The Disabilities Trust

The Maples

Inspection report

Tokers Green
Reading, Berkshire RG4 9EY
Tel: 01189 071982
Website: www.thedtgroup.org/

Date of inspection visit: 5 October 2015
Date of publication: 16/12/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We inspected this service on 5 October 2015. This was an unannounced inspection.

The Maples is a residential care home registered to provide accommodation for persons who require nursing (without) or personal care. They support up to 15 people who have autism and accompanying learning disabilities. The service was supporting 13 people at the time of inspection.

There was not a registered manager in post. 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. The service was being managed by a manager who had applied for registration with the Care Quality Commission.

There were shortfalls in relation to care records. Some people's care records had not been kept up to date. Other information to ensure people remained safe, such as risk assessments, had also not been kept updated.

Arrangements for accessing medication was not always effective and in line with national pharmaceutical guidelines.

Summary of findings

Relatives felt those at the service were safe and spoke well of the staff and felt staff did their best to support their relatives in a caring way. However, we saw some poor practice by staff when delivering care.

Staff had not felt supported as not all staff had received adequate supervision and appraisal.

Staff were knowledgeable about people's individual needs and preferences. They took the time to understand people where they had communication difficulties. People were supported to make decisions about their care.

Most staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be unable to make their own decisions. Where restrictions were in place for people we found these had been legally authorised.

People's privacy and dignity was not always maintained when staff accessed their rooms.

Improvements were required to ensure the service was well led. A manager was in the process of registering with the Care Quality Commission. Robust quality assurance systems were not in place. Some of the improvements needed to improve the service had been identified by the management team and there was a plan in place to address them.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we took and what action we told the provider to take.

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?

The service was not always safe. People's medicines were not always managed in a safe way.

Risk assessments had not been kept updated.

People were protected from the risk of abuse because staff were knowledgeable about the procedures in place to recognise and respond to abuse. Safeguarding notifications had been raised appropriately.

Relatives told us people at the service were safe.

Requires improvement

Is the service effective?

The service was not always effective. There were gaps in staff supervision and appraisal which meant staff were not supported to improve the quality of care people received.

Staff were not all aware of the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People had access to healthcare professionals as and when required.

Requires improvement

Is the service caring?

The service was not always caring. People were at risk of social isolation. Staff did not routinely interact with people.

People's privacy was not always respected as staff entered people's rooms.

Staff were knowledgeable about the care people required. People's choice, likes, dislikes and preferences were respected.

Relatives were happy with the care their relatives received.

Requires improvement

Is the service responsive?

The service was not always responsive. Records of people's care were not always up to date. This meant people were at risk of inappropriate care or treatment.

People were involved in developing their support plans and enabled to participate in activities they enjoyed. There were a range of activities for people to engage in, tailored to people's preferences and needs.

Requires improvement

Is the service well-led?

The service was not consistently well led. Quality assurance systems were not being used effectively to improve the service.

Staff and relatives spoke well of the management.

Requires improvement

Summary of findings

The management team had identified changes and improvements that were required.

The Maples

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 checked whether the provider was 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.

This inspection took place on the 5 October 2015. It was an unannounced comprehensive inspection. The inspection team consisted of four inspectors. Prior to our visit we reviewed the information we held about the service. This included notifications, which are information about important events which the service is required to send us by law.

We also contacted and received feedback from three professionals who visited people. This was to obtain their professional view on the quality of the service provided to people and how the home was being managed.

