Maypole Health Care Limited

Maypole Grove

Inspection report

20 Maypole Grove
Birmingham
West Midlands
B14 4LP

Tel: 01214303094

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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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 15 February 2018 and was unannounced. This was the first inspection of the service since the provider registered with us in April 2017.

Maypole Grove is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Maypole Grove accommodates a maximum of 30 people who may have mental health needs, Dementia or physical disabilities in one adapted building. At the time of the inspection, there were 14 people living at the home.

There was a manager registered with us. However we were informed prior to the inspection that the registered manager had left their position and that a new manager had been recruited. 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.

People were supported by staff who knew how to report concerns and manage risks to keep people safe. Recruitment systems reduced the risk of inappropriate staff being employed. Staffing levels had been impacted by staff absences but this was addressed by the provider to ensure there were sufficient numbers of staff to support people. People were given their medication in a safe way.

People had their rights upheld in line with the Mental Capacity Act 2005 although staff knowledge of Deprivation of Liberty Safeguards varied. People had their dietary needs met and were given choices with regards to their meals. People had access to healthcare services where required and there was an emphasis placed on health promotion. People were supported by staff who had received training and supervision. The decoration of the home was not always appropriate to support the needs of people with Dementia.

People were supported by staff who were kind, caring and had developed warm relationships with people. People had their privacy and dignity respected and were supported to maintain their independence where possible. People's personal history including their culture and communication needs were respected.

People were involved in the planning and review of their care. People's care records held personalised information about them and people were able to voice their preferences with regards to their care. There were activities for people and people were supported to take part in these where they wished. Complaints were investigated and resolved.

There were concerns about the stability of management due to a high turnover of managers in previous

months. Notifications had not always been sent to Care Quality Commission as required. There were systems in place to monitor the quality of the service and people had opportunity to feedback on the quality 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?

Good

The service was safe.

People were supported by staff who knew how to report concerns and manage risks to keep people safe.

The manager was taking action to address high levels of staff absence and there were sufficient numbers of staff to support people. Staff had been recruited safely.

Infection control procedures were in place and followed by staff.

Medications were given in a safe way.

Is the service effective?

Good

The service was not always effective.

People had their rights upheld in line with the Mental Capacity Act but staff knowledge of Deprivation of Liberty Safeguards varied.

People were supported by staff who received appropriate training and supervision.

People had their dietary needs met and were supported to access healthcare services where required.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring.

People's communication needs were met by staff.

People had their privacy and dignity respected and were supported to maintain their independence where possible.

Is the service responsive?

Good

The service was responsive.

People were involved in the planning and review of their care.

People were supported to take part in activities where they wished.

Complaints made were investigated and resolved in line with the providers procedures.

Is the service well-led?

Requires Improvement

The service was not always well led.

Notifications that the provider was required to submit to the Care Quality Commission had not been sent.

There was no registered manager in post.

Systems were in place to monitor the quality of the service and people's feedback on the service was acted upon by the provider.

Maypole Grove

Detailed findings

Background to this inspection

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

The inspection was prompted in part by a high number of safeguarding referrals being made in relation to incidents between people who live at the home. We looked at this during the inspection.

The inspection took place on 15 February 2018 and was unannounced. The inspection was completed by two inspectors, a specialist advisor who was a registered nurse and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of service.

We reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted the local authority who commission services to gather their feedback. Due to technical problems, the provider was not able to complete a Provider Information Return as this had not been received. 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. We took this into account when we inspected the service and made the judgements in this report.

We spoke with two people who lived at the service, one relative, as well as three members of care staff, a nurse, the chef, the service user engagement manager, the manager and the operations manager. We looked at care records for five people, staff recruitment records for three members of staff as well as records held in relation to medication, accidents and incidents, and quality assurance records including manager audits.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. One person told us, "I am safe, the staff are watching you all of the time, they are very kind". A relative added, "Yes, [Person's name] is safe".

Staff we spoke with had received training in how to safeguard people from abuse and knew the actions they should take if they had a concern that someone could be at risk of harm. One member of staff told us, "If I had a concern I would speak to the nurse and they would do something about it". We saw that where concerns had been raised, the manager had acted on these and made referrals to the local authority safeguarding team and Care Quality Commission as required.

