HC-One Limited

Maple Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Maple Court Nursing Home is a care home providing personal and nursing care to 42 people at the time of the inspection. The service can support up to 80 people in one adapted building, over two floors. At the time of the inspection there were two separate units, one on each floor, providing support to people with differing needs. Saunders unit was upstairs and predominantly supported people living with dementia or other mental health needs and Elizabeth unit was on the ground floor.

People's experience of using this service and what we found
People felt safe at the service, however some people said there weren't enough staff to meet their needs. Improvements had been made to the way people's risks were managed and we saw people's falls had reduced as a result of this.

There had been improvements to infection control practices though further improvements were required. People's medicines were now managed safely.

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. However, there were some inconsistencies in the way staff applied the Mental Capacity Act (2005).

People were treated with kindness and compassion; however, some people felt staff deployment impacted on their choice and control.

A new registered manager was in post since the last inspection and they had implemented new ways to manage and monitor the quality and safety of the service. These were working well but needed to be further embedded into practice and sustained.

Some staff did not feel well supported and involved in the service, but other staff told us they felt the registered manager had a positive impact on the service.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 6 February 2021) and there were multiple breaches of regulation. We took enforcement action and the provider completed an action plan to show what they would do and by when to improve. At this inspection we found improvements had been made in most areas, though further improvements were required, and the provider was still in breach of some regulations.

This service has been in Special Measures since the last inspection. During this inspection the provider

demonstrated that some improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an unannounced inspection of this service on 2, 4 and 10 December 2020. Five breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, safeguarding, staffing, dignity, good governance and notifications to CQC.

We undertook this focused inspection to check they had followed their action plan and to confirm whether they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective, Caring and Well-led which contain those requirements.

A rating from a previous comprehensive inspection for the Responsive Key Question was used in calculating the overall rating at this inspection.
The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to staffing and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring 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 Nursing Home

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 team consisted of three 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 care service.

Service and service type
Maple Court Nursing Home 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 had 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.

Notice of inspection
This inspection was unannounced.

What we did before 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 12 people who used the service about their experience of the care provided. We spoke with 16 members of staff including the registered manager, deputy manager, unit lead, two nurses, six care staff, two activities coordinators, two kitchen assistants and a member of domestic staff. 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.

We reviewed a range of records. This included eight people's care records and multiple medicines records. We looked at three staff files in relation to recruitment and staff supervision. 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 registered manager to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

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 inadequate. At this inspection this key question has now improved to requires improvement. This meant some aspects of the service were not always safe. There was an increased risk that people could be harmed.

Staffing and recruitment

At our last inspection the provider had failed to ensure that enough staff were effectively deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst improvements had been made to staffing levels and deployment, not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● People who lived on the ground floor told us there were not enough staff to meet their needs. One person said, "There aren't enough staff. This weekend the staffing was awful because some staff didn't come in. I had to wait to go to the toilet and I didn't have a shower on Saturday when I was supposed to. They said I can have a shower tomorrow" and "They forget I'm there [waiting in my room]". Another person said, "They need more carers. I get up in the morning much later [than I'd like]. I like to get up between 11 and 12. But these days it's closer to 1 o'clock. Sometimes it's later. They [staff] just about get me up in time for lunch. Today they've told me that it will be just before lunchtime."
● We observed on the ground floor that lounges were not always staffed, and people did not have access to call bells to summon help. We saw one person shouting for staff to help them to the toilet, but they could not make themselves heard as there was no staff in the vicinity.
● Staff who worked on the ground floor said there was not enough staff deployed to meet people's needs, which resulted in people having to wait for support. A staff member said, "The residents have to wait, they know we are short staffed, it's not fair on them. They ask for the toilet and you have to say, 'you will have to wait, I'm in the middle of washing someone, or just about to hoist someone.' You don't have time to spend with them when there's no staff."

This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The new registered manager had implemented unit leads on each floor and staff now worked consistently on one unit or the other. This meant people had greater consistency and staff were able to get to know people and how to meet their needs safely.
● New staff had been recruited and there was a reduced reliance of agency staff. Staff recruitment was ongoing.

● Our observations on the upper floor showed there was enough staff deployed to meet people's needs. Staff confirmed this.
● Following the inspection, the registered manager said they would consult with people and staff regarding staffing numbers and confirmed that long lead call bells had been requested to improve access to call bells for people on the ground floor.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to protect people from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● People told us they felt safe. One person said, "I feel safe and secure. I don't worry about anything these days. I used to before I came here. But now I don't need to worry about anything."
● Staff understood their responsibilities in recognising and reporting safeguarding concerns. One staff member said, "I would report it to the nurse and escalate if I felt it was not dealt with. I would go to [the deputy manager] or [registered manager] or I could whistle blow. I'd go to the Police, safeguarding or CQC if I needed to."
● The registered manager had implemented new systems and supported staff to ensure they recognised and reported any concerns as required. We saw that these systems were working effectively, and appropriate safeguarding referrals had been made to the local safeguarding authority when required. This ensured that necessary investigations took place and people were protected from abuse or improper treatment.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● People's risks were now appropriately assessed and managed, and plans were regularly reviewed. Staff knew how to manage people's risks and we saw they supported people in line with their management plans. We observed a marked reduction in one person's falls since the last inspection as their falls risk was now appropriately managed.
● People mostly felt safe when being supported with their mobility. One person said, "I am safe. I need a sling to move from my bed to a chair and back again. I feel safe with the carers when they are using it. Most of them anyway, sometimes when there's a new carer it's not so good but they learn."
● We observed safe moving and handling practices and staff confirmed they had received additional training and support in safe moving and handling since the last inspection.
● Wound care plans were now in place for all people who required them. They were fully completed, reviewed regularly and the unit leads had good oversight of the wound management plans in place.

