Maple Health UK Limited

Maple House

Inspection report

1 Amber Court
Berechurch Hall Road
Colchester
Essex
CO2 9GE

Tel: 01206766654

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Maple House is a residential care home that provides personal care and support for up to five people who have a learning disability and/or autistic spectrum disorder. On the day of our inspection there were five people living at the service.

The service had 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. The manager is registered for this service and one other service other local, nearby care service and is also one of the organisation's directors.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. Risks to people's health, welfare and safety had been assessed and guidance provided for staff with recorded action they should take to mitigate these risks.

People were cared for safely by staff who had been recruited and employed after appropriate checks had been completed. People's needs were met by sufficient numbers of staff.

There were systems in place to ensure that staff were trained and people received their medicines as prescribed. However, gaps in medication administration records for the application of creams and lotions did not assure us that people always received these medicines as prescribed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice. However the current practice of holding staff handover meetings in people's communal lounge did not fully protect the confidentiality of their information and consider their rights to have their communal space protected without intrusion.

Staff were provided with training in Safeguarding Adults from abuse. However, policies which guided staff in how to report poor practice had not been reviewed since 2009 and safeguarding people from abuse policy since 2011. These policies contained out of date information and did not provide up to date, relevant guidance in line with local safeguarding protocols and current regulatory requirements.

Staff were provided with training in understanding their roles and responsibilities with regards to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). People's capacity to make decisions about their everyday lives had been assessed and their consent was considered in the planning and provision of their care and support

Staff were able to demonstrate that they knew people well and we observed treated people with dignity and respect. However, we recommend that the current practice of holding staff handover meetings in people's

communal lounge be reconsidered as this did not fully protect the confidentiality of their information and consider their rights to have their communal space protected without intrusion.

People had sufficient amounts to eat and drink to ensure that their dietary and nutrition needs were met. People's care records showed that, where appropriate, support and guidance was sought from health care professionals, including GPs and dentists.

People were provided with the opportunity to participate in personalised, meaningful activities according to their assessed needs, wishes and preferences. People were encouraged to develop as much independence as possible and learn new life skills. People had access to annual holidays and opportunities to be integrated into the local community.

The provider had a system in place to respond to suggestions, concerns and complaints. The service had a number of ways of gathering people's views including; one to one monthly meetings and satisfaction surveys. The provider and registered manager carried out a number of quality monitoring audits to help ensure the service was running effectively and to plan for improvement of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff were provided with training in safeguarding adults from abuse. However, whistle-blowing policies which guided staff in how to report poor practice had not been reviewed since 2009 and safeguarding people from abuse since 2011. These contained inaccurate information.

People received one to one care and support from staff as commissioned.

Checks were undertaken on staff to reduce the risk of the provider recruiting staff who were unsuitable for the role.

There were systems in place to ensure that staff were trained and people received their medicines as prescribed. However, gaps in medication administration records for people with prescribed creams and lotions did not assure us that people always received these medicines as prescribed.

Is the service effective?

Good

The service was effective.

Staff received training relevant to their roles. Newly appointed staff received an induction and training which provided them with the skills and knowledge that they needed to fulfil the role for which they were employed.

There were systems in place to support people to maintain their health and wellbeing. People had balanced nutritious food provided. People were supported to access health care including learning disability specialists.

Staff had a good understanding of their responsibilities under the Mental Capacity Act 2005. There were systems in place to make decisions on people's behalf by those qualified to do so when people did not have the capacity to consent to their care and treatment.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were supported by staff who knew them well and were kind in their approach.

People were listened to and supported to express their individual, choice, wishes and preferences in how they lived their daily lives. Care and support plans reflect this. However the current practice of holding staff handover meetings in people's communal lounge did not fully protect the confidentiality of their information and consider their rights to have their communal space protected without intrusion.

Is the service responsive?

Good

The service was responsive.

People's needs had been assessed and care and support plans outlined their preferences and how they should be supported.

People were supported to access the community and follow their interests.

There was a system in place to manage complaints but did not always evidence the outcome of any investigation with actions taken in response.

Is the service well-led?

Good

The service was well-led.

People and their relatives were confident in the management of the service.

Staff were clear about their roles and responsibilities and were well supported.

There were systems in place to review incidents and audit performance as well as monitoring the quality and safety of the service.

