Bupa Care Homes (ANS) Limited

Maypole Care Home

Inspection report

Lower Northam Road
Hedge End
Southampton
Hampshire
SO30 4FS

Tel: 01489782698

Date of inspection visit:
21 November 2018
22 November 2018

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

What life is like for people using this service:
• We received a number of notifications about the service which caused concern as to the standard of care that people may be receiving. When we inspected we found that while there were areas that would benefit from improvement the service met the characteristics of a good rating in all areas.

• When things went wrong the registered manager would facilitate reflective learning opportunities so that staff could consider actions and improve them in future.

• A range of activities were provided for people however due to staffing pressures there were limited opportunities for people being cared for in their rooms or in bed to participate in meaningful activities.

• The registered manager and management team had skills and qualities that complimented each other and were working towards improving support for the wider staff team through recruiting additional senior care staff and care practitioners.

• More information is in the full report below.

Rating at last inspection: Good (report published 10 August 2017)

About the service: Maypole Care Home is a residential home that was providing personal and nursing care to 60 people aged 44 and over at the time of the inspection.

Why we inspected: We bought forward the inspection in response to concerns and risks we were aware of from information supplied by the provider and third parties. Areas of concern raised included would care and skin integrity, personal care, cleanliness of the premises, medicines and nutrition.

Follow up: We will follow up on this inspection as per our re-inspection programme, and through ongoing monitoring of information received about 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 Details are in our Safe findings below.	**Good**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was well-led Details are in our Well-Led findings below.	**Good**

Maypole Care 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 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.

Inspection team: The inspection team consisted of two adult social care inspectors, a specialist advisor (SPA) who was a registered nurse, an assistant inspector and an expert by experience (ExE). 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: Maypole Care Home 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 Care Home accommodates 68 people in one purpose built property. When we inspected, 60 people were living in the home, three of whom were in hospital.

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: The inspection was unannounced and we attended the service on 21 and 22 November 2018.

What we did: Before the inspection we reviewed information we already held about the service including:
• Notifications we received from the service. A notification is a report about a significant event at the service that the registered manager must tell us about by law.
• Previous inspection reports.
• Information the provider sent us in the Provider Information Return in February 2017. This is information we require providers to send us at least once annually to give some key information about the service, which helps us when planning our inspection.

• We looked at 14 care records, five staff recruitment files, risk assessments, records about the premises and sought feedback from the local authority, health care professionals and commissioners. Records of accidents, incidents and complaints.
• We looked at audits, quality assurance reports and compliments.
• We spoke with 20 people using the service and 11 relatives.
• We spoke with three care staff, three nurses, two kitchen staff, a maintenance technician, the registered manager, the resident experience manager and the clinical services manager (clinical lead).

After the inspection the registered manager supplied us with information that we had asked for including:
• Policies and procedures
• Internal audits
• Quality assurance questionnaires

Good

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm

Good: People were safe and protected from avoidable harm. Legal requirements were met.

• People told us when asked if they felt safe, 'Yes. It's a happy place and safe; there are people to care for me". A second person said, "Yes, the fire alarm has been explained to me and there's always people about.'

Systems and processes
• The provider had a robust safeguarding policy and procedure. The registered manager actively encouraged staff to alert concerns and had set up a system of readily available forms to report on.
• There were several safeguarding concerns that had been raised with the local authority that remained opened. The registered manager had sought further information on these cases with a view to closing them and were awaiting a response.
• Staff were aware of and prepared to use the whistle-blowing procedures. A whistle-blower is an employee that reports misconduct. There are laws that protect whistle-blowers from being fired or mistreated for reporting misconduct. One staff member told us, "If I had a concern over something in my workplace, I'd raise it with my manager. If I had a concern about my manager, I'd raise it with someone higher". Another staff member said they would consider whistle-blowing if they saw things happen that 'were not right'.
• The registered manager had supplemented some of the providers processes with additional information to improve information sharing to maintain people's safety. The provider had a handover sheet that was completed daily and did not hold sufficient information. A more in-depth sheet was used alongside the providers system which informed staff of changes to care, medicines and general well-being which ensured people received appropriate care at all times.
• There was a strong culture of reporting concerns, accidents and incidents. These, along with 'near-misses' were reported to the registered manager and acted upon at the earliest opportunity. These were reviewed for themes by the registered manager, we will report more fully on this in the well-led section of this report.