Preventing and controlling infection

At our last inspection the provider had failed to assess the risk of, prevent and control the spread of infections. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● Whilst improvements had been made to infection prevention and control practices, we saw that side tables were shared between people without being sanitised in between uses and some people were supported to sit at dining tables that had not been cleaned or sanitised since their last use. The registered manager was receptive to feedback and told us they would take action to make improvements in this area.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that 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.

Using medicines safely

At our last inspection the provider had failed to ensure the proper and safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● When people required their medicines to be administered covertly, the correct professional guidance and instructions were in place, to ensure people received their medicines safely, and in their best interests.
● People who were prescribed 'as required' (PRN) medicines had protocols in place to guide staff on when and how to administer these medicines so that people received them when they needed them.
● Systems and processes were operated to effectively to ensure that medicines practices were safe, and people got the medicines they needed, when they needed them.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant the effectiveness of people's care, treatment and support was better but inconsistent.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure that staff were suitably trained and supported to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18 in relation to staff training.

- Staff told us they had received suitable training. For example, they told us they had recent training in safer people handling. A staff member said, "Everyone is now up to date with manual handling training. I've been trained to be a safer people handler and I enjoy delivering the training to other staff."
- The registered manager had good oversight of staff training and development needs and there were plans in place to address any gaps. In addition to mandatory training, additional training had been arranged to further enhance staff knowledge and skills.
- Whilst most staff felt supported, some staff told us that supervision sessions were not useful or supportive. A staff member said, "[Supervision] is a piece of paper to read and sign, it's not a sit down and listen or being supportive. It's telling you to wear your mask, do this or do that but it's not a supportive supervision."
- The registered manager told us that 'themed supervisions' had been rolled out to staff since the last inspection to implement positive changes to practice. However, there were plans to make supervisions more personalised and valuable to staff and we saw some of these positive supervision sessions had started to be carried out.

Ensuring consent to care and treatment in line with law and guidance; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At our last inspection the provider had failed to ensure that any restrictions on people had the necessary legal authorisation in place. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of

regulation 13.

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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● We found that authorisations had been applied for, in line with the law, when restrictions were placed upon people.
● Some people had conditions on their DoLS authorisations that were complied with. However, records were not always clear and staff were not always sure about what the conditions were and how they were being complied with.
● Mental capacity assessments had been carried out when required, in line with the law. However, there were some inconsistencies in the application of the MCA. For example, one person had been assessed as lacking the capacity to make decisions about their medicines and had then been asked to sign consent to taking a new medicine.
● Care plans showed that people's needs and choices were appropriately assessed including consideration of equality and diversity.

Adapting service, design, decoration to meet people's needs
● Saunders unit, upstairs, mostly catered for people living with dementia. However, the environment was not always dementia friendly. For example, it was not easy for people to identify their own bedrooms and signage was placed up high so was not easy for people to see.
● The registered manager told us a refurbishment was planned that will make the environment more dementia friendly.

Supporting people to eat and drink enough to maintain a balanced diet
● The upstairs dining room was noted to be uncomfortably warm on the day of the inspection, though it was a particularly hot and sunny day. More drinks were offered to people due to the hot weather. However, we observed one person, who had been enjoying the sun outside, asking staff numerous times for water. The request was not responded to, so an inspector had to ask staff to get the person a drink of water.
● People enjoyed the food on offer and told us they had choices. Comments included, "I only have what I like. This morning I had a bacon sandwich. It was lovely" and "I like the vegetarian options and we get a choice."
● We saw that people were offered and provided with alternatives when they didn't fancy what was on the menu. However, some people told us, and we saw that what was on the printed menus was not always what was available on the day.
● People were encouraged and supported to be independent whilst eating and aids such as plate guards

supported this.
● When people were unhappy with the food, we saw action was being taken to make improvements for them. For example, a mealtime feedback sheet was completed with people, the chef spent time with people who had any concerns and a 'you said, we did' board was being developed.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Appropriate referrals were made to health professionals such as the dietician and care plans were updated with the advice, which we observed staff were following.
● Where people had lost weight or had poor appetite, actions were taken to reduce risks to them including fortified diets, referral to the GP or dietician and supplements were considered.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant that whilst improvements were noted, people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

At our last inspection the provider had failed to ensure that people were always treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 10. However, some improvements were still required.