We spent time with people on all three units and observed the way staff interacted with people. We spoke with three people and three relatives. We also spoke with the manager, the clinical psychologist, and five care workers. We looked at records, which included six people's care records, the medication administration records (MAR) and six staff files. We also looked at records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

People did not always receive their medicine as prescribed. Most medicines were stored safely and stock levels were regularly checked. However we identified arrangements for accessing medication was not always effective and in line with national pharmaceutical guidelines. These guidelines stipulate that the responsible person must keep keys on their person at all times. This was not happening. When reviewing one person's epilepsy medicine there was a lengthy delay in being able to access this medication due to difficulty in accessing the cabinets and then finding the correct key. As this was emergency medication the delay could have caused harm to the person who may have required it. We were also informed not all staff had received training in how to administer this medication. The manager told us that they had applied for this training and there was a procedure in place for staff not trained to administer this emergency medication.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who could explain how they would recognise and report abuse. Staff we spoke with had a good understanding of safeguarding, what constitutes abuse and what to do in the event of suspecting abuse. Staff told us they had received training in safeguarding but there were gaps in this training. The home had a safeguarding policy in place and there was information about how to whistle blow if staff were concerned. Staff spoken to said they thought the home was a safe place for people. One staff member said "I think people are safe here". Another one said "I would report any concerns to the manager". The service had sent safeguarding notifications appropriately to the relevant agencies.

We looked at how accidents and incidents were managed. The manager told us that a new system had been introduced recently. Staff now had an email account and could complete accident or incident forms for every event which were then sent electronically. The manager ensured that appropriate and detailed information had been recorded. This was designed to ensure that each incident was recorded and assessed so the appropriate and prompt action could be undertaken to prevent reoccurrence where possible. There was evidence care workers used body maps when incidents or accidents occurred. A staff member said they reported incidents but would like to see some feedback of the outcome of these and what needed to change. This was fed back to the manager on the day to action.

There were not always enough staff on duty to meet people's needs. There were occasions throughout the day when staff were not always deployed in a way that ensured people's safety. For example, some people in the service required one to one support and staff were also responsible for cooking and domestic tasks. Therefore the required level of support was not always possible. We were also told by some staff that it was not always possible to take breaks due to not getting the required cover. One staff member told us, "It's not good for staff or service users as things can get quite frustrating and you need a break".

Most of the staff we spoke with had worked at the service for some time and this meant they knew people well. Relatives of people at the service commented: "[relative] never seems to worry about anything – I think he would tell us if he did". Comments about the staff were: "No problems" and "They are very patient". They felt staffing levels were adequate and that the staff were calm which helped.

People had risk assessments in place to ensure risks in relation to their needs could be supported safely. However, we found that these risk assessments were not always updated or reviewed in a timely manner. For example, one person's multi-disciplinary meeting had identified an additional risk regarding which routines could be a trigger for their behaviour. The risk assessment did not identify this risk. Not all staff we spoke with were aware of this risk. The manager had identified the need to get all risk assessments updated and had arranged for support for staff to complete these as a priority. Staff were able to tell us about risks and guidance for those they supported.

The service followed safe recruitment practices. Staff told us about their recruitment and we looked at personnel records of six staff. One file did not have the Disclosure and Barring Service Certificate (DBS) available. We spoke with the manager, they told us the certificate was missing and that this had been now applied for. The staff member was not allowed to work alone until a satisfactory clearance had been obtained.

Requires improvement

Is the service effective?

Our findings

The service was not always effective. Some staff we spoke with told us they had not received an adequate induction. One staff member told us their induction had not prepared them to work with people in the service and they did not feel confident. This staff member told us that they had received a refresher induction recently that had helped and this had highlighted how much knowledge they should have had when they first joined the service. The manager advised a new induction programme for new staff was in place and that existing staff will also undergo this refresher induction process. The staff who had undergone the new induction process told us that they felt it was 'much clearer'. We also spoke with the consultant clinical psychologist who showed us the training pathway that had been developed for staff. The manager told us new staff were surplus to the staffing numbers when they first joined. This was to allow them to complete the online training and shadow staff before working alone with people.