Assessing risk, safety monitoring and management
• The provider had an online system that held information on checks such as water safety, servicing of equipment such as hoists and thermostatic mixer valves (TMV) and safety certificates. We looked at a sample of the information held and found it to be current with no outstanding items. The maintenance record was also checked and we noted that most works were completed within 24 hours of being reported.
• We had received information before our inspection that alleged that some maintenance was not being completed and some safety features such as fire doors were no longer fit for purpose. The provider had acted upon concerns raised and all necessary works had been completed, though some had taken time due to requiring bespoke parts. We found that the provider had robust systems that ensured health and safety checks and maintenance were completed as scheduled.
• We checked the premises to ensure the environment was safe and free from hazards. We found that firefighting equipment had been serviced to schedule and there was adequate evacuation equipment in the form of multiple sleds and evacuation mats.

• Fire emergency boxes were available at the main entrance, one for each of the two floors of the service. These contained personal emergency evacuation plans, (PEEP), torches and emergency blankets. A clear plan was in place if the premises had to be evacuated, short term and longer-term plans had been considered along with staffing and equipment requirements.
• We saw care plans containing various risk assessments including well known assessments of skin integrity and malnutrition. Risk assessments were comprehensively completed and reviewed on a regular basis. We were concerned that actions to mitigate risk were not stated clearly enough on one person's epilepsy plan. It stated that regular checks should take place. To ensure staff were clear as to their responsibility, the frequency for checks should be recorded.
• Risks associated with activities were assessed and, for example, a planned fireworks display had not taken place as the risks of holding it were too great and could not be mitigated effectively.

Staffing levels
• We received mixed feedback about staffing levels. One person told us, "Sometimes there aren't enough. At night they say there's only two people. They need 4-6, but they would all have to be paid. If they're busy or there's an emergency, you've got to wait. I like to go to bed at 10.30, but if they're busy it's after 11.00 and that's a bit late for me". Another person told us, "They're short staffed, there's not enough when you want to find someone, there's no one about. It's like the Mary Celeste". A third person living in the home, when asked if there were enough staff told us, "I think so, you never have to wait".
• We spoke with the registered manager about people's concerns and the time they had to wait for their call bells to be answered. The registered manager had done extensive analysis of the call bell system and had noted anomalies, calls that had been recorded on the log but that were not made, they had come from people who were unable to use the call bell or, in a case witnessed by a member of the inspection team, calls logged and received by staff on pagers that were not actually made. Calls made by people were mainly answered within the providers target of eight minutes, all calls over this length of time were monitored and reviewed to find a cause and prevent it happening again. The provider is fitting a new call bell system which will show staff locations and that can be interrogated to ensure staff and the system are working effectively.
• The provider had robust recruitment and selection processes. Staff recruitment files held all necessary records including two references, interview records, applications and checks including a Disclosure and Barring Service check (DBS). The DBS check enables employers to make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. The provider also verified that nurses were registered to work with the Nursing and Midwifery Council. All checks were completed before staff commenced in post.
• Staffing levels were calculated using a dependency tool. People's needs were allocated a level and staffing allocated accordingly. Currently there should be 14 care staff working during the morning and 10 in the afternoon. Six care staff worked at night alongside two nurses and three nurses worked during the day. Staffing was as planned on the days we inspected. When asked, staff members told us, "I've been very happy recently following a little period when we were short". They cited an occasion when there had been seven carers on duty for several hours during the day but "management helped" and "I was proud of the girls that day." Another carer told us that staff numbers met the "recommended number for safety".
• If it were not possible to staff at the assessed level, a risk assessment would be completed taking into account how many people were in residence and if there were any specific concerns such as illness or appointments to account for. If, after assessment, risks were mitigated and safe care could be provided, staff would be supported by the management team who would step in to cover or provide personal care to people as required. Care staff and the management team commented that this was a successful way of managing the few occasions when it was not possible to staff at the assessed level.
• The provider used agency staff and had developed positive working relationships with several agencies who ensured that a known selection of staff were supplied. An agency nurse told us they had been well supported by permanent staff and the clinical lead and had been allocated the same people to care for on

each of their shifts enabling them to get to know people's needs and ensuring continuity of care.

