Knights Care (2) Limited

The Maple Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
The Maple Care Home is a residential care home with nursing and can accommodate up to 63 people across three floors, each of which has separate adapted facilities. One of the floors specialises in providing care to people living with dementia and another provides nursing care. At the time of the inspection there were 47 people living in the home at the time of our inspection.

People's experience of using this service and what we found
People felt safe living at the home and relatives we spoke with were happy with the care provided. One person told us, "I certainly do feel safe, it's close knit. It's just lovely."

Not all risks were adequately addressed. Fire drills did not take place in line with the provider's policy.A more robust system was required to investigate allegations of abuse. We have made a recommendation about this. Some staff told us they were concerned about staffing levels. Most people told us they were happy with how quickly staff attended to their needs, however, others described staff as 'very busy' and said at times they had to wait for assistance. Medicines were managed safely although some records could be improved. We were assured with the infection control measures in place. However, initial screening of visitors to the home needed to improve.

People and their relatives were happy with the management team. Relatives told us communication with the home had been good during the pandemic. We had mixed feedback from staff who did not all feel supported in their roles. Quality checks were carried out but did not highlight all of the issues we found. Some care records had not been updated on the electronic system and some staff found the system difficult to use. The provider was planning to replace the system to avoid these issues in future.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 23 May 2018)

Why we inspected
We received concerns in relation to the management oversight and staffing levels at the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those

key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this full report. The provider has already taken some action to mitigate the risks and we will continue to monitor to ensure they have been effective.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Maple Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified a breach in relation to risk management.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Maple Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Maple Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and six relatives about their experience of the care provided. We spoke with thirteen members of staff including the provider, operations director, registered manager, deputy manager, nursing staff, senior care workers, care workers and maintenance staff.

We reviewed a range of records. This included seven people's care records and multiple medication records. A variety of records relating to the management of the service, including audits and quality checks.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at additional information that was sent to us electronically including fire drill records, additional care records and several of the provider's policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● People's weights were not always correctly monitored or recorded. Tools used to calculate risk of malnutrition had not always been completed correctly.

● Risk assessments were not in place for every identified risk. Whilst some risk assessments contained a good level of detail, we found others were not in place. This meant staff did not always have access to the information necessary to minimise risk.

● Fire drills were not taking place in line with the provider's policy. Not all staff had opportunity to participate in a drill over the last 12 months. One member of staff told us they had not taken part in a drill since starting work at the home. They told us, "I think I would panic if the fire alarm went off." The registered manager assured us a drill was scheduled this month and all staff would take part in a drill as soon as possible.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● A more robust system was required to investigate allegations of abuse. There were some inconsistencies around the way procedures were followed and comprehensive records of investigations were not always kept.

● Staff had received safeguarding training and knew how to raise concerns but some staff felt allegations were not always fully investigated.

We recommend the provider reviews their safeguarding procedures in line with current best practice.

Staffing and recruitment

● People told us there were always staff around to meet their needs. Most people said they did not have to wait long for assistance but some people told us staff seemed very busy and at times they did have to wait. One person told us, "I feel very safe, sometimes you have to wait a bit. I can see they are busy so I don't say anything."

● The home was fully staffed in line with the tool used by the provider to calculate safe staffing levels. However, some staff we spoke with expressed concern about the number of people who required two staff to support them in areas where only two staff were on duty. They worried about people having to wait for

support when staff took a break and felt it was sometimes difficult to keep up to date with records. We discussed this with the registered manager and provider who were going to review this.
● There was a robust recruitment policy in place and appropriate checks were done prior to staff being employed. This minimised the risk of unsuitable people working at the home.

Using medicines safely
● People were receiving their medicines as prescribed. An electronic system was in place to manage medicines and this was working effectively. Some paper-based records had not always been fully completed and we discussed this with the registered manager who was going to review the systems in place.
● People were happy with the way their medicines were managed. One person told us, "[Staff] are very prompt. They just give you what you need."

Preventing and controlling infection
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. No temperature checks were conducted on inspectors' arrival and no health screening was done to establish whether inspectors had symptoms or recent contact with positive cases. The registered manager assured us a health questionnaire will be used regularly from now on.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some areas were identified as needed repair or refurbishment in order to clean them effectively and this was actioned immediately.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong
● Accidents and incidents were recorded and reviewed by the registered manager. Actions were taken to minimise future risk such as the involvement of external professionals. For example we saw one person who had a high number of falls had been referred to the specialist falls team for review.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff felt confident to raise any issues with the registered manager. However, there was mixed feedback regarding the action that would be taken. One staff member told us, "One thing was an issue for me but I discussed it with [the registered manager] and it got sorted." Another said, "I feel confident to speak to [the registered manager] and if there was an issue I would go to them. I'm just not sure it would be acted on."
- Staff morale was mixed and whilst some staff spoke very highly of the management team and the support they received, others did not feel well supported. The registered manager and deputy held staff surgeries where staff could approach them to discuss anything they wished. However, the registered manager told us these were not well attended. Individual supervision meetings had not been taking place regularly and the registered manager told us this was to be addressed.
- People and relatives gave positive feedback about the management team. One person told us, "The manager is marvellous, he comes and talks to me like I was his sister, no airs and graces. He gets things done."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager understood their responsibility to be open and transparent when things went wrong. Family members were alerted straight away if any safeguarding allegations were made. Relatives were also contacted immediately when incidents occurred such as a fall or deterioration of health. Records of these conversations were not always kept and therefore there was no way to evidence whether relatives were happy with the outcome.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had a comprehensive system of audits that included oversight of medicine records and systems at both management and provider level. These audits had effectively identified some areas where improvement was required, however, they had failed to pick up all of the issues we found during our inspection.
- The registered manager did not report safeguarding incidents to us in line with regulatory requirements. We discussed this with the provider and registered manager who reassured us they would send all required notification in future.

● Staff did not always have access to up to date or accurate records due to issues with laptops not being regularly synced. The laptop used by the inspector had not been update since 24 February 2021, a week prior to our visit. Some staff told us they found the electronic care plan system difficult to use. We found gaps in some records and errors in others. The provider was planning to move to another system as a result of the difficulties.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● A staff survey was conducted and an action plan was put in place to address those areas where staff had raised issues. However, some of the feedback we received from staff indicated further work was still required to improve staff morale.

● People were encouraged to be involved in the home. One person told us they had recently attended a resident's meeting. They said, "[The meeting] went alright. One lady started to speak; I've never heard her speak before. It was a quiet meeting, nobody got heated."

● Relatives told us communication with the home had been good during the pandemic. One relative said, "'They have been very helpful, when I phone up, they do take their time to go through everything, they don't treat me like it's a bother."

Working in partnership with others

● There were some concerns regarding partnership working. Feedback we received from external professionals indicated working relationships did not always run smoothly and at times communication with the service had been difficult. This had not had any direct impact on people using the service however good partnership working is important to ensure people receive the best all round care possible.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risk to people were not always correctly assessed or recorded. Appropriate precautions had not been taken to minimise the risk to people in the event of a fire.