Staff had not always been appropriately supervised. Staff comments included, "I have been here six months, I have never had a supervision" and "I have asked about supervision and the manager knows that lots of people need it, I have been told there have been people here longer so I will have to wait". Only one of the records showed evidence of supervision in the last three months and none of these records showed appraisals had taken place. The manager was aware of the lack of supervisions and had devised a programme to ensure all staff receive supervision as soon as possible and schedule these in regularly. However, staff told us they could go and speak to the manager for informal supervision when required. Staff told us that they felt supported and that they felt the manager was 'easy to approach' and that they were 'working well as a team'. The staff spoken with felt the support for the team had improved since the current manager had been in her post. Clinical supervisions were regular and took place every three months. These were facilitated by assistant psychologists in addition to usual supervision sessions which encouraged staff to have space to reflect and improve skills.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received training. "Training helps us to support the people in the service". Staff had been trained to manage people's behaviours and told us about the needs of the people they supported. However, one member of staff said "Some staff leave the service as they do not feel fully trained and equipped to manage the needs of the people who use the service". Training records showed gaps in people's training and the manager had identified this and training had been planned to ensure everyone was up to date.

Staff showed some understanding of the Mental Capacity Act (MCA) 2005. The MCA is the legal framework for ensuring that people are not unlawfully having specific decisions made on their behalf. One staff member we spoke with gave an example how this had been reflected in their practice, they commented: "One person with very limited communication skills is still involved in menu choices and when we place pictures of various meals he pushes the ones that he does not like to one side'. We saw MCA assessments in some people's folders; however MCA assessments were not always decision specific.

People had applications in place under the Deprivation of Liberty Safeguards (DoLS). DoLS are in place to ensure that people's freedom is not unlawfully restricted or when assessed to be in their best interest, is the least restrictive means. Staff had knowledge of which people had these in place.

People did not always benefit from a varied and balanced diet of their choosing. There wasn't a cook in the service and care workers had to do the cooking alongside their caring role. One care worker we spoke with felt that some care workers can't cook and the food isn't always very appealing. A relative commented: "Food options and meals are dependent on which carer is preparing them".

People had access to healthcare professionals as and when required and health action plans had been completed. People were supported to attend GP appointments and visits to the dentists. The service also accessed support of other professionals such as speech and language (SALT) and district nurses when required. We spoke with a visiting professional who stated she felt the individual she cared for was "Supported well". A relative said their relative was taken to the dentist regularly and supported appropriately if unwell.

Requires improvement

Is the service effective?

The décor was being updated and we saw from minutes of meetings that people in the service attended, stating they had been involved with choosing colours they wanted for the communal areas.

We recommend the service reviews the MCA policy with all staff to ensure they have a clear understanding of their responsibility and understanding of the Act.

Requires improvement

Is the service caring?

Our findings

The service was not always caring. Some people we spoke with told us how they valued their relationship with some staff, but also told us they did not get on with others. Staff also told us that some of the staff members approach did not always appear caring and could on occasions make people feel uncomfortable. For example, we saw two people at the dining table and one of the care workers was leaning against the wall by the door. There was no interaction apart from when one person grabbed the other's sandwich and the care worker said "No don't do that". The care worker did not offer the person another sandwich. Staff seemed to focus on the negative behaviour rather than using positive reinforcement, for example, one person tried to tell us that "People in bungalows do mix with each other". A staff member interrupted them without an appropriate reason. This did not demonstrate respect or understanding of this person's wish to interact in a positive conversation. We also observed staff did not knock on bedroom doors before entering the room. This demonstrated staff did not always respect the person's right to privacy. A notification had been received from the service prior to the inspection of staff failing to interact with a particular person.

Staff did not always respond clearly to people or communicate with them. We found most staff were still observing people rather than supporting them. We noted that some staff showed no facial expression and at times stood with their arms folded. We also found that whilst some people needed very clear and firm communication about their behaviour, this approach was used by some staff at times as the main form of communication. We did see that each person had a communication profile in place to support their understanding of people's methods of communication. However some staff we spoke with were not able to tell us clearly what these methods were and we saw clear references in team meeting minutes that staff were not reading peoples support plans. This meant there was a risk that people's preferred methods of communication were not always understood and responded to consistently. Staff told us they didn't really use specific techniques. Comments included, "Not all staff use the training, they just choose not to talk" and "I'm not sure I've seen anyone use any specific techniques, not all staff read the support plans". However, we did observe a number of interactions throughout the day between staff and people who were able to communicate and engage with staff. These interactions showed that some staff had the skills and experience to communicate with people effectively.