Using medicines safely
• Medicines were safely managed and well organised. Medicines were only administered by registered nurses or senior care staff who had completed online training and a workbook achieving a minimum standard. Medicines training was updated annually.
• People told us they usually received medicines when they needed them. When asked, one person told us, "Yes, [I receive medicines] at the prescribed time". Another told us, "They try to. My insulin gets a bit late. I take it before and after breakfast or I can go into a hypo. Sometimes I'm waiting half an hour after breakfast for it. The nurses are busy all the time. They are good but overstretched. The nurses really try hard". People also said they could have pain relief when they asked for it.
• Staff administering medicines wore a red tabard to discourage people and staff from disturbing them on the medicines round. This reduced the risk of errors being made.
• The provider is working closely with their pharmacist to implement a repeat dispensing system to reduce the number of steps in the medicines ordering process and reduce the potential for errors. The system in still in its early stages and some medicines have been missed so the registered manager and clinical lead have added an additional registered nurse to check medicines when delivered to ensure errors are addressed immediately.
• Medicine administration records, (MAR) were clearly maintained and we did not note any gaps in signatures. When medicines were omitted there was a clear rational as to why.
• 'When required' medicines, (PRN), had supporting protocols which contained clear guidance on the dose, frequency, route and reason for giving the medicines. These were reviewed every three months. Some PRN medicines were for pain relief and the providers protocol was for staff to complete a pain assessment tool to identify pain levels. The tool was retained in people's care files and not in the medicines file and was completed monthly.
• We saw that some MAR sheets for topical medicines had gaps in recording. Creams and ointments were applied by care staff and registered nurses who had completed relevant training. Some MAR charts for prescribed oral hygiene products had also not been signed. We recommend that nurses follow up with care staff to ensure that both topical and oral hygiene products are being applied as per instructions and to the required frequency.
• New containers of fluid thickener granules were stored in the clinical room however once opened, containers were stored on a shelf in people's wardrobes. This ensured that their own prescribed granules were used and the products were securely stored as per current advice. One container we saw had no label, this had been removed. We asked the staff member how they knew which consistency to mix and they told us the information was "In the care plan". We told the registered manager about the unlabelled prescribed thickening granules and they commenced an investigation into why this had happened.
• A weekly medicines audit is completed by the registered manager. The last one we saw had identified a few photographs of people were over one year old. These had all now been updated. Any actions required from the medicines audits were communicated to the registered nurses who added them to an action plan and completed them.

Preventing and controlling infection
• People told us the premises were clean. One person told us, "Clean? They clean it every day, it's a big job". Another person said, "Spotless" and a relative said, "Yes. The carpets are worn, but they're clean".
• We saw staff wearing appropriate personal protective equipment (PPE) during our inspection. There was a plentiful supply of gloves and aprons available on linen trolleys in the corridors. On one occasion we saw a carer leave the bathroom after supporting a person with a shower. They were not wearing an apron and there was no apron in the bathroom bin so they must have provided support without using PPE.
• We saw that some of the ensuite facilities were being used as storage areas for incontinence products and

night bags for people's catheters. In one of the ensuite showers there were 12 packets of incontinence pads and a wheelchair which prevented any access to the room and use of the facilities. There was no alternative storage available and the person received full personal care support so this impacted only on their visitors.
• One of the catheter night bags we saw in a bathroom had no cap on the end that connects to the catheter. Leaving catheter tubing uncapped is an infection hazard and could cause an infection in the urinary tract. We advised registered nurses of this who addressed it immediately.
• The premises were mid-way through refurbishment. Shower rooms were being completely stripped back and replaced and other communal areas were next to be refurbished followed by resident's rooms. When we inspected there was chipped paint and areas looked tired and though clean, quite worn. The refurbishment will alleviate the infection control risks that damaged surfaces brings.
• There were no unpleasant odours present when we were inspecting and we saw housekeeping staff cleaning throughout our visit.
• We checked two cushions unzipping them and checking inside. One was intact and the interior was clean, the second had a worn outer cover causing the interior to become contaminated. There was no routine cleaning/ checking schedule for pressure relieving cushions, particularly foam cushions and the need to check interior and cover integrity.

Learning lessons when things go wrong
• The provider investigated all accidents, incidents and complaints when received and if relevant would share learning from incidents with staff. For example, a medicines delivery did not contain a specific medicine for one person who became unwell as a result of not receiving that medication for a period of time. A reflective practice session facilitated by the registered manager identified specifically what happened, what went well, what didn't go well and missed opportunities and what would be done differently in future. Procedures for following up when items are missing from the medicines delivery have been improved and if needed the out of hours GP service are contacted for a new prescription. Medicines are now more specifically referred to in the daily 'Take 10' meeting of nurses and management.
• All events that would benefit from a reflective practice session are discussed and learning is cascaded to relevant staff members to minimise the risk of future occurrences.

