HC-One Limited

Maple Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 19, 20, and 23 October 2017 and was unannounced.

Maple Court Nursing Home is a care home providing accommodation, personal and nursing care for up to 80 people. The home was divided into two separate units. Elizabeth suite on the ground floor provides general nursing care and Saunders suite on the first floor provides nursing care for people who may be living with dementia or with more complex support needs. At the time of this inspection 72 people were using the service.

There was no 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 provider told us that a new manager had been recruited and they were undertaking an induction with the provider before commencing in post at Maple Court Nursing Home. An acting site manager was responsible for managing the home until the new manager was in post.

At our previous inspection on 27 July 2016 the home was rated 'Good'. At this inspection we found that there were breaches of Regulations and the home was rated 'Inadequate'. The service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

Risks to people's safety, health and wellbeing were not always suitably assessed and managed and plans in place to manage risks were not always followed by staff.

There was not always enough suitably skilled staff deployed effectively to keep people safe or to meet their needs. Staff were not always trained to provide safe and effective care.

People were not always protected from the risks of avoidable harm and abuse because incidents of possible abuse were not always identified and reported to the local authority as required. Action was not always taken to protect people from further occurrences.

We found that medicines were not managed safely and people were at risk of not receiving their medicines as directed by the prescriber.

Systems in place to consistently assess and monitor risks to people and the quality of care provided were not operated effectively. This meant that issues with the safety and quality of the care were not reliably identified and rectified.

People did not consistently have choices about food and drinks and improvements were needed to ensure that people were supported in a timely manner at mealtimes.

People told us they had access to healthcare professionals when they required them. However we observed that staff did not seek medical attention for one person who was experiencing pain.

People were not always offered the reassurances they needed because staff did not have time to spend with them. People's dignity was not always respected and promoted.

Some people told us they were happy with the care they received and that staff knew their care needs and preferences. However, we saw that some staff did not know people well and did not have time to read care plans so this meant there was a risk that people did not receive personalised care.

Some people had access to activities although others were not supported to engage in meaningful activity.

There was a complaints procedure in place and formal complaints were responded to in line with this procedure.

People who were able to make their own choices were supported to have maximum choice and control of their lives. When people were not able to make their own choices, staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health, safety and wellbeing were not always suitably assessed, planned for, managed and reviewed to promote their safety.
Medicines were not safely managed to ensure that people received their medicines as prescribed.
There were not always enough staff deployed effectively to meet people's needs and keep them safe.
Staff knew how to recognise and report abuse. However, effective systems were not in place to ensure that potential abuse was reported and investigated in order to keep people safe from avoidable harm and abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always supported by staff who had the required knowledge and skills to provide effective care.
People did not always have choices about their food and drinks and improvements were required to ensure that people had the support they required to allow them to enjoy the mealtime experience.
People said they had access to healthcare professionals when required however, we saw that a person was not supported to access medical advice in a timely manner.
People's consent was sought before support was provided. The principles of the Mental Capacity Act 2005 were followed so that people were supported to receive care
that was in their best interests when they were unable to make decisions for themselves.

Is the service caring?

Inadequate

The service was not consistently caring.
Staff did not always have a good understanding of people's care needs and preferences.
People's dignity was not always promoted and staff did not always have time to spend with people to give them the reassurances they needed.

People were not always supported to express their views and make choices about their care.
Some people were happy with the way they were treated by staff and the care they received and we saw some caring interactions between people and staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.
People were not always supported to have up to date care plans that reflected their care needs and preferences.
Some people received personalised care that meet their needs and had access to activities they liked. However, some people were not supported to engage in meaningful activity.
Complaints were listened to and responded to in line with the provider's procedure.

Is the service well-led?

Inadequate

The service was not well-led.
There was no registered manager at the home and the provider had not ensured that the acting manager had support to enable them to monitor and improve the quality of the care provided.
Systems were not operated effectively to assess and monitor the safety of the service.
People's feedback about the care was not always acted upon.
People told us the acting manager was approachable and visible at the service.

Maple Court Nursing Home

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 inspection took place on 19, 20 and 23 October and was unannounced.

The inspection team consisted of two inspectors, a medicines inspector, an expert by experience who has personal experience of caring for someone who uses this type of care service and a specialist advisor who is a nurse with specialist experience in caring for older people with mental health needs.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information help formulate our inspection plan.

