Mapleford (Nursing Home) Limited

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Inspection report

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Ratings

Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service responsive?	Requires improvement

Overall summary

Mapleford (Nursing Home) Limited provides accommodation, nursing and personal care for up 54 people living with a dementia or with mental health care needs. At the time of the inspection there were 42 people using the service.

Mapleford is a purpose built care home situated in a residential area of Huncoat approximately two miles from the town of Accrington. There is a car park for visitors and staff.

The service was managed by a registered manager. 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.

During this inspection visit we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to failing to maintain accurate records in respect of care and treatment and failing to protect people from the risk of unsafe care and failing to consider the risks to people's safety on admission. The Care Quality Commission is continuing to investigate issues related to some of these breaches of the Regulations. As such the Commission is not yet in a position to determine the actions that may be taken at the conclusion of those investigations.

Summary of findings

We found individual risks had been identified in people's care plans and kept under review. However, we were concerned that safety measures had not been put in place to protect people from harm and to reduce the risks to themselves and others.

There was information to guide staff with responding appropriately to behaviours that challenged the service and staff had received training in this area.

The community mental health team and the rapid intervention and treatment team (RITT) had been involved in people's care and support and had been contacted when staff needed advice.

There were sufficient skilled and experienced staff available to meet people's needs. The deployment and availability of staff had been reviewed following a recent incident.

Staff received a range of appropriate training to support them with meeting the needs of people in their care.

We found records were not reflective of care and treatment provided in relation to meeting a person's health needs and the provision of pain relief.

The service was working within the principles of the Mental Capacity Act (MCA) 2005. Appropriate applications had been made where any restrictions were in place, which would help to ensure people's best interests and safety were considered.

Each person had a care plan which reflected the care and support that was being given, the care people needed and how care would be delivered by staff. The information had been kept under review.

Information was gathered from a variety of sources and covered all aspects of the person's needs before they moved into the home. However, we found that people's behaviour and how this would impact on the safety of other people living in the home had not been fully considered. We were told the admission process had been revised following a serious incident.

Summary of findings

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 consistently safe.

Risk assessments had been kept under regular review and had been updated to reflect any changes in people's behaviours. However, control measures had not always been put in place.

The service had sought advice and support from appropriate agencies involved in people's care.

We found sufficient skilled and experienced staff were appropriately deployed to meet people's needs.

Is the service effective?

Requires improvement

The service was not consistently effective.

Records were not clear whether one person had received appropriate support with their healthcare needs or management of their pain relief.

Staff received a range of appropriate training to help them meet the needs of people in their care.

The service was working within the principles of the Mental Capacity Act 2005 and conditions or authorisations to deprive a person of their liberty were being met.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

The care plans and associated risk assessments had been regularly reviewed by staff and where possible, people living in the home or their relatives had been involved.

Before a person moved into the home an experienced member of staff carried out an assessment of their needs. However, full consideration had not been given to how people's behaviour would impact on the safety of other people living in the home.

Mapleford (Nursing Home) Limited

Detailed findings

Background to this inspection

We carried out an unannounced focused inspection of Mapleford (Nursing Home) Limited on 19 November 2015 and 6 January 2016. The inspection was carried out by one adult social care inspector.

Prior to the inspection we received some concerning information about the service. This inspection was carried out to look into the concerns and to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We inspected the service against three of the five questions we ask about services; is the service safe, is the service effective and is the service responsive.

Before the inspection we reviewed the information we held about the service such as notifications, complaint and safeguarding information. We were aware of two serious incidents and a number of concerns that had been raised about the service provided. We also spoke with the local authority safeguarding team about the service.

During the inspection visits we spoke with the registered manager and the deputy manager. We looked at one person's medication records and three people's care plans and other associated care documentation. We also looked at staffing rotas and records relating to staff training.

Requires improvement

Is the service safe?

Our findings

We looked at how the service managed risk. We found individual risks had been identified in people's care plans and kept under review. Our records showed there had been 25 reported incidents involving people living in the home over a 12 month period. The local authority safeguarding team told us they were looking into this.

The registered manager told us there were currently twelve people living in the home who presented with varying degrees of behaviour that challenged the service; one person was receiving twenty four hour one to one staff support.

We looked at two people's records and found risk assessments were in place in relation to behaviours that challenged the service. We saw there were strategies recorded to guide staff with responding to behaviours that challenged and information was recorded which would help staff to identify the triggers to certain behaviours. Most staff had received training in this area which would help them respond appropriately and keep themselves and others safe. We noted the community mental health team and the rapid intervention and treatment team (RITT) had been involved in people's care and support and had been contacted when staff needed advice.

We looked at one person's care records with regards to a number of reported incidents. Information indicated 'remain in eyesight at all times' and 'not allowed upstairs unsupervised'. However, there was no indication these control measures had been followed as further incidents were recorded. We were concerned that following this person's admission to the home and following the incidents safety measures had not been put in place to protect other people.

Another person's risk assessment indicated they experienced 'periods of verbal aggression towards others', was 'intolerant of others' and 'at risk of altercations'. There were no records to support how this person was monitored to reduce the risks to themselves and others.

Records of incidents had been maintained although behaviour monitoring charts were not routinely used. The registered manager told us the mental health team would be consulted when staff had concerns about people's behaviour and records supported this. It was clear from the records the home had sought advice and support from the rapid intervention and treatment team (RITT) when one person's behaviour had deteriorated.

The provider had failed to protect people from the risk of unsafe care. This was a breach of Regulation 12 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is continuing to investigate issues related to this particular breach of the Regulations. As such the Commission is not yet in a position to determine the actions that may be taken at the conclusion of those investigations.