- People told us they were treated with kindness by staff who cared for their welfare. One person said, "They are very good staff. They are very helpful. They are so kind to everyone. I get everything I want, and I'm well looked after."
- However, some people told us that whilst staff were kind and caring, staffing levels impacted upon people's choice and control over their lives. One person said, "It's up to me when I get up and go to bed, as long as there is enough staff on." Another person said, "The staff are very kind and pleasant. I just wish there wasn't so much waiting at weekends."
- We observed that staff treated people with respect. However, there were some occasions when staff did not maintain people's dignity. For example, a staff member asked a person if they would like a drink and they replied yes. The staff member said, "yes what?" This was not respectful to the person and was not dignified.

Supporting people to express their views and be involved in making decisions about their care
- Some people were supported by staff to sit at the dining table. However, staff placed them at the dining table facing a blank wall, with their back towards the area food was being served. This meant people were not always given choice of where to sit and staff did not consider their experience of being able to see what was happening or be involved in the dining experience.
- People told us they were supported to express their views and that the service did their best to cater for their choices and preferences. One person said, "I had a brand-new chair and I really didn't like it. I told [registered manager] and she got me my old chair back. Everything I've asked for, I've got it."
- People told us that new residents' meetings had been arranged by the new registered manager. People told us they were encouraged to express their views and be involved in decisions about their care. One person said, "It's a chance to have our say. But not everyone wants to speak up."

Requires Improvement

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 inadequate. At this inspection this key question has now improved to requires improvement. This meant the service management and leadership needed to further embed changes. Leaders needed to ensure changes were fully embedded and sustained in order to 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

At our last inspection the provider had failed to ensure good governance. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst improvements had been made to the governance structure, more improvement needed to be embedded and sustained and the provider was still in breach of regulation 17.

● Since the last inspection, a new registered manager had been employed at the service. They had improved oversight of risk. However, they had not identified how staffing deployment was impacting on the safety and quality of care provided to people.
● Daily walkaround helped to ensure issues on the floor were identified and dealt with. However, they had not identified people's and staff's feedback about how the staffing levels and deployment were impacting on people's care.

The provider's quality monitoring systems had failed to identify the issues in relation to staffing. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager understood their responsibilities of registration with us and we saw the current rating was displayed in the home and the website, as required by law.
● The registered manager had improved oversight of people's needs and risks. They had implemented new quality assurance systems and ensured the provider's systems and processes were being followed. This meant that they had a better oversight of the service and mostly knew where improvements were still required. They had plans in place to address shortfalls.
● The registered manager had implemented a new management structure which meant they were supported by a deputy manager and unit leads, in addition to the nurses and heads of department. This meant there was a clear management structure and that all understood their roles and responsibilities. This improved the oversight of people's needs and risks and helped to lever change when required.
● The registered manager needed to ensure that new systems and processes were fully embedded to lever further change and sustain the improvements already made.

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

At our last inspection the provider had failed to notify us when a person had an authorisation to deprive them of their liberty. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● Since the last inspection, we received notifications of incidents that the provider is required, by law, to notify us of.
● The registered manager understood their responsibilities under duty of candour and explained how they would use the provider's policy and procedure to ensure they were open and honest with people if something went wrong.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Most staff said the manager was approachable and supportive and gave positive examples of improvements in the last 6 months. However, some staff felt unable to approach the registered manager with their concerns. One staff member said, "[Registered manager] is doing a good job, trying her hardest and things have got better but I don't know how to approach her. I haven't had the opportunity to approach her, she's so busy sorting things out, she has a lot going on." Another staff member said, "It's better now that [registered manager] is here. She listens to us and she says yes."
● People told us there was a positive atmosphere and that they felt included. One person said, "The whole atmosphere here, it's nice. All the time, I'm very pleased with it. I am very content and happy with it."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
● The registered manager had taken a number of steps to improve the engagement and involvement of people using the service. Two people told us they were involved in staff recruitment processes. They said they were keen to be involved and enjoyed taking part, in order to influence staff appointments.
● Some people told us about the newly arranged residents' meetings. They said it was a good opportunity to express your views and they felt listened to. One person said, "We told them we like the quizzes and we like the garden." Another person said, "They are quite good. They are new to us. We asked for fish and chips from the chip shop and we got them. Much better than the fish and chips here."
● Most staff said they felt in engaged and involved in the service. One staff member commented, "We feel supported now. It wasn't always like that. It's changed since [registered manager] came. She is all for the residents getting involved." However, some staff felt they needed more opportunity to express their views. One staff member said, "We get no thanks, we need a big staff meeting to get it all out in the open."

Working in partnership with others
● The service was working on developing partnerships with others and community links. The 'Random Acts of Kindness' scheme had been implemented and helped improve community links, even during the pandemic. There were plans in place to further expand on community involvement.

This section is primarily information for the provider

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality monitoring systems had failed to identify the issues in relation to staffing. Therefore, no action had been taken to make improvements. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient deployment of staff to meet people's needs on Elizabeth unit. This meant people had to wait for the support they needed. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.