We checked the information we held about the service and provider. This included the statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also reviewed the information we had received from the public and the local authority. This included complaints about the service which had prompted us to bring the planned inspection forward. We also used this information to help formulate our inspection plan.

We spoke with eight people who used the service and eight visiting relatives or friends. We did this to gain people's views about the care and to check that standards of care were being met. We also spoke with 11 members of care staff including two nurses and two nursing assistants. We spoke with the acting site manager, a turnaround manager who worked for the provider and the area director to help us to understand how the service was managed.

Some people who used the service were not able to speak to us about their care experiences so we observed how the staff interacted with people in communal areas and we looked at the care records of ten people who used the service, to see if their records were accurate and up to date. We also looked at records

relating to the management of the service. These included six staff files, staff rotas, training records and quality assurance records.

Inadequate

Is the service safe?

Our findings

People's risks were not always suitably assessed and managed to keep themselves and others safe. A number of people who used the service displayed behaviours that challenged such as verbal or physical aggression. A visitor told us "[Person] has bad days and can be difficult to support, the staff are unable to keep [Person] safe when they get like that." We found that behaviours were not always effectively assessed and planned for to promote people's safety and wellbeing. For example, one person had assaulted other people who used the service on a number of occasions. These assaults included kicking, scratching and throwing items at other people who used the service. Although an assessment identified the risk to others, suitable plans were not in place about how staff should support the person and how the risk was being managed so these assaults continued to happen. The manager told us that a referral to a Community Psychiatric Nurse had been made as the person's needs had changed. However, suitable plans were not in place to manage the risk in the meantime and a suitable plan of care had not been put into place when the person's needs changed and the risk to others was identified. Regular incidents occurred but they had not triggered a review of the risk so action had not been taken to prevent similar incidents from occurring again.

Some people who used the service were assessed as being at high risk of falls. However, we saw that risk assessments and plans were not always being followed by staff to manage these risks. For example, one person moved around the service independently and was known to be at high risk of falls. Their risk management plan said they should be encouraged to wear slippers to reduce the risk of falls. However we saw that the person wore socks whilst walking around which increased the falls risk as they were more likely to slip. Staff we spoke with told us they were aware this person was at high risk of falls but they did not intervene to manage the risk when the person was seen wearing socks. Records showed that the number of falls this person had experienced had increased in August and September 2017 and although their falls assessment had been reviewed each month, no changes had been made to help manage the risk. The manager told us that the GP had visited the person to complete a medication review as certain medicines may have been increasing their falls risk. However, the documented risk management plans were not being followed to protect the person. This meant the person continued to be at high risk of falls as the plans in place to reduce the risk were not being followed.

Risk management plans in relation to choking risks were not always followed by staff to ensure that people's risks were minimised. Staff told us and records showed that one person was at very high risk of choking. There were clear guidelines in place for staff to follow which had been developed by a Speech and Language Therapist (SALT). These stated that staff should assist the person with all eating and drinking, they should have a teaspoon amount of pureed food and staff should ensure they swallow before supporting with the next teaspoon amount. We observed that the person was given a bowl of porridge and desert spoon by a staff member who then left the room and the person fed themselves. A staff member said, "[Person] is supposed to be assisted. [Person] is at high risk of choking. Maybe the staff member didn't know." This left the person at high risk of choking and meant that staff were not following risk management plans to ensure people's safety.

We observed two members of staff support a person to move in an unsafe manner. We spoke with one of the

staff members about this and they recognised that the transfer was unsafe. They were unaware of what was documented about how to transfer the person safely and said they would arrange for the person to be reassessed to use the hoist. The person's risk assessment and management plan said they should be supported to transfer using a hoist if they were unable to weight bare, however we observed that staff did not do this as they were not aware of the risk management plan. This meant the person was at risk of harm because staff were not aware of the plans in place for them to be supported to move safely.

People's medicines were not safely managed to ensure that they received their medicines as prescribed. For example, one person told us, "Sometimes they run out of my medicine and I go a day or two without them. This makes me feel unwell. They ordered my medicine last week and I still haven't had it." Records showed that the person had not had some of their prescribed medicines for eight days and they told us this made them feel unwell. We found a further six people had not received some of their prescribed medicines because they were out of stock in the home. These medicines included anti-depressants, medicines used to treat dementia and anti-anxiety medicines. This meant there was a risk that people's health could deteriorate because the home had not taken action to ensure that people's prescribed medicines were available to them. The manager was not aware that people's medicines were out of stock until we told them about this; they told us they would take action to ensure that people's medicines were available to them.