Good

Is the service effective?

Our findings

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

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed before they went to live in the care home. A relative told us, "The lead up to him coming here was brilliant, all the process, the staff were good to me and [person]". A person told us, "Yes, the care's all in my folder", another said, "They went through the procedure and I got everything I needed ". One person was less positive about their assessment and told us, "Yes, but they should update it".
• People had assessments, risk assessments and care plans for a variety of areas including moving and handling, bedrails, skin integrity, washing and dressing, going to the toilet and weight and nutrition.
• Peoples protected characteristics under the Equalities Act 2010 had been identified in their assessments and care plans and were recognised in the care delivered.

Staff skills, knowledge and experience
• People were supported by staff who had participated in training to develop the necessary skills to meet their needs. Staff we spoke with confirmed they had completed induction training when they started in post and had annual updates for training including moving and handling, safeguarding, fire safety and infection control.
• Senior care staff told us they had completed or were working towards a level 3 qualification in social care to support them in their roles.
• The provider had recently added a role of care practitioner to the staff team and staff had been recruited into these roles. Training for the position would involve an 18 month diploma and staff successfully completing the training would support registered nurses with tasks such as venepuncture, administering medicines and setting up percutaneous endoscopic gastrostomy (PEG) feeds to free up nursing time to be named nurses to people.
• The clinical lead supported nurses with the revalidation process. Revalidation is the process nurses must complete every three years to renew their registration with the Nursing and Midwifery Council (NMC).
• The provider had a target of staff having two supervision sessions with their line manager per year. The registered manager had set the services target as providing a supervision session for each staff member every two months. They aimed to achieve this target in 2019.
• Staff told us they had some supervision sessions however these had not been "for a little while". The registered manager was aware of the shortfall in supervision meetings and had planned training for senior care staff so they could provide supervision for the care assistants. The previous manager had supervised over 80 staff and the current registered manager had reorganised the structure to manage supervisions more effectively.

Supporting people to eat and drink enough with choice in a balanced diet
• We received mixed feedback about the meals provided. People told us they were appetising and plentiful

while others found them inedible. A relative told us, "It's a good choice. They ask what you would like" and a person said, "It's very good. Except the Brussel sprouts, they give you Brussel sprouts with everything. I swear I ordered a plain omelette and that came with Brussel sprouts". Another person told us, "Some days it's better than others. If you don't fancy what's on the menu, they'll do a jacket potato or sausage and mash". We were also told by a person, "Sometimes the dinner is really nice, sometimes it's not eatable. Sometimes I don't eat it, I tell the waiter who takes the plates away… The puddings come up cold, they're brought with the main meal and they're quite chilled when they come and colder when you come to eat them".

• People were also concerned that meals did not always meet their needs, "It doesn't cater for my diabetic needs. I have to get all my desserts brought in. They will do boiled potatoes instead of mashed, but they won't make special desserts or have pasta or something like that. I do have green milk instead of blue milk, but that's as far as it goes. They seem to pay lip service to it, they don't realise how important it is". This comment was contradicted by a relative telling us, "He's diabetic on insulin. They do custard made with sweetener. They will give him fruit if it's in fruit juice, not in syrup". The registered manager clarified the points made by the person and told us that they did provide desserts however the person had declined these as they were not to their taste and had chosen to purchase their own desserts rather than engage with the service to find a suitable compromise. The provider could support people with specific diets and prepared a number of specialist meals each day which met people's needs and were enjoyed.

• Fluid charts were completed for people but we noted there were no recommended daily intake targets recorded on them meaning that care staff may not know how much they needed to provide and prompt with fluids.

• There were drinks available at meal times and from a tea trolley in between meals. We did not see drinks available for people to help themselves to between meals in the communal areas though they could request drinks from staff. We saw drinks available to people in their rooms and the registered manager told us that following the refurbishment there would be accessible drinks stations in dining areas.

• Menus were the same across all the providers services, you would be served the same meal in every home on the same day. The menu was calorie and allergen controlled however did not allow for creativity by the chef. The registered manager hoped they would be able to adapt the menu and make it less prescriptive so they could, for example, vary the day they served meals. There was also no set vegetarian option, there was a fish option available if requested but options such as Halal or vegan were as yet untested due to them not having been requested.