We looked at the records of one person who needed 15 minute checks due to risks to their personal safety. We noted staff had conducted regular checks to ensure the person was safe and prompt action had been taken when needed. Risk assessments had been kept under regular review and had been updated to reflect any changes in the person's behaviours. Records showed there had been ongoing involvement with appropriate mental health and social care professionals.

Prior to the inspection we were told people were left unattended for periods in the morning when staff were receiving a handover from the night staff. During this time a serious incident had occurred between two people using the service.

We looked at the staff rota and found sufficient skilled and experienced staff to meet people's needs. We found there were two nursing staff and three care staff on night duty; this number had recently been increased to four care staff. There were two nursing staff and seven care staff throughout the day and two nursing staff and four care staff in the evening. The registered manager was available five days each week and provided on call cover as needed. Appropriate numbers of ancillary staff were provided.

We noted any shortfalls, due to sickness or leave, were covered by existing staff or agency staff. We found the same agency nursing and care staff were being used on a regular basis; this helped to ensure people were looked after by staff who knew them. However, the rota did not clearly record the full names or qualification of the agency staff. We noted agency staff always worked with permanent staff and would not be left in charge of the home.

We discussed the deployment of staff with the registered manager. We were told previously all staff attended the

Requires improvement

Is the service safe?

morning and evening handover and would then be deployed to work in different areas of the home. This meant people were unsupervised for periods of time and had resulted in a serious incident occurring. The registered manager and the deputy manager told us, following the incident staff were now available in areas of the home during handovers and until such time as people were in the communal areas. This would help to improve people's safety and provide timely intervention by staff when needed.

Requires improvement

Is the service effective?

Our findings

We looked at how people were supported with their health. Prior to our inspection we had been told one person had not received appropriate pain relief on return from hospital. We looked at how the service had managed this. We looked at the person's medicine administration record (MAR) and also at the care records. We found records were not clear about why the person had not been prescribed pain relief either by a locum GP or by the hospital and also why prescribed medicines did not arrive until the day after following the GP visit. The daily report showed on the day the medicines arrived the person was 'relaxed and comfortable' but the records did not explain why the medicines were not administered. We discussed this with the registered manager and found records were not reflective of action taken.

The provider had failed to maintain accurate records in respect of care and treatment. This was a breach of Regulation 17(2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service trained and supported their staff to meet the needs of people in their care. We looked at the training matrix and found staff had attended a range of mandatory and role appropriate training. Training included safeguarding vulnerable adults, moving and handling, fire safety, infection control, emergency first aid, food safety, health and safety, medicines management and the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Training had also been provided in dementia, risk assessment and the management of challenging behaviour. We found there were effective systems to ensure training was completed in a timely manner. However we noted a number of gaps in the provision of training in areas such as dementia and the Mental Capacity Act 2005 (MCA). The registered manager gave us assurances that ongoing training was planned.

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 the mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met. The service had policies in place to underpin an appropriate response to the MCA 2005 and DoLS. The registered manager expressed a good understanding of the processes relating to MCA and DoLS and most staff had received training in this subject. We found appropriate applications had been made which would help to ensure people were safe and their best interests were considered. Care records included details of any conditions in place. These had been kept under review and where possible discussed with the person concerned. Any changes or conditions that were not being met had been discussed with appropriate others such as the mental health team and kept under review.

Requires improvement

Is the service responsive?

Our findings

Each person had a care plan which reflected the care and support that was being given, the care people needed and how care would be delivered by staff. There was information about people's likes, dislikes and preferences and routines. This information helped staff provide each person with a personal service and in particular to help them support and make decisions for people who were unable to make decisions for themselves. Daily records detailed how each person had spent their day.

The care plans and associated risk assessments had been regularly reviewed by staff and where possible, people living in the home or their relatives had been involved.

We looked at the information obtained before people were admitted to the home. We noted before a person moved into the home an experienced member of staff had carried out an assessment of their needs. Information was gathered from a variety of sources and covered all aspects of the person's needs, including personal care, likes and dislikes, mental and physical health, mobility, daily routines, social and leisure interests and relationships. This would help to determine whether the person's needs could be met at Mapleford (Nursing Home) Limited.

We looked at two people's pre admission assessments and noted there was clear and detailed information about how their behaviour presented and how this had previously placed others at risk. Records did not support that consideration had been given to how people's behaviour would impact on the safety of other people living in the home and effective strategies were not in place at the time of admission. We noted one person's hospital discharge plan indicated a number of strategies to help keep people safe. These included weekly visits by the person's care co-ordinator and access to the rapid intervention and treatment team (RITT). There were no records to support the ongoing involvement of the care co coordinator or that the RITT had been involved until the situation had deteriorated.

The provider had failed to consider the risks to people's safety as part of the pre admission assessment process. This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is continuing to investigate issues related to this particular breach of the Regulations. As such the Commission is not yet in a position to determine the actions that may be taken at the conclusion of those investigations.

The registered manager told us there were currently twelve people who presented with varying degrees of behaviour that challenged the service and that people living with varying degrees of dementia and mental health issues were cared for together. During our inspection the registered manager told us the admission process had been reviewed. We were told three recent admissions to the home had been refused following serious consideration about how their behaviour would impact on other people living in the home.

From looking at the records we found one person had recently been admitted to hospital and the home was notified they were ready for discharge. The registered manager visited the person in hospital and spoke with ward staff. The registered manager decided the person was not yet fit to return to the home and discharge arrangements were delayed until the person was ready. This showed the registered manager had considered whether the person's needs could be met.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had failed to maintain accurate records in respect of care and treatment. This was a breach of Regulation 17 (2)(c)**