One person was prescribed a controlled drug for pain relief. This medicine needed to be administered every 12 hours in order to gain the maximum analgesic effect. We found this medicine had not been administered every 12 hours which meant that there was a risk that the person had experienced unnecessary pain. After an intervention by a 'turnaround manager' who worked for the provider, the records showed that from 20 October 2017, the home had started to administer this medicine correctly and the person told us that their pain relief was much better now.

We found where people had to have their medicines administered by disguising them in food or drink the provider did not have all of the necessary safeguards in place to ensure these medicines were administered safely. For example, we looked at the records for two people and we found the provider was not able to demonstrate what advice they had taken from a pharmacist on how the medicines could be safely prepared and administered. We also found that there was no written information to tell staff how to carry out this process safely and consistently.

Medicines were not always being stored securely for the protection of people using the service. For example, we found topical medicines were being kept in people's rooms and therefore people using the service could inappropriately use these products with a detrimental effect to their own health.

Medicines that had been prescribed on a when required basis had written information in place. However we found the information was not comprehensive enough to support staff on when and how these medicines should be administered. For example, there was very little written information about how pain should be managed for a person who we found crying out in pain. We found the staff were not aware of how this person's pain should be managed and as a consequence this person's pain control was not being managed effectively.

We looked at the records for a person who was administering some of their medicines independently. We found a risk assessment had been completed however the assessment only examined the risk for one medicine when this person was independently administering four medicines. We also found that systems were not in place to monitor the use of these medicines and therefore the service could not be sure that these medicines were being administered as they were intended to be.

The above evidence demonstrates that people did not always receive safe care. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff were not always available to provide them with the care and support they required in a timely manner. Comments from people included, "There is not enough staff" and "I sometimes have to wait a long time for help when I press my buzzer." Some relatives we spoke with expressed concern about the staffing levels and the use of agency staff within the home. A relative said, "The staff are so busy they do not always respond to buzzers, you have to go and look for them." All of the staff we spoke with confirmed that that they did not always have the time they needed to meet people's care needs and keep people safe. A staff member said, "Staffing levels are not safe. Buzzers are going off but they are not being answered. If we had more staff there would be less falls. If I needed care I wouldn't live here because there are not safe staffing levels." Another staff member became upset when they told us about the impact that staffing levels had on the quality of care provided. They said, "[Person] has missed a pad change because of staffing levels. Care is carried out but not at the level it should be, staff are rushing around and it affects their ability and the quality of care provided." Another staff member said, "Management say there is enough staff but there isn't. Pad changes are late and lounges are left unsupervised. At times when we are supporting people with personal care needs, others are left without the support they need." This meant that people's care needs were not always met as planned or in a timely manner because staff were not always available to do this.

We observed that lounges and corridors where people spent time were often left unsupervised, despite a number of people being at risk of falls or at risk of harm from others. Records showed that falls and incidents occurred unwitnessed. Staff told us that lounges should be supervised to ensure people's safety but there was not enough of them to ensure this happened. We observed that people had to wait for support. For example, one person needed two staff to support them to move. We saw that one staff member put a sling around a person and they were then left alone sat on the sling for at least ten minutes whilst the staff member went to find another staff member to help them to move. Another person who required support to eat was sat at the dinner table for one hour with no lunch as there was no staff available to support them. They looked uncomfortable as they fidgeted and played with a napkin. This showed that staff were not effectively deployed to meet people's needs.

We asked the manager and provider how staffing levels were assessed and monitored to make sure they were sufficient to meet people's needs and keep them safe. The manager said that a dependency tool was used by the provider to look at people's individual needs and this helped to determine how many staff were required to meet those needs. The manager had recently requested that the provider complete a review of the home's dependency levels to ensure that there were sufficient staffing levels. However, this had not yet been completed as the person responsible for this was on annual leave. The provider was unable to show us the dependency assessment that the current staffing levels were based upon. We saw that people's needs had increased and new people had been admitted to the home but staffing levels had not changed to reflect this. This meant that the provider could not be sure that sufficient numbers of suitably qualified staff were available to meet people's needs.