People were supported to manage risks to keep them safe. We had received a high number of notifications about incidents that had occurred between people living at the home. We looked at this and found that some people could display behaviour that challenged and had potential to be physically aggressive to others. We saw that where this was the case, risk assessments were in place that clearly detailed how staff should reduce this risk. The assessments included details about triggers that may cause distress and the signs that someone may be becoming upset. The assessments provided further details about how to prevent a situation from escalating and what staff should do if the person continued to exhibit behaviours that challenged. Staff we spoke with showed a detailed knowledge of this guidance and how they should support people to reduce the risk of incidents occurring. Where people's behaviour may mean they pose a significant risk to themselves or others, staff had received specialist training called NAPPI (Non Abusive Psychological and Physical Intervention) to ensure people remained safe. All staff spoken with were aware that this training should only ever be used as a last resort and informed us they had not yet been required to use this training. Records we looked at confirmed this.

Where people had been identified as at risk, due to being unable to mobilise safely due to health issues, we saw that action had been taken to ensure they were safe. This had included implementing a risk assessment that had been completed in conjunction with specialist nurses and moving and handling trainers. We saw that staff had a detailed knowledge of how to support people with their moving and handling needs and that people were supported in a safe way. We observed staff encouraging and supporting people to walk independently where they were able and this had been assessed as safe to do.

People told us that they did not always feel there were enough staff to support them and that there was a high number of agency staff being used. One person told us, "They use a lot of agency, especially at night and weekends". This was confirmed by staff and one member of staff told us, "There is usually enough staff but you get a lot of staff off sick or leaving. We aren't rushed though and there is lots of time". Another staff member said, "We have to have agency staff as there is so many staff off sick". All of the staff spoken with told us they felt that the manager did all they could to ensure there were enough staff and that when staff members were unwell, agency staff were sought to support people. Our observations showed that although some agency staff were present, there were sufficient numbers of staff available to support people and people were being responded too in a timely way. We spoke with the manager and saw that they were already aware of the concerns around staffing levels and had begun taking action to address this. We saw

that a recruitment drive was on going and saw that new staff had been recruited and were expected to begin work shortly. The manager had also sought to reduce the impact of using agency staff by using a regular team of agency workers so that people could get to know them. Agency staff had received an induction into the home to ensure they had the information they needed to support people safely.

There were safe recruitment processes in place to reduce the risk of inappropriate staff being employed. Staff told us that prior to starting work, they had been required to provide references from their previous employer as well as complete a check with the Disclosure and Barring Service (DBS). The DBS would show if a staff member had a criminal record or had been barred with working with adults. Records we looked at confirmed that these checks took place. We saw that where nurses were recruited, regular checks were carried out on their nursing registration to ensure that they remained safe to practice.

We saw that there were effective infection control procedures in place. Staff we spoke with could tell us how the ensured they followed best practice guidance around infection prevention. One member of staff told us, "We make sure we use PPE (Personal Protective Equipment) and take this off before leaving the person's room, we keep the home clean and make sure we use the correct bags when handling soiled clothes". We saw that staff used appropriate PPE when supporting people and that extra gloves were available in areas where personal care may be delivered. The home was clean and there was a team of staff available to ensure cleanliness was maintained.

People living at the home had support with their medication. A relative told us, "I am happy with the medication support [person's name] has". Medication support was provided by nursing staff only. We observed staff supporting people with medication and saw that this was done in a safe way. We saw that staff supported the person to sit upright, before explaining to the person that it was time for their medication. The supporting nurse then stayed with the person while they took their medication and ensured they were able to take their time.

Some people required medication on an 'as and when required' basis. Where these medications were required, there were protocols in place informing staff of when these should be given. This ensured that these medications were given in a consistent way. One person received their medication covertly. Covert medication is medication that is given with food or drink. We found the appropriate documentation in place for this and that healthcare professionals including a GP and pharmacist had been involved in ensuring the safe administration of these covert medications. Where people required cream applying, there was a record directing staff as to where the creams were required. Some people required medication to be given via a Percutaneous Endoscopic Gastrostomy (PEG). A PEG is a tube that provides a way to introduce foods directly into a person's stomach, where oral intake is not possible. We found that there was a clear protocol in place informing staff of how these medications should be administered. Records we looked at showed that staff had been following this protocol to ensure that medication was given safely and that the PEG site remained free from infection. Records we looked at had been fully completed and indicated that people had received their medication as prescribed.