Maple House

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 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.

This comprehensive inspection took place on the 27 April 2017 and was unannounced.

The inspection was carried out by one inspector.

Prior to our inspection, we reviewed previous reports and notifications that are held on the CQC database. Notifications are important events that the service has to let the CQC know about by law. We also reviewed information received from a local authority.

Some people using the service had complex needs with limited verbal communication skills which meant that they could not readily tell us about their experiences of using the service. During our inspection we observed staff interactions with people and spoke with two people who used the service. We also spoke with the registered manager, team leader and three care staff.

We reviewed two people's care records, two staff recruitment files, staff training matrix, assessed the management of people's medicines and reviewed quality and safety audits and policies.

Following our visit to the service we spoke with two relatives of people who used the service and stakeholders including local authority commissioners.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe with all of the staff who supported them with their one to one care. They named their particular favourites and the people they would go to if they were concerned or worried about anything.

People's relative's told us that they were assured that their relatives were safe living at the service. One relative said, "The care is excellent a vast improvement on where [relative] lived before." Another relative said, "We have always been impressed with their care. [Relative] is very happy there and we are confident [relative] is safe and well cared for. We can tell by their confidence in approaching staff that they feel safe."

Staff were provided with training in Safeguarding Adults from abuse. However, policies which guided staff in how to report poor practice had not been reviewed since 2009 and safeguarding people from abuse policy since 2011. These policies contained out of date information and did not provide staff with up to date, relevant guidance in line with local safeguarding protocols and current regulatory requirements. For example, policies contained inaccurate information, referring staff to Health and Social Care Regulations no longer relevant and incorrect CQC contact information. The policies also failed to provide written guidance for staff as to local safeguarding protocols and the legal responsibility of the provider and staff to refer to safeguarding authorities who have the statutory responsibility to take the lead in any allegations of abuse investigations.

People were safeguarded from the potential risk of harm to their welfare and safety. Risk assessments identified how people could be supported to maintain their independence with guidance for staff in steps they should take to mitigate risks to people's, health, welfare and safety. Risk assessments had been personalised to each individual and covered areas such as the risk of self-harm, access to the community, medicines management and behavioural management strategy plans. There were also risk assessments in relation to environmental risks.

People were allocated one to one staffing according to their assessed needs and as commissioned. One relative said, "Staff come and go but on the whole it appears to be a stable team of staff. I think they use a lot of students so once they have qualified they move on but we are assured [relative] is provided with one to one consistency of care." Another told us, "I have had no concerns about there not being enough staff. There have been a couple of changes of keyworker in the last two years. If I did have any concerns I would certainly have something to say about it but they keep me informed and I get regular updates when I visit."

The provider had established and operated recruitment procedures effectively to ensure that staff employed were assessed as safe to work with people who may be vulnerable and who had the skills necessary for the work they were employed to perform. Staff recruitment records we reviewed showed us that the provider had carried out a number of checks on staff before they were employed to make sure staff recruited were of good character. This included enhanced disclosure and barring checks (DBS), checking their identification, health, conduct during previous employment and checks to make sure that they were safe to work with vulnerable adults.

Medicines were safely stored and only trained and competent staff administered people's medicines. We carried out an audit of stock and found that the amount of stock tallied with the medicines administration records. Each person had a medicines protocol which described medicines prescribed, any allergies and how people liked to take their medicines. For one person we found their protocol described medicines no longer prescribed. We also found that not all prescribed creams and lotions had been signed for when administered by staff. This meant we could not be assured that people received these medicines as prescribed. We saw from a review of records that the manager and pharmacy provider completed regular audits to check that people's medicines were managed safely. Following recommendations made by the pharmacy provider, action plans had been implemented with timescales for actions to be completed.

Good

Is the service effective?

Our findings

Staff were knowledgeable about each person's needs, wishes and preferences and provided support in line with people's agreed plans of care. This meant the service was effective in meeting their care and support needs.

Staff received training relevant to their roles. Training provided included understanding and supporting people with autism, positive proactive intervention, epilepsy awareness and core training such as infection control and health and safety, including risk management. The majority of staff had been provided with training appropriate for the roles they were employed to perform. Staff told us that they were provided with equality & diversity, dignity & respect training. For newly employed staff, this took place as part of their induction whilst working towards the nationally recognised Care Certificate, which all staff completed commencing employment.