Staff told us that recruitment checks were in place to ensure staff were suitable to work at the service. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure staff were suitable to work with people who used the service. However, when we looked at staff records we saw that a person who worked at the service had only one suitable reference recorded. The manager told us that the provider's policy in relation to safe recruitment stated that two suitable references should be checked before employment is commenced. The manager was not aware of this issue until we bought it to their attention. This meant that the provider was

not following their own policy in relation to safe recruitment and therefore they could not be sure that persons employed were suitable to work with people who used the service.

The above evidence demonstrates that there was not always sufficient, suitably qualified, competent staff deployed to meet people's needs. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from avoidable harm and abuse. Staff had been trained to recognise and report abuse and staff we spoke with were able to demonstrate that they understood the different types of abuse and how to report concerns. A staff member said, "I would report any concerns to management. I have done this before and action was taken." We saw that when the manager had been made aware of allegations of abuse, these were reported to the local authority in line with safeguarding adult's procedures.

However, we saw some incidents of potential abuse documented in care records that had not been reported to the manager and therefore no action had been taken to protect people. For example, records showed that one person had, "broke residents jewellery off her wrist and tripped and kicked the resident". It was documented that this, "caused the resident distress and pain." The manager was not aware of this incident and it had not been reported to the local authority or suitably investigated. We could not see that action had been taken to relieve the person's pain or distress and no plans were put into place to reduce the risk of further incidents. The only action recorded following the incident was the person was "redirected". We also saw unexplained bruising recorded on a body map for one person. The manager was not aware of this and no action had been taken to investigate or report this. This meant that people were not being protected from abuse and systems were not operated effectively to ensure that allegations were investigated and action taken to prevent further abuse.

The above evidence demonstrates that people were not consistently protected from potential abuse and improper treatment. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

People were not always supported effectively by staff who had the required knowledge and skills. A visitor told us, "They put new staff upstairs without proper training." A number of people who lived on Saunders suite were living with Dementia or had mental health needs and some people displayed behaviours that challenged such as verbal or physical aggression. Staff told us they had not completed sufficient training to help equip them with the skills to support these people effectively. One staff member said, "I've had no training about how to manage behaviours or to communicate with people. It makes me feel sick and depressed." Another staff member said, "I have had Dementia training but some staff haven't. This means staff are unaware of how to support people or communicate with them. This adds to people's confusion and this is when we see the challenging behaviours." We looked at training records which showed these gaps in training. The manager told us that the training figures were not reflective of actual training received because online training modules had been revised and some staff had not yet completed the updated version. However, staff told us that they did not feel they had the required skills to support people effectively and our observations supported this. For example, one person who was living with Dementia repeatedly asked for reassurances and was inconsistently supported by staff.

Some people who used the service required low level holds to ensure personal care was provided in their best interests at certain times. Whilst this was suitably documented, we saw that a high number of staff had not been trained to use these techniques. The manager told us that only trained staff would support these people when techniques were required. However, one staff member told us they used low level holds to support a person despite not being trained. This meant there was a risk that the person was not supported safely or effectively.

We saw that when training had been delivered it was not always effective. For example, staff who had received training in moving and handling were seen using unsafe practice. Staff who told us they had received safeguarding training had not reported unexplained bruising as a potential safeguarding incident. Staff who had received training in The Mental Capacity Act 2005 (MCA) could not tell us about their role in ensuring the Act was followed to protect people's rights. The provider had not checked staff's competency after training had been received which meant they could not be sure that staff had the required skills and knowledge to support people effectively.

The above evidence shows that staff were not always suitably skilled to meet people's care needs in a safe and effective manner. This was an additional breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they enjoyed the quality and quantity of the food at the service. One person said, "We get enough to eat and drink." Another person said, "Food is sometimes better than others, there's not much of a choice." We saw that people who ate a normal diet had a choice of two meals and when one person said they were not enjoying their meal, they were offered alternatives and smiled when an omelette was mentioned, so the kitchen staff made this for them. However, when people required a soft or pureed diet we observed and staff confirmed that there was no choice of meal and they were served liver. This

meant that not everyone who used the service had a choice about their meals.

