very safe here."

Assessing risk, safety monitoring and management

- Risks to people were assessed and recorded. Action had been taken where possible to mitigate risks.
- Checks in place to ensure the safety of the service were regularly completed and thorough records kept. Equipment had been serviced at regular intervals to ensure it remained in good working order.

Staffing and recruitment

- Safe recruitment processes were in place and followed. Staff files clearly evidence appropriate pre-employment checks had been completed prior to employment commencing.
- Although staffing levels were not always in line with dependency calculations, we found no evidence of impact.
- The interim manager was open and honest with regards to staffing levels. The service had struggled to recruit permanent staff and were reliant on the use of agency staff who at times were unreliable.
- People and relatives told us there was enough staff. Comments included, "Yes, there seems to be plenty of them. I've got no trouble with the staff" and "I think so (there is enough staff). Of course, more staff means more attention for each resident, but I think there's enough."

Using medicines safely

- Medicines were stored, administered and recorded appropriately. People told us they received their medicines on time, as prescribed.
- Regular audits were completed to monitor medicines and staff had received appropriate training and had their competencies assessed.
- We identified some minor recording shortfalls with regards to the use of 'as and when required' medicines. However, the medicine audit completed by the manager had already highlighted these and action was being taken to address the issues.

Preventing and controlling infection

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

- We were assured the provider was meeting shielding and social distancing rules.
- We were assured the provider was admitting people safely to the service.
- We were assured the provider was using PPE effectively and safely.
- We were assured the provider was accessing testing for people using the service and staff.
- We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong

- Lessons were now being learnt when things went wrong. The manager had improved all lines of communication with staff and this included learning when things went wrong.
- Accidents and incidents were thoroughly analysed to prevent reoccurrence and identify any patterns and trends.

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Effective quality assurance processes were fully established and used to monitor the quality and safety of the service.
- Audits had been completed on a regular basis. They were effective in identifying shortfalls.
- Senior managers were actively involved in the service and conducted monitoring and support visits on a regular basis.
- There was not a registered manager in post. The last registered manager de-registered in May 2021 and recruitment was ongoing to recruit a permanent manager. Where services do not have a registered manager in place, they cannot be rated higher than requires improvement in the well-led domain.

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

- People told us they were happy living at Maple Court. There was a warm, welcoming and relaxed atmosphere.
- Staff told us the culture of the service had improved. They spoke positively of the manager and their approach. One staff member said, "[Interim manager's name] is excellent. Morale has really improved over the past couple of months. Feels like we have turned a corner."
- The manager had taken action to ensure they regularly engaged with people and staff to promote an open and honest culture.

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

- The provider and manager understood requirements in relation to duty of candour and had an open and honest approach.
- The provider and manager continued to communicate with relevant professionals to highlight any issues or concerns within the service, and any action that was being taken to address these.

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

- The manager had increased engagement with people and relatives to ensure they were fully up to date with any changes and improvements within the service. Their views were listened to and acted upon.

- Staff had strong links with other health and social care professionals. Visits from other professionals had continued to take place during COVID-19 restrictions to ensure people had access to the care and support they needed.
- Staff had used technology and regular telephone calls to engage and involve people who used the service with relatives during COVID-19 restrictions. Visiting was taking place in line with government guidance.

Continuous learning and improving care

- The provider and manager had recognised the impact the number of changes in the management team had on the people who used the service and staff team. They had taken measures to learn from this, so further changes could be effectively managed to minimise impact.