A relative commented that staff "Move on a lot" and this could be unsettling as people don't have time to build up relationships with staff. We spoke with one relative who told us "Agency staff were not always familiar with their relative" and this resulted in support with their complex behaviour not being cared for by staff who knew them well.

These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, some people experienced positive interactions with staff. For example, we saw one member of staff engaging with a person doing an activity the person had chosen. The person clearly enjoyed the experience. We saw another person getting verbal reassurance when they became anxious. Some relatives felt the staff were caring. A relative stated they felt the approach of staff being "Placid, calm and easy going" was a positive in respect of supporting their relative to manage their behaviour. Another relative felt the service was supporting their relative well compared to a previous placement.

People's support plans evidenced that people were involved in their care planning where they were able. The support plan included other details from people who knew the individual well, for example, their relatives. We saw that people at the service had met and discussed issues around holidays and trips out, menu planning and redecorating the accommodation. Other meetings had discussed choice of keyworker. We saw from these records that these discussions had been followed up and were being actioned at the time of the inspection. One person was being moved to another bungalow as it was identified their level of independence was not being supported in their current accommodation on the site.

Requires improvement

Is the service responsive?

Our findings

People did not have all necessary information on their files to reflect their support needs. For example, information such as autism profiles and behaviour support plans had been removed from files to be updated in July 2015 but had not been completed at the time of our inspection. It is important this information is available so that staff can ensure people receive the appropriate support with accurate and current guidance. We saw in one person's records that recommendations had been made regarding their care. For example, the recommendations were to increase exercise and to improve the oral health care of the person. We also saw a recommendation to encourage this person to spend less time in their room. However, staff were not aware of the changes highlighted in the review. We also found that this person's support plan had not been updated with these goals. On the day of our inspection we saw this person did not come out of their room.

People's needs were assessed prior to admission to the service to ensure their needs could be met. People had been involved in their assessment. For example, one care plan noted '[Person] has been able to talk directly about some preferences, such as what food and hobbies they enjoyed'. Other people had been involved with care planning as another person's care plan stated 'they have difficulties with communication and staff and relatives have helped to complete the plan'.

People's support plans were arranged in a way that highlighted important information. Each person's file was colour coded using a traffic light system. This identified information staff must know, may need to know and information the person would like staff to know. Support plans had been updated. However, some notes were typed and others handwritten and not always dated which meant it was not always certain which areas were still relevant and up to date. People were involved in support plan reviews. We saw people had an initial review after being in the service for a short period of time. These reviews were used to look at the care provided and to see if any changes were required.

People benefitted from a range of activities. The service had a full time learning centre co-ordinator who was responsible for planning activities and the transport for people. Activities arranged included cookery lessons, arts and crafts. Identifying what activities to plan was gathered from meetings with people in the service, views of staff and annual reviews. Where people had difficulty in making choices, pictures were used to assist people with their choices. For example, a visit to the local fire service had taken place after being requested by one of the people at the service. One person told us about a recent holiday they had been on and told us of other activities such as music, a social night and going to a disco on a Friday evening. They had also been involved in distributing some leaflets around the local village about recruiting local staff. The management told us that one person had recently visited the head office to feedback their views of the service. The management told us that the internal residents' meetings were happening on regular basis and we saw records of these meetings.

The service employed an assistant psychologist who worked with a consultant psychologist to analyse people's needs. People's care plans were updated with information following the psychologist's assessment. For example, we saw in one person's behaviour assessment new triggers had been identified in relation to their behaviour. These were updated in the person's support plan and staff we spoke with were able to tell us how this information allowed them to respond more effectively to people's needs. Staff told us what activities the person they supported liked and also stated they felt their responsibilities were clearer now due to new management. The consultant clinical psychologist told us positive behaviours would be captured in daily notes and through multi-disciplinary team meetings. Staff we spoke with told us they were focused on people's behaviour which was potentially dangerous to others. Comments included, "We all watch our own person really and try and predict what might happen next" and "We concentrate on keeping people safe as people's behaviour changes quickly".