We observed that the mealtime experience upstairs on Saunders suite was chaotic. There was a high number of agency staff on duty who did not know people's needs in relation to eating and drinking which meant they had to wait for regular staff to ask them questions about people's needs. We heard an agency staff member ask another staff member whether one person could have a normal lunch option. The other staff member said they didn't know because they usually worked at another of the provider's services so they went to check the person's care plan to find they required a soft option due to their risk of choking. We saw this person sat at the table for one hour before anyone bought them their lunch. They were not offered a choice. We observed another person had fallen asleep at the dining table and their lunch had gone cold. There were no staff available to support this person. A relative said, "I come in at mealtimes to help feed [my relative] as they seem to be short staffed." Improvements were needed to the organisation of the mealtime to ensure that people got the support they required in a timely manner, were offered choices and given the opportunity to enjoy the mealtime experience.

People told us they had access to healthcare services when they required them. One person said, "They ask for the GP when I need them and they come quickly." A relative said, "The chiropodist comes and sees [my relative]." However, we observed that one person was crying out in pain and staff had not requested any medical advice for them. Their relative told us that the person was constipated and this was causing the pain and that staff had said they have given the person some pain relief medication. However the person was still in pain and no action had been taken to relieve their pain. We asked the manager to ensure the person had the correct support and a GP was contacted who reviewed the person's medicines. The next day, the person told us they felt better after the change in medicines. However staff had not acted swiftly to ensure the person's healthcare needs were met and they did not have access to medical input as soon as they required it.

People who were able to tell us about their care told us that staff asked for their consent before they supported them. One person said, "Staff always ask for my consent before they do anything for me." 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. We saw that people's ability to consent had been assessed when required and that the principles of the MCA had been followed to ensure that care was delivered in people's best interest when required.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that DoLS authorisations were requested when required. One person had a condition on their DoLS authorisation and staff told us how this was being met.

Inadequate

Is the service caring?

Our findings

Some people said that the high use of agency staff impacted on the quality of the care they received because staff did not always know how to support and care for them. One person said, "I tell [agency staff] what to do and they do listen. The general staff are pretty good." Our observations confirmed that some staff did not know people well. Some staff that we spoke with, in particular the agency staff on Saunders suite were unable to tell us basic information about people, such as their names and how they needed to be supported to eat and drink. For example, we saw an agency staff member supporting a person to eat a soft diet. When we spoke with the staff member they were unable to tell us the person's name. They told us they were supporting the person to eat liver as they had been directed by another staff member but that the person was not offered a choice and they didn't know whether liver was something the person enjoyed. This meant people on this unit were not always supported in a caring manner as staff did not always have a good understanding of their care needs and preferences.

Staff told us and we observed that they did not have time to spend with people. A staff member said, "People are cared for but there's no time for the little things, no time to sit with them and talk." We saw that one person was upset and crying. A member of staff approached them and asked them what was the matter, however when the staff member left, the person became upset again, shouting, "Oh help me." This happened regularly throughout the day and we saw that some staff walked past the person without offering reassurance. When we asked staff about this, they told us the person needed a lot of reassurance but that they didn't always have the time to spend with them. One staff member sat with the person and held their hand for a short period of time before they were called to another task and the person cried again. This meant that staff did not have the time to give people the reassurance they needed; this was not a caring approach.

People were not always supported to express their views and be involved in decision making about their care. One person said, "They don't ask my opinion." We observed and staff told us on Saunders Suite that people needed support to make choices. A staff member said, "When people need help, I show them two meals and explain what it is. They can point at what they want. I can also tell by facial expressions." However, we observed that staff did not do this and people were not consistently offered choices. People were not verbally offered or visually shown choices of meals to support them to make a choice. We observed that when people were supported to move, staff did not ask them where they would like to sit. This meant that people were not supported to make choices and decisions about their care and support.

Some people said their privacy and dignity was respected and promoted. One person said, "Doors are closed when they administer personal care, they treat me with respect." However, one person said, "Sometimes the staff are sharp with me." We observed that people's dignity was not always promoted. For example, we saw that one person was left alone in a dining room after lunch. They had a bowl of yogurt which they had spilled over their clothes and prompt action was not taken to help them clean up. They were eating scraps of food which had been left on the table from lunch time. A staff member came in and told us the person had spooned their drink onto the table and we saw the table cloth was soaked. The staff member then left the room, leaving the person alone again. This meant the person's dignity was not respected and

promoted.