Staff received support through one to one supervision meetings with their line manager, regular staff meetings and annual performance review appraisals. These provided opportunities to monitor staff performance and support planning for staff development and identify any training needs. We noted from a review of staff meeting minutes that these were provided on a regular basis and provided opportunities to discuss team working performance issues, planning for improvement of the service and enabled staff to raise any concerns they might have. All of the staff we spoke with told us they enjoyed their work and worked closely as a team. One told us, "I love to come to work, it's a good place to work." Another told us, "This is a good team. I love working with the guys who live here."

There were systems in place to ensure important information about people's health, welfare and safety needs were shared with the staff team. This included daily handover meetings. We saw from a review of handover records that staff had been supported with guidance to enable them to meet people's needs and evidence when tasks had been completed, which also provided an audit trail for management reference.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

There were systems in place to make decisions on people's behalf by those qualified to do so when people did not have the capacity to consent to their care and treatment. The manager completed assessments as appropriate to check people's understanding and capacity to make decisions. Where assessments indicated a person did not have the capacity to make a particular decision, there were processes in place for others to make a decision in the person's best interests. The team leader and manager understood their roles and responsibilities with regard the MCA 2005.

People told us they were provided with choice in how they lived their daily lives. For example, what time they got up and went to bed and involved in planning their weekly activities displayed on a pictorial planner in their rooms.

Staff recognised potential restrictions to people's freedom of movement and these were appropriately managed. Staff understood the need to respect people's decisions and actively supported people with limited verbal communication to express their choices wishes and preferences. For example, we observed staff to seek consent and offer choice in relation to activities using communication methods appropriate to the individual. This assured us people's human rights had been considered and were being safeguarded.

People were supported to have choice in the planning of menus and encouraged to develop life skills including the preparation of meals and clearing away. Support plans evidenced where nutritional assessments had been carried out and people's weight had been monitored for signs of loss or gains.

People were supported to access healthcare as required. The service had good links with other healthcare professionals and specialists such as, intensive support learning disability nurses, occupational therapists, GPs and dentists. People were supported to attend annual health checks with their GP when required. We saw from observation and a review of records that staff were very observant of people's changing health conditions and sought prompt medical advice for them. Hospital passports had been developed to provide clinical staff with detailed information about each person should there be a need for them to be admitted to hospital. One relative described staff prompt response to an accident which occurred whilst they were at college. "The college did not pick up on the injury sustained but as soon as [relative] got back to the home the staff picked up on it, took [relative] to accident and emergency and contacted me. They keep you well informed of any changes and updates. I honestly cannot fault them."

Requires Improvement

Is the service caring?

Our findings

People told us they liked the staff who supported them and said they were happy living at Maple House. We observed people to be comfortable in the presence of staff. One person spoke positively about the staff who supported them on a one to one basis. Staff were knowledgeable about people and demonstrated respect for them in the way they interacted with, and spoke about them.

People's bedrooms were personalised and contained photographs, art work and personal items which reflected people's individuality and personalities. Staff respected people's private space, for example waiting for a response from people before entering their room. However, we observed the staff handover meeting to communicate information from one shift to another. This meeting took place in people's communal lounge whilst two people who used the service were present. Just prior to the start of the meeting one member of staff told one person, "Can you turn the TV down as we need to start the handover meeting." This meant that both people could no longer hear the TV and their right to have access to their lounge without intrusion had not been protected. We discussed this with the team leader who said that sensitive information would not be shared in these meetings with people present. However, this was contrary to what we observed. We recommend that the current practice of holding staff handover meetings in people's communal lounge be reconsidered as this did not fully protect the confidentiality of their information and consider their rights to have their communal space protected without intrusion.

People's care and support plans included personal profiles which described in good detail; 'What's important to me' and 'Things I want to achieve'. People met with their keyworker each month and their views and opinions were assessed. We noted action plans had been developed from these meetings with actions agreed with timescales.

We saw that people with limited verbal communication skills were supported to express their needs, wishes and preferences through a variety of communication tools such as; objects of reference and the 'Picture Exchange Communication System' (PECS). This enabled people with to communicate using objects, pictures and symbols.

Good

Is the service responsive?