The manager had submitted notifications to us about medication errors that had occurred at the service. We spoke about these and found that the manager had taken action to ensure these did not happen again in future. The manager told us, "We are holding a meeting to discuss communication as the errors were a result of communication. A nurse will also be doing more regular stock takes on medication to keep a closer eye on it". This showed that the provider was keen to learn from incidents that occurred at the home and was taking action to drive improvement following incidents.

Good

Is the service effective?

Our findings

The provider had ensured that people had appropriate space to use outdoor areas, pursue activities and spend time with others. There was a 'hub' within the home that provided social activities for people. The room was intended to be a space for people to meet up, take part in activities and spend time together. There were communal lounges for people to also spend time together and spacious bedrooms for when people wished to be alone. However, on the first floor, there were people who were living with a diagnosis of Dementia. While people currently living at the home with dementia have been involved in decisions about their own needs, we expect further work to be carried out to decorate this area in a way that will provide support for current and future service users with dementia. This should involve orientations aids or contrasting colours, to ensure that they will feel assured and be independent. We raised this with the manager who assured us they would address the decoration on this floor to support people's needs.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. Staff we spoke with were aware of the importance of seeking consent prior to supporting people. One member of staff told us, "I always ask people for consent". There were people living at the home who would be unable to verbally consent and the staff we spoke with could explain how they support the person to give consent via other means. One staff member explained how they use hand gestures for people who cannot verbally communicate. Our observations showed that staff sought consent when supporting people and we saw staff ask people before providing their support and give them chance to respond before continuing with the task.

Some people had Deprivation of Liberty Safeguards authorisations. We saw that these had been applied for appropriately. However, staff we spoke with were not always aware of who had DoLS authorisations in place. One member of staff told us, "I don't know who has a DoLS in place but I do know where I can find the information". Without a knowledge of who had a DoLS authorisation, the provider cannot be sure that the authorisations are being adhered too. However, we did not see any person being supported in a way that would not be in line with their authorisation. We told the manager that staff knowledge on DoLS authorisations varied and they informed us they would address this with the staff team.

We found that people's needs had been assessed prior to moving into the home. We looked at people's care records and saw that initial assessments took place and addressed a number of areas including; medical history, personal care needs and dietary needs. We could see evidence from the assessments that people had been asked about their needs in relation to some of the protected characteristics under the Equality

Act; such as religious needs. However we could not see that people had been asked about their needs in relation to their sexuality or other protected characteristics. We spoke with the area manager about this who informed us that this is discussed at assessment stage if the person wished to discuss it.

Staff had been required to complete an induction before starting work. The induction included completing training and shadowing a more experienced member of staff. Staff we spoke with spoke positively about the induction and felt this equipped them with the skills they needed to support people. One member of staff told us, "I enjoyed my induction. I went through policy and procedures and did training and shadowing". Another staff member told us they were supported by more senior members of staff who acted as mentors. The member of staff said, "[Person's name] is my mentor. I am being very well supported". New staff were required to complete the Care Certificate. The Care Certificate is an identified set of standards that care workers must adhere too. Records showed that staff had completed training to ensure they supported people effectively. However, we saw that training in areas specific to people's individual needs such as Brain Injury training had not been given to all staff. We spoke with the management team about this and we were informed that this had already been identified and that where training updates were required, these courses had already been booked. Records we viewed confirmed this. Staff told us they were supported with their personal development and could ask for extra training and support if needed. One member of staff told us, "[Senior staff member's name] asks if there is anything extra I would like to do". The staff member went on to explain that they had requested extra training and that this was being sourced by the provider for them.

Only one person we spoke with provided feedback on the meals provided. This person did not speak positively about the meals and commented that they were often cold. We spoke with Staff about this who were aware of the person's complaints and were providing support to address these. As others were unable to tell us their experience of meals, we observed a mealtime. We saw that there was a relaxed atmosphere and people were enjoying their meals. We saw that people were offered choices at mealtimes and that if they did not want what was on the menu, they were able to request an alternative. Where people required support to eat, this support was provided by staff in a discreet and encouraging way. Adapted cutlery was available to support people to eat independently where possible. A relative we spoke with spoke positively about meals and told us, "They do [person's name] well with meals. He doesn't always eat but they persevere".