The above evidence demonstrates that people were not always treated with dignity and respect. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they were happy with the care they received but comments were not consistently positive. Comments included, "I am sometimes happy with my care" and "Some staff are very good and look after me well but sometimes not." A visitor said, "Generally, the care is good. The carers look after [my relative] well." We saw that staff who regularly worked at the home knew people well and had good relationships with people. We observed some caring interactions between people and staff. For example, we saw a staff member ask if they could help a person to clean their face. This showed that staff showed concern for people's wellbeing and dignity. The person smiled when the staff helped them as they treated with kindness.

Requires Improvement

Is the service responsive?

Our findings

People were not supported to have care plans that reflected their needs and preferences. For example, one person's plan said they walked with a zimmer frame but we didn't see them with this. We asked staff about this and they told us, "Care plans are not up to date, we don't have time. How can you write a care plan when you are trying to watch people?" Another person displayed some behaviour that challenged including verbal and physical aggression and we saw there was no care plan in relation to this to guide staff on how to support the person. We asked staff how they supported the person. One staff member said, "I'll be honest, I don't know [Person]. Today is the first time I've seen [Person] and we don't have time to read care plans." Another staff member said, "Information is usually in the care plan but you just get to know them." This meant that staff, including agency staff who did not know people well, did not have access to up to date information in order to provide people with consistent, personalised care.

We observed on Saunders unit that people were often not engaged in meaningful activities. For example, we saw that one person spent most of their time walking around the corridors and lounges. We observed they had no interaction with staff or people for a long period of time and staff did not take action to support the person to engage in meaningful activity. Later, we saw them pushing a large armchair along the corridor which could have been a danger to themselves or others and staff walked past without intervening. A staff member told us, "We don't have time to do activities with people, there are lots of incidents and altercations because of lack of stimulation." Another staff member said, "Care is more about routine and not when needed. It's task orientated and we don't have time to talk with people. It's like a 'tick box' system." This meant there was a risk of people being isolated and some people were not supported to participate in activities suitable for their needs.

We saw that some people had been involved in the development of their care plans when they were able to. A visitor said, "We make sure that we are involved in [relative]'s care plan and assessments, we go through their care plan regularly." Some people's care plans included information about their personal history, likes and dislikes so that staff had information about the person in order to provide personalised care. However, a number staff told us they did not read care plans and agency staff told us they relied on other staff knowledge about how to support people. A visitor said, "Some staff meet needs but others do not take care to read care plans, it depends who is on." This meant that information was not always used appropriately to provide people with personalised care and support.

The above evidence demonstrates that people did not always receive person-centred care that met their needs and preferences. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people who lived on Elizabeth Suite told us they received personalised care that was responsive to their needs. One person said, "They get me up in the morning when I want to, wash and change me and get my breakfast. In the better weather, they wheeled me into the garden. That was nice because I hadn't been out in ages." People on Elizabeth Suite also said they enjoyed the opportunity to participate in activities they enjoyed. One person said, "I have a newspaper every day and I sometimes take part in the activities." A

visitor said, "My [relative] has a CD player in her room, the staff put on music for her and she enjoys that." Another relative said, "There are a lot of activities, singers, arts and craft, music, appropriate quizzes." We saw that an entertainer came into the home and people were singing and dancing and enjoying the experience. Other people told us they enjoyed trips out of the home. People were supported to practice their faith. A visitor said, "My [relative] has holy communion once per month, their priest comes in." This meant that some people did receive support to follow their interest and take part in social activities.

People told us they felt comfortable to raise concerns and complaints and that these were acted upon. One visitor said, "I have requested that [my relative] is shaved more often as he did always care about his appearance, this is now done." Another visitor said, "We meet as and when needed with carers and managers rather than wait and get upset." We saw that when formal complaints were made, these were responded to and dealt with in line the provider's procedure.

Inadequate

Is the service well-led?

Our findings

There had been no registered manager at the home since 12 July 2017. However, the manager actually left the home in May 2017. As part of the provider's condition of registration they are required to have a registered manager in post. This was a breach of Regulation 5 of The Care Quality Commission (Registration) Regulations 2009 (Part 2).

At the time of the inspection, the provider told us that a new manager had been recruited and was currently undertaking an induction at another of the provider's locations. They were due to start at Maple Court Nursing Home on 30 October 2017.

An acting site manager was in place to manage the home; however they also had responsibilities as a registered manager at another of the provider's locations which meant they had to spend some of their time at this other location. There was no deputy manager currently in post at Maple Court Nursing Home and there was also a vacancy for a unit manager on Saunders Suite which meant that additional pressures were placed on the acting site manager.