Our findings

People were supported to take part in a range of activities and personal interests outside of the home. Some people attended college and school. Each person had an individual programme of activities which they planned with support of staff. This was displayed in an easy read pictorial format. People attended local weekly social clubs, went shopping, enjoyed trips to sport events, and music sessions. We observed people were supported to access community activities such as shopping, meals out and visits to the pub. People told us they liked the activities they took part in and were supported to go on holiday each year. One person told us of the many sporting events they had attended with staff. We were assured that people were provided with activities which were meaningful and personalised.

People's support plans were person centred and reflected their needs and where appropriate a pictorial support plan was in place to enable them to understand their plan of care more effectively. Support plans included information on maintaining people's health and wellbeing, likes and dislikes and their daily routines. Support plans set out what people's needs were and how these should be met. This gave staff specific information about people's care and treatment needs including support required to support people to maximise their independence.

Staff told us they had easy access to care plans and involved in their review to ensure up to date information was provided to reflect people's changing needs. Staff knew people well including their preferences for care and their personal histories. Staff told us that they supported people to maintain their independence as much as possible and helped them to develop life skills such as personal care, cooking and housekeeping skills.

Support plans we reviewed reflected the current care and support needs of each person with up to date and relevant information about their healthcare, personal care support, likes and dislikes and aspirations. Relatives told us they were invited to regular care reviews. However, local authority reviews for people with their allocated social worker were for some people infrequent which meant that there was a lack of monitoring from those who commissioned people's care.

Where people presented with distressed behaviours which put them and others at risk, behavioural management plans had been produced following advice and guidance from specialists such as learning disability nurses and intensive support teams. Support plans contained guidance for staff as to potential triggers and steps they should take to support people from or staff to take if physical de-escalation was required in a safe and dignified manner.

Support plans were all regularly reviewed and were up to date to reflect people's current care and support needs. Daily records were completed by staff and contained information about what people had been supported with, what they done and what they had eaten. There was also a communication book and handovers between shifts which enabled staff to have the up to date information they needed to respond to individuals changing needs and information about the daily running of the service.

The provider had a system in place to respond to suggestions, concerns and complaints. This was freely accessible and in a pictorial format. Relatives told us that when they had raised any concerns these had been responded to promptly with outcomes to their satisfaction.

Good

Is the service well-led?

Our findings

We observed people were comfortable and at ease with the manager and staff. One person laughed and joked with the manager about sport and it was clear the manager knew them well.

Relatives told us, "We are confident in the management of the home. They are fantastic. The manager has been hands on showing the staff what to do when needed." and "I have no concerns about the manager and any of the staff. They talk to [our relative] as an adult, they don't babysit them."

Staff morale was positive and staff told us that issues were openly discussed. Staff were clear about their roles and responsibilities as well as the organisational structure of the service and who they would go to for support if needed. Staff told us the manager was supportive and approachable should they have any concerns. Comments included, "This is a good place to work. The manager is helpful and approachable.", "I have found the manager easy to talk to you just go to the office if you have anything you need help with" and "I love to come to work, there is a good team here."

There were clear communication systems in place such as regular staff meetings, staff daily handover meetings from one shift to another and communication books. The provider had systems in place to support staff and monitor performance such as one to one supervision and annual, appraisal meetings where staff could discuss their training and development needs. Staff told us they were actively encouraged to question practice and make suggestions for improvements and their ideas were listened to. Staff meeting minutes showed us that staff feedback was encouraged.

Staff were aware of their responsibilities and roles within this. They told us that there were clear arrangements in place in the event of an emergency. Staff performance was monitored through regular competency observations of staff practice. Where shortfalls were found, additional training and support was provided.

There were a range of systems in place to ascertain people's views about their experience and identify areas of improvement. Annual in-house reviews were carried out with involvement of people's next of kin or advocate. Satisfaction surveys to ascertain people's views were carried out including the views of relative's and staff.

Where people could not verbally express their views communication tools were used such as referral to objects of reference and pictorial prompts to enable people to express their wants, needs and feelings.

The team leader provided us with copies of the audits that had been carried out to check on the quality and safety of the service. These included medication management audits, health and safety environmental and support plan audits. Where issues were identified these were actioned. The provider carried out regular visits to the service and produced a brief report of their findings with follow up actions recorded. However, further work was required to ensure the provider's policies and procedural guidance was regularly reviewed and updated to reflect current good practice and regulatory requirements.