There was a complaints policy in place. We spoke with relatives who made comments about their frustration and difficulties when communicating with the service due to their calls not being answered. One person said that the situation was a "Nightmare and still is". They stated this issue had "Upset them more than anything else". The complaints log showed three entries in the last four months. One was a concern raised by a relative who did not feel that it was necessary to proceed via the formal complaints route. Two other complaints were raised by the same family of one person. There was evidence the manager had ongoing contact with the family and the

Requires improvement

Is the service responsive?

person's social worker. We spoke with the family who were satisfied with how the manager had dealt with the complaint. Another relative had discussed an issue that had arisen and stated "Nothing is hidden and the situation was dealt with very well".

Requires improvement

Is the service well-led?

Our findings

The provider did not effectively monitor the quality of the service. The provider had an auditing system in place but audits had not been carried out when required. For example, we found the audits file did not reflect the audit schedule displayed in the office. Some documents, for example, the hazardous substance risk assessment was marked as 'to be revised' but it was not clear whether this had been completed. Medication audits were completed but did they not identify the concerns we found on the day of the inspection. The manager told us that the service had plans underway to audit and action more effectively.

Staff identified they needed a strong senior team to support them to ensure everything was monitored effectively so all staff met their expectations. One member of staff told us ''We would definitely benefit from having a strong leadership and guidance from team seniors". Another said "Communication between the staff in different roles could be better". We saw that a request had been made to the directors to employ additional team leaders which ensured better leadership on the day to day running of the service.

Concerns identified were not always appropriately dealt with. Staff meeting minutes reflected that areas of concern had been identified. For example, the minutes from the staff meeting in April 2015 stated 'daily notes are not written in an appropriate language' and 'service users care plans not always being adhered to'. There was no evidence that these issues had been followed up or were being monitored.

We observed that the staff were more risk averse than empowering people, and this was noted from the language used in the care documentation. For example, nutritional audits contained reference to people who use the service as 'they' – 'they have snacks when they go out'. We discussed this with the management and they told us that they had acknowledged that there was a need for the culture to be changed to ensure people who use the service received personalised care. The manager told us that they were working to improve the culture within the service and that they would work closely with their HR department to ensure that the right calibre of staff were recruited. We spoke with a professional who said things had improved at the service recently and the culture was slowly improving. They did comment that recording about decision making could be improved to evidence actions taken at later stages, for example, whether they could manage to continue supporting a person and if not, reasons why. The manager also had a clear vision about where they would like to see the service developing. This was that that people living in the more supported area of the service could develop skills to enable them to move to more independent accommodation on site and then potentially into the community.

People's opinions were sought to improve the service. A survey had been conducted in June 2015 with people, relatives, staff and stakeholders. The results identified that paperwork was not up to date. Families wanted more progress reports and more interaction between staff and people at the service. Actions had been taken which identified improvements. Relatives felt there were some improvements but the inspection identified paperwork was not up to date and communication could be improved.

The staff told us the support for the team had improved since the current manager had been in post. We saw the manager had re-introduced monthly staff meetings. An incident review had been planned on a fortnightly basis. The manager told us the new rota system ensured fairness amongst staff which enabled them to support people more effectively to partake in activities they had identified. Some staff felt the manager needed more support in her role as there was "Lots to sort out" and she "Worked very hard". A relative stated that 'some managers have not been as good as others'. They stated the new manager was "Very good – excellent". They felt issues had been identified more effectively and therefore dealt with in a consistent manner.

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	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not always treated in a caring and compassionate way. Regulation 10(1) People's privacy was not always respected. Regulation 10(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medication was not available in the case of emergencies. Regulation 12(2)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff had not received appropriate support, supervision and appraisal to enable them to carry out the duties they were employed to perform. Regulation 18(2)(a)