• Meals were provided in a variety of ways to meet people's needs. We saw fork mashable meals, pureed meals and taster plates prepared for people who mainly received nutrition through a PEG but could have small amounts of well pureed foods so they had some interest and variety around food. Meals were also fortified for people who needed to increase their calorie intake. Pureed meals were chosen by people from the daily menu so they could have something they liked rather than what was pureed that day.

• Staff supported people with their meals both in the dining rooms and in their own rooms. Equipment such as plate guards and dual handled mugs were available to maintain people's independence.

• The chef was present when meals were served and had a good knowledge of people living in the home. They chatted informally with diners and asked for feedback about their meals. If any extra items were requested the chef dealt with them swiftly.

• People who had their dietary needs met through PEG had clear care plans that detailed the regimen prescribed by the dietician and the position the person should be in to safely receive the feed. We saw one person who was laying too far down in the bed to prevent reflux of gastric contents. We asked carers to reposition the person and a relative told us "[Person] is too low down on the bed, they are always too low." We noted that the backrest on the bed was in the correct position and believe the person may slip down in the bed. We checked the person again on the second day we inspected and they were correctly positioned. On the second day all eight of the people receiving PEG feeds were correctly positioned.

• PEG care plans lacked information on the actions to take if the PEG were blocked or dislodged. There were

instructions on cleaning and rotating the PEG and MAR sheets were fully completed to reflect feeds given. The providers guidance sheet on choking was available in people's rooms if they received alternate diets, PEG feeds or had a Speech and Language Therapy (SALT) safe swallow plan.
• The chef told us they received at least weekly updates about people's dietary needs. They did not routinely meet with people or their relatives to discuss menu choices or how food is provided, however would if requested.

Staff providing consistent, effective, timely care
• A GP visited the service twice per week and people were happy with their availability, "You tell the nurses you want an appointment and they organise it, it's quicker here than when you're out". Other people were happy with the support they had with hospital appointments, "Yes, I used to have to go to hospital and a member of staff went with me to make sure I was OK and they helped with the transport", another person told us, "They had a letter from the hospital, they organised the transport and kept us informed and gave us the letters".
• A range of professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. Professionals included the tissue viability nurse, speech and language therapist (SALT), and members of the community learning disability team.
• We saw that people had been repositioned in line with their care plans and saw photographs provided by a physiotherapist showing how to support people with positioning and what equipment was needed.
• Oral care was not well documented. For a number of people their oral care should be provided at the same time as they should be repositioned. There were records of the repositioning however no oral care was noted as being given. The registered manager agreed to look into this but understood it was due to the care being refused and staff not recording their refusal.
• The provider was in the process of introducing RESTORE2, a system to enable staff to provide a standard response to people when they are unwell. The system includes 'soft signs' such as a new pain or feeling short of breath, that can be noted by care staff and alerted to nurses who can take observations and use clinical judgement about whether to escalate to a medical professional and when.

Adapting service, design, decoration to meet people's needs
• The provider had just begun a full refurbishment of the premises when we inspected. The shower rooms were the first stage of the improvements and other communal areas would be completed next followed by people's rooms.
• The registered manager had a clear plan of the image they hoped the service would have once refurbished. The home has tired and dated décor and the registered manager hoped the refurbishment would provide an environment that appealed to people and that would be a lifestyle choice for people living with disabilities and health conditions.
• As yet, plans for the whole refurbishment had not been discussed with people living in the home and plans such as including a pub in the lounge area were at an early stage.
• People could choose the décor of their own rooms and one person had chosen the colours of the football team they supported.

Ensuring consent to care and treatment in line with law and guidance
• Staff showed an understanding of consent and offered choices. They also told us it was vital to tell people what they were doing at all times, this was key to providing care.
• 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. Some care assistants could cite the key principles of the MCA 2005. They told us, "There's five" and mentioned that "Everyone's deemed to have capacity; people have the right to make an "unwise decision" and that safety measures that affected a person's liberty should be the "least restrictive" option.

• We saw mental capacity assessments for decision including, making choices on about activities, making choices and decisions about care and consents to be admitted to the service.

• 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 application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

• The registered manager had made appropriate applications to the local authority to deprive people of their liberty in order to provide them with suitable care and maintain their safety. They had also taken steps to follow up on applications made from 2015 onwards however many applications had not yet been authorised.

Good

Is the service caring?

Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect and involved as partners in their care.