We spoke with the chef and found that they were aware of people's specific dietary requirements and how these should be met. We saw that records held by kitchen staff clearly indicated where people had specific needs in relation to their diet and staff were aware of these records and the information held in them.

People's weights were monitored and where concerns were identified, we saw that these were being acted upon. Staff told us and records confirmed that where people had been assessed as being overweight, staff sought additional support for the person to support them in losing any excess weight. We saw that people had been supported to visit slimming clubs and exercise classes with a view to working towards a healthy weight. Meals provided to people who were taking part in weight loss programmes were adapted to ensure they supported the person in their goal.

We saw that people had access to healthcare services where required. Records we looked at showed that people had accessed services including the GP, dentist, physiotherapy and dieticians. We found that the provider had a proactive approach to health promotion and had supported people to improve their own health where requested. People had been supported to access weight management classes as well as smoking cessation services. Staff we spoke with displayed a detailed understanding of people's health needs and how they should be supported with this.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were kind and caring to them. One person told us, "Our girls are golden, they are always kind". A relative added, "I am happy with the care". We saw that staff had developed friendly relationships with people and that people responded positively when spending time with staff. For example, we saw one person sitting with staff in the communal area, staff were chatting with the person and they were laughing about what football team they both supported... The person was visibly enjoying the company of staff and smiled and joined in the conversation where able. All of the staff we spoke with discussed people in a caring way and displayed warmth when discussing their relationships with people. One member of staff told us, "I love it here, we look after people really well".

People who had specific communication needs or whose first language was not English were supported to express their views and action had been taken to remove barriers to communication. For people whose first language was not English, the provider had ensured that signs placed around the home had translations underneath the text so that all people could access the information. People's care records included everyday phrases in the person's chosen language to support staff to communicate with the person. We spoke with the manager about the number of languages displayed on signs around the building and the manager told us that some were for relatives who visited the home as they also required support with communicating with staff. This showed that the provider was not only considering the communication needs of people living at the home but had taken active steps to improve communication with relatives.

Staff showed respect for people's background and personal history. Some people did not originate from the UK and came here as children. Staff had actively taken time to find out about each person's country of origin and care plans included information for staff about the person's culture. This had supported staff to understand more about the person and their culture. Staff we spoke with displayed a good understanding of people's cultures and how to respect this.

We saw that people were involved in their care and given choices. Throughout the day people were asked about activities they wished to join in with as well as what they would like to eat and what area of the home they wished to spend time in. Relatives we spoke with also felt that they were able to be involved in their loved ones care with one relative explaining, "Yes, they [staff] do keep me involved". People's privacy and dignity were respected by staff. We saw staff knocking and waiting for permission prior to entering people's rooms and where support with personal care was offered, this was done in a discreet way. Staff we spoke with had a good understanding of how they should respect people's dignity. One member of staff gave examples that included ensuring curtains were closed when supporting with personal care and respecting people's views.

People were supported to maintain their independence where possible. We saw that people were provided with adapted cutlery to support them to eat independently and that where people were able too, they were encouraged to take their own laundry to the laundry room for washing.

People had access to advocacy services where required. An advocate can be used when people may have

difficulty making decisions and require this support to voice their views and wishes. We spoke with the manager who was aware of how to make referrals for advocacy support for people where required.

Good

Is the service responsive?

Our findings

Before people moved into the home, an assessment was completed to ensure that the provider would be able to meet their needs. The assessment looked at their care needs as well as their medical history and health needs. Records we looked at confirmed that people had been involved in these initial assessments. A relative we spoke with confirmed that they had also been given opportunity to be involved. The relative said, "They assessed [person's name] needs before moving in and [relative's name] attended".

We saw that care records were individual to each person and fully reflected people's physical, mental and social needs. For example, we saw that people had been asked about their life history to support staff in getting to know people. People had also been asked about their preferences with regards to their care. Records showed that people were given opportunity to discuss their gender preference in relation to the staff supporting them, what time they wished to get up and go to bed, whether they wish to vote and what beauty products they liked to use. People felt that staff knew them well and we found that staff knowledge of people and their preferences reflected what was in the care records. We saw that care records were reviewed regularly to ensure that the information held remained accurate. A relative we spoke with confirmed they were able to be involved in care reviews. The relative told us, "We do attend meetings".