Systems were not operated effectively to assess, monitor and improve the safety of the service. We found that some potential safeguarding adults incidents had not been reported the local authority because the manager was not made aware of these. Staff we spoke with confirmed the process that incidents are reported to the nurse in charge, who would complete an incident form which is sent to the manager who would complete a safeguarding adult's referral if required. We found this process had not been completed on some occasions. This meant that safeguarding adults concerns had not been identified and reported as required, investigations had not taken place, protection plans were not implemented and people remained at risk of further harm or abuse as a result of this.

We saw that a number of people displayed behaviours that challenged staff and posed a risk to staff and other people who used the service. These behaviours were being recorded on Antecedents Behaviour Consequences (ABC) Charts in order that they could be reviewed and assessed to look for triggers and trends so that suitable management plans could be put into place. The manager told us these would be reviewed by the nurse. However, a nurse we spoke with told us it would be unit manager's responsibility to do this. As there was no unit manager in place, these reviews and assessments of behaviours were not taking place. We saw that suitable management plans had not been put into place as a result of this which left people at further risk of harm.

Some people had fluid monitoring charts in place when there were concerns about their health. We saw that fluid monitoring charts were not being suitably completed by staff. They did not contain vital information such as target amounts and daily totals so it was not clear to see accurate records of the person's fluid intake. The guidance to staff indicated that people whose daily fluid total fell short of the target amount for three consecutive days should be referred to a doctor. We calculated target and total amounts for a person and found that when this occurred, they had not been referred to a doctor. Regular reviews of these records were not taking place and this meant that risks to their health were not being effectively, monitored,

managed and mitigated because effective systems were not in place to do this.

Systems were not operated to effectively assess, monitor and improve the quality of the service. We found that regular care plan audits were not being completed. A 'turnaround manager' who worked for the provider had completed audits of two care plans in September 2017, however we could not see what action had been taken to improve the quality of care plans following this audit. We found that people's care plans were out of date and some records lacked vital information such as dates of incidents and staff signatures. As these care plans and records had not been reviewed, no action had been taken to ensure that accurate and complete records were being kept. The manager told us they were aware of some of these issues but had not had time to prioritise taking action to ensure that accurate and complete records were kept and people's information was update to date.

Feedback was sought from people who used the service and relatives using a survey carried out in June 2017. However this feedback was not acted upon to allow the provider to evaluate and improve the quality of care provided. A resident's comment included, "Emergency bell always out of reach and I have to ask for it." A relative's comment included, "When visiting it is often difficult to speak to staff and it is always someone new or from agency." No action had been taken to address the feedback; the manager told us they had not had time to formulate an action plan. They told us that residents meetings were held to help gather feedback, however the records of the meetings showed that only activities at the home were discussed and people's feedback about the care provided to them was not sought during these meetings. This meant the provider was not seeking and acting on feedback to improve the services provided.

Staff did not feel actively involved in the development of the service. The manager told us and staff confirmed that regular staff meetings were held, however some staff did not feel that these helped them to be involved in continual improvements at home or that their views were listened to. One staff member said, "We have monthly staff meetings but all we do is [talk] about different departments in the home for example, laundry or domestic staff. Nothing positive had ever come out of those meetings. No positive changes to the service. Staff views are not listened to." Another staff member said, "I just want this place to be run right. I have no say. I can see what needs doing but I can't do it." This meant that staff did not feel listened to and an inclusive culture was not promoted.

The above evidence demonstrates that systems and process were not established or operated effectively to ensure that people received a good quality and safe service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the acting site manager was approachable and visible at the service. One person said, "The [manager] has come to my room to see I'm alright. He's quite friendly." A relative said, "I know who the manager is, he is approachable and things get sorted out." We found that the manager was available to people and staff to provide advice and support. However, due to the lack of deputy manager and unit manager and support, they did not have enough time to ensure that quality monitoring systems were used effectively. The manager had requested the provider complete an internal inspection of the home to highlight areas for improvement and trigger support for the service to move forward. This had been completed and the provider told us that an action plan was being developed to support continuous improvements. However this had not been completed at the time of the inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 5 Registration Regulations 2009 (Schedule 1) Registered manager condition There was no registered manager at the location since 12 July 2017. The manager actually left the service in May 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive personalised care that met their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.