Ensuring people are well treated and supported
• People felt cared for and were mostly complimentary about the staff who supported them. We asked people if they got on well with staff and if staff were caring. People told us, "They would do anything for you", "They're good. You have a good laugh" and "Yes, definitely. You can't complain about anyone". Other people were less happy with staff telling us, "Some are better than others. Some are more thorough than others. Sometimes they rush", "There's a couple of really outstanding ones. Others don't seem to listen if you've got a problem", and "The majority are kind, but some can be sharp and they say, 'You have to wait.' I say, 'I have been waiting'".
• We saw positive interactions between staff and people and staff seemed to have a genuine fondness for people they cared for. A care assistant told us, "Everyone tries their absolute best. It's a very difficult home." They clarified that difficult referred to the wide range of complex health conditions and disabilities that people were living with. Another care assistant told us, "I love it here. It's very intense." This again referred to the complexity of people living in the home and the many tasks that staff completed.

Supporting people to express their views and be involved in making decisions about their care
• People had expressed their preferences as to how care should be delivered and this was recorded in their care plans.
• We spoke with the registered manager as we were concerned that some people had not had baths but had been washed in bed instead. They told us that they would have been asked if they wanted a bath but had declined and staff, being busy had supported a bed wash which was a quicker option. This had become more frequent since good care practice had stopped the use of bath rotas. One person had asked to have their bathing added to a rota as they felt this was the best way to support them to maintain their personal hygiene.
• Resident meetings were held throughout the year and people could make suggestions about activities.

Respecting and promoting people's privacy, dignity and independence
• We saw people supported with dignity and respect throughout our inspection, During the medicines round, people were asked if they wanted their medicines and received them as per their preferences. For example, one person was given all their medicines together rather than one or two at a time. The nurse explained this was a preference of the person who took them all together without problem.
• There were no signs on peoples' doors to indicate of care tasks were in progress. We saw that staff always knocked doors before entering rooms however did not always wait for a response before entering which could compromise someone privacy.
• We saw people being supported with their meals in a kind and caring way and saw a lot of fun exchanges between staff and people, for example a kitchen assistant was joking with someone at lunchtime as they

served meals pretending to add foods people didn't like to their meals. The person found this very funny.
• People looked clean and tidy and well cared for. They had clean, appropriate clothing on and their hair was clean and brushed. We noted one person returning from the shower room to their bedroom to be supported to get dressed. They were wrapped and fully covered in towels which maintained their dignity and kept them warm.
• People's privacy was generally maintained however a staff member was overheard speaking in the corridor saying, "We need to wash [resident], she's on the toilet in a nightie". This was said within earshot of other people and their relatives and could be heard in people's rooms.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means that services met people's needs

Good: People's needs were not always met through good organisation and delivery. Regulations may or may not have been met.

Personalised care
• We received mixed feedback about how well people felt staff knew them. One person told us, "They should know by now. They can ask if there's anything they're not sure of. Some aren't so familiar with English so it's harder, but they are all very nice girls". Another person said, "I know my needs more than they do. I know myself, they don't because they've got loads of residents to take care of".
• We saw staff members interacting with people in a warm and friendly way and they seemed to know them and their family members well. Despite this, people seemed to be concerned that their needs would not be met.
• We asked staff about responding to people's changing needs, and a care assistant we spoke with told us "We're very, very good with that".
• We saw one relative arrive and see the person they were visiting was not appropriately positioned in bed. They were lying almost completely flat even though a notice on the wall stated that their head should be elevated. In the flat position the person had laboured and noisy breathing, we saw them later sitting up and their breathing was much quieter and not bothering them.
• We saw that epilepsy and behaviour care plans lacked detail. Epilepsy care plans did not hold descriptions of people's seizures such as the type, duration and frequency which would guide clinical decisions about the required care such as rescue medications. One person's behaviour care plan had been reviewed in June 2018 and needed more detail on triggers and possible de-escalation techniques. The November care plan review added one line to the plan but nothing regarding triggers or effective de-escalation.
• An activities assistant provided activities every day apart from Sunday. There would usually be two staff but due to long term absence, only one staff member was delivering activities to the 60 people living in the service.
• We received positive and negative feedback about activities provided. We were told by one person, "There's not much to do here. There aren't any activities. There's not a lot of things to do. I've got my books". Other people were more enthusiastic about activities telling us, "I like to get involved. I like the quizzes. I go on the day trips, when they have them. Blue moon comes to mind, there's no transport", "Some of the entertainers are very good" and "I do get up for the quizzes and things. I have a busy week".
• An activities staff member told us, "I have more interaction with the residents. I get to enjoy time with them. The main thing is knowing your residents". We were concerned that people who received care in bed received very little input from activity staff. Room activity records held very little information about activities however we found separate records that showed that some interaction had happened with people who did not leave their rooms. The activities staff had sat and had conversations about the weather, the war, and for some people, regular conversations about the football results, a masseur visited and gave massages, there were regular dog therapy sessions and some of the visiting activity providers including one that bought in a selection of animals and insects had visited people in their rooms.