People were supported to take part in activities and access the community where they wished. We saw that people had been asked about the activities they wished to take part in. This information was provided in an easy read format to support people to be able to choose what activities they would like. The provider had set up an area of the home called 'The Hub' that was intended as a social area where people could go and socialise with others. Although we did not see people use this, we were able to view photographs of events that had been held in The Hub. We saw people going out with staff throughout the day, there were shops local to the home and people were being supported to visit these. We saw a variety of activities taking place including arts and crafts and a visit from a company that specialise in animal therapy. The people taking part in the animal activity were visibly enjoying getting to hold the various animals and one person said, "I love it". We saw that plans were in place to further extend the activities available for people and the manager was negotiating with a local allotment to get the home an allotment space for those who enjoy gardening to have a place to practice this.

People were encouraged and supported to maintain relationships with those people closest to them. People and their relatives told us that they were able to visit at any time. One person told us, "Your family can come whenever they like". One relative told us they were encouraged to join in with the activities and social events at the home. The relative told us, "We come to the functions when they have entertainers on".

There were systems in place to support people to make complaints if they required. We saw that information was available in communal areas informing people how they could make a complaint. This was available in an easy read format to support people's understanding of how to complain. We looked at records held on complaints and saw that where a complaint was made, this had been responded too and resolved in line with the providers complaints procedure.

Although no one was in receipt of end of life care, we found that people had been asked about their wishes at the end of their life. Records showed that people were asked about their preferences and choices at the end of their life and this was clearly recorded in people's care records.

Requires Improvement

Is the service well-led?

Our findings

We found that the provider had failed to notify us where people had Deprivation of Liberty Safeguards in place. It is required by law that we are notified of any application made in relation to depriving a person of their liberty where the application has been authorised. The provider was not aware that these notifications had not been sent as required. The provider sent the notifications in retrospectively.

There was a manager registered with us. However we were made aware prior to the inspection that the registered manager no longer worked at the home and that a new manager was in place. The new manager had intentions of registering with us as manager and supported this inspection. Following the inspection, we received further information that this manager had also left their position. This meant that the provider was not meeting the condition of their registration to have a registered manager in post. The high turnover of managers also raised concerns about the stability of the management team at the home. Following the inspection we received information about concerns relating to the care and support being given to people at the home. We are aware that the new manager of the service has been working with the local authority to ensure that the concerns are addressed.

We received mixed feedback from people when asked about the management of the service. One person we spoke with did not speak positively about the management at the home. The person told us, "I do ask to see her but you have to wait". A relative we spoke with was happy with the management at the home and told us, "I have met the manager and she would address and issues we had". Staff we spoke with told us they felt supported by the manager. One member of staff told us, "I do feel supported, I would like to think she [the manager] would act on any concerns". One staff member told us they had recently raised a concern with the manager and that they were confident that this was being acted upon.

We saw that where incidents had occurred at the service, the manager had notified us of these as required. The staff were all aware of how to raise concerns and could explain the whistleblowing process. One member of staff told us, "We covered how to whistle blow in our training".

There were systems in place to monitor the quality of the service. We saw that the manager completed audits monthly that reviewed areas such as medications, care plans and safeguarding. We saw that where areas for improvement had been identified, actions had been recorded to ensure that the required improvements could be made.

The provider had a proactive approach to gathering feedback from people and was using innovative methods to support people to feedback on their experience of the service. We spoke with the service user engagement manager who informed us of a new 'service user council' where each home run by the provider would nominate a service user to represent their home and feedback to the provider about what they like about their home and what they would like to see improved. We saw that the provider was acting on the feedback given by the service user council and was currently implementing WIFI for all service users across each home based on the recommendations of the council. Service users were also encouraged to write blog posts for the provider about their experiences. We saw these and saw that people spoke positively about

their care and were able to express their wishes for their future at the home.

The area manager had a clear vision for the future of the home and had strategies in place to improve the current service. For example, they were looking to introduce further education and employment opportunities for people as well as investing in their own Occupational Therapist and Physiotherapist to ensure that people living at the home have timely access to these services when required.