• Though there were recordings of some activities taking place for those people who were cared for in bed, activities were infrequent. We heard from the registered manager shortly after we inspected that a temporary staff member had been recruited internally to cover the activities with existing staff until Christmas to ensure there were sufficient sessions for everyone to participate in.
• The provider had considered peoples communication needs and care plans described how best to communicate with people and advised that people needed to wear spectacles for example. The Accessible Information Standard requires services to identify record and meet people's communication needs. The provider worked consistently with this standard.

Improving care quality in response to complaints or concerns
• The provider was proactive in dealing with concerns and achieving a positive outcome for people when possible. There was a management presence in the service every day and concerns that arose were dealt with immediately before they could escalate into a more complex situation.
• Again, we received mixed feedback from people and their relatives about the response to complaints. For example, we were told, "There were one or two things and they were sorted within the hour. Once I spoke with a carer and she recommended I spoke to the manager. She [the manager] spoke to me straight away and she wrote a letter back", and, "Things get sorted out, slowly but surely". Other people told us, "They took the complaint but they didn't act on it, or they did for a short while and then it began again. It was about being short staffed".
• We saw an extensive file of complaints and concerns and most had been dealt with in a timely and efficient way. We saw that recent complaints had all been responded to Investigations had been undertaken, relevant outside agencies such as safeguarding and the Care Quality Commission had been informed. Some of the concerns raised were low level and were due to some people's expectations not matching what was reasonable to provide. For example, one person felt that when their call bell was sounded, regardless of what else was happening or who was being supported, staff should attend to their needs as a priority even if that meant leaving another person mid-way through personal care. Clearly the registered manager was unable to provide the outcome the person wanted.

End of life care and support
• The provider had a form called, 'My Day, My Life, My Future' which contained people's needs and wishes about the last stages of their lives. Legal information such as details of next of kin and lasting powers of attorney were recorded along with who should and should not be contacted when the person became very unwell. There was an opportunity for people to detail what interventions, if any, they would like to have towards the end of their life, a type of advanced care directive. The document also contained person centred details of the persons wishes such as places they would like to visit and people they would like to meet in their final years of life. There was also information about their final days, such as who should be there, did they want any spiritual contacts such as a priest and where did they want to be, in the service, hospital or a hospice.
• The service provided extensive palliative and end of life care. The registered manager had extensive experience in providing end of life care and had planned to hold more open conversations about death and dying in future recognising that more could be done to ensure that people had a dignified, pain free death of their choosing.
• There were 'do not attempt cardio pulmonary resuscitation' (DNACPR) forms on file and the DNACPR status of each person is recorded on the daily handover sheet to ensure that in an emergency, people receive the care they have chosen.

Good

Is the service well-led?

Our findings

Well-Led – this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Good: The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Leadership and management
• The leadership team had all commenced in post in the last 10 months. The registered manager told us they had several staffing changes over that period however were now almost fully staffed and all key personnel were in place.
• People mostly didn't see the registered manager and the management team telling us they saw them, "Not as often as I'd like. They're busy people", "Not terribly often", and "Not very often. They're always busy, they would if they could. It all depends on how busy they are, that goes for [other managers] as well". One person told us, "She comes in here and has a little chat".
• Staff gave positive feedback about the management team, "They've been brilliant. I can't fault their support", "To me it seems very well organised" and, "One of the managers (name) is absolutely excellent".
• During our inspection the registered manager, clinical lead and the residents experience manager were all available, visible and approachable and happy to assist staff when they could. We also saw from looking at staff rotas that the management team would hold pagers and respond as needed if there were not enough care staff deployed. This would only happen after a risk assessment and numbers of people resident were considered.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong
• The service had access to extensive specialist support from the provider. This included a legal department to draft letters related to the duty of candour. If something had gone wrong and a duty of candour letter was being sent, the registered manager would speak to the people concerned and ensure they received an apology and relevant information as there would be a delay in them receiving the letter. This showed how seriously the registered manager took their responsibilities in that they would ensure involved parties were not left uninformed.
• The registered manager had a clear plan for the future, they had addressed many aspects of the service when we inspected and had recruited a string team to support them. They were engaging with the staff team and would work with them to achieve a shared vision.
• The registered manager wanted to modernise Maypole to secure a better quality of life for people and to make it less old fashioned. They had identified areas for improvement such as the dining rooms which they considered to be like school canteens and thought that having a pub area with a dartboard, bar, TV and access to the garden would be a positive addition. When this had been presented to people in the home they had received a round of applause. The registered manager "wanted to give people their lives back". We were impressed with the registered managers vision and commitment to the future of the service.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements

• The management team had specific responsibilities in terms of monitoring the service. The clinical lead for example, maintained an audit of wounds. The wound tracker is updated daily and is a live document available to all registered nurses for information. Wound care is also discussed at every handover meeting.

• The provider completed 'Quality and Compliance Internal Audits' of each service at intervals reviewing the service under the five domains that CQC inspections follow. There had been three audits since the current manager commenced in post, the first had been during their first month working with the provider. The first internal audit had assessed the service at 'red'. This indicated there were significant concerns about several aspects of the service. We saw reports of the three audits and noted that the registered manager had annotated the documents and had created action points which were ticked as completed. The second and third audits which took place four months and nine months after the registered manager had commenced in post all showed significant improvement and all areas were audited as being good or 'green'.

• The provider submitted notifications to CQC as required, and audited practice within the service to ensure that all care activities were delivered in line with best practice and regulations. Additional reviews were completed by the regional director each month and finally the internal audit ensured the service was performing well.

Engaging and involving people using the service, the public and staff

• The registered manager had increased the frequency of staff meetings from quarterly to monthly and arranged them alternately in the afternoons and in the evenings to ensure that staff on both day and night shifts could attend. As a result, staff had told the registered manager they felt their concerns were now being listened to.

• The registered manager had introduced a 'You said, we did' board. Concerns raised by staff were shown on the board and actions taken by the service to address the concerns were added.

• A staff survey had recently been issued and a 50% response rate achieved. As yet the results had not been collated, the registered manager will share these with us when received. They were also intending to break the results into 'bite sized' pieces to inform staff of the results.

• The provider is working to improve staff engagement and is appointing staff members to be 'engagement champions' so they can lead staff in improving people's experiences. Initiatives so far have included a flower show where the service competed with other services in the region to have the tallest sunflower and the best vegetables. People, staff and relatives had engaged with the show, staff had dug the garden when not on shift and relatives had helped by sowing seeds.

• The provider issued questionnaires to people and their relatives to obtain feedback to respond to and improve services. A relative told us, "We did it anonymously, we filled in a form. The home wanted it done. [person] had no complaints", a person living in the home said, "Occasionally there's questionnaires. I think they act on them. I believe in patient power. I go to the meetings; I'm in the minority. I like to be heard". A relative was not sure if actions followed the questionnaires telling us, "I have no idea if they take any notice, there's been no response". The registered manager told us that responses to questionnaires were not viewed by the service and an overview report is supplied with concerns. The actions from reports are available for people to see on noticeboards in the service.

• There were display boards on both floors of the service and information about events and issues of interest to people and their relatives was displayed. There were boards such as an infection control board for staff and a regular newsletter was issued. Photographs of people that were used on the services social media pages or for display were also printed for the people they showed so they had copied to share with their friends and family.

Continuous learning and improving care

• The clinical lead had introduced a 'Wednesday Words of Wisdom' session. This was at least 30 minutes of

training each week. The clinical lead would present sessions themselves or would invite guest speakers. When we inspected a representative from a PEG feed supplier was delivering training to registered nurses and care staff.
• The provider has increased the number of senior care assistant posts in the service. This has been done to facilitate additional support to care assistants through more frequent supervisions and peer support and to offer career progression to care assistants.
• Reflective practice sessions were held when things went wrong and staff were encouraged to consider how they had acted and how they could improve in future similar situations.
• The handover sessions were inclusive of care assistants and registered nurses as well as the duty manager.

Working in partnership with others
• The provider had positive links with healthcare providers and in future had plans to strengthen their working relationships with their pharmacy and develop links with dentists and opticians as currently services provided were reactionary. The clinical lead was looking to develop more regular access for people.