Care Centred Ltd

Maple House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Maple House is a domiciliary care agency providing personal care to seven people at the time of the inspection.

People's experience of using this service and what we found
People did not always receive care in a way that protected them from avoidable harm. This was because risks were not always appropriately assessed and managed, including risks associated with the management of medicines.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. This was because the provider did not always adhere to the correct legal processes to ensure people who did not have the capacity to consent would only receive care that was in their best interests.

There were systems to protect people from the risk of abuse and for the provider to learn from accidents and incidents. People received care in a way that protected them from the risk of infection. There were enough staff to care for people safely, although improvements were needed to the recruitment process to ensure the provider had all the information about their staff that was required by law.

People received care from staff with the appropriate skills and knowledge, who had the support they needed to do their jobs well. The provider assessed people's needs in line with best practice, working alongside other organisations when appropriate, which helped to ensure people had good outcomes in terms of their healthcare and nutrition.

Staff were caring and respectful, taking time to build up good relationships with people. People were involved in planning their care and had opportunities to make choices about how they were cared for on a daily basis. Staff promoted people's privacy, dignity and independence.

People told us they were happy with the quality of their care. Although care plans needed more detail to ensure staff were fully aware of how to meet people's needs and preferences, at the time of the inspection the small staff team meant staff knew people well and were responsive to their needs. Staff knew how to communicate effectively with people. We have made recommendations about considering people's diverse needs when planning care and about exploring people's preferences about end of life care.

Although the provider's governance system required improvement because they had not identified the issues we found, people were happy with how the service was managed. There was a robust complaints policy in place and the registered manager regularly sought feedback about the service from people, their relatives and staff. They monitored staff closely to ensure they provided good quality care.

Rating at last inspection
This service was registered with us on 07/03/2018 and this is the first inspection.

Why we inspected
This was a planned inspection based on the date of registration.

Enforcement
We have identified breaches of the regulations in relation to safe care and treatment and the need for consent at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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 effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Maple House

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.

Inspection team
This inspection was carried out by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. 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

We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the registered manager would be in the office to support the inspection.

Inspection activity started on 5 July 2019 and ended on 9 July 2019. We visited the office location on 5 July 2019.

What we did before the inspection
Before the inspection, we reviewed the information we held about this service. This included the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We reviewed a range of records. This included three people's care plans, two staff files and records relating

to the management of the service such as policies and procedures.

After the inspection
After the inspection we spoke with one person who used the service, three relatives of people who used the service and three members of staff. We reviewed additional documentation we had asked the registered manager to send to us.

Requires Improvement

Is the service safe?

Our findings

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

This was the service's first inspection. At this inspection this key question is rated 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

- Risk assessments did not always contain enough detail to ensure staff had sufficient information to care for people safely. For example, in one person's falls risk assessment the only information about how staff should support the person to reduce their risk of falling was "zimmer frame." The assessment did not include details about how staff should ensure the person was using their frame safely or whether the person needed support to do this.
- Risks to people were not always recorded in their risk assessment. Staff had discussed a risk to one person at a staff meeting two months before our inspection, but there was no mention of this in the person's care file and no information about how to reduce the risk. Other than falls, moving and handling and medicines, individual risks were not assessed in detail. One person's needs assessment indicated they may have been at risk of coming to harm through developing pressure ulcers, self-neglect, malnutrition, choking, social isolation and mental ill health, complications arising from diabetes, and another health condition that could cause breathing difficulties. However, the provider had not formally assessed any of these risks and there was no information for staff about how to reduce the risks or what to do if complications arose that put the person in danger of harm.
- Relatives told us staff used lifting equipment such as hoists safely when their family members needed it. Staff understood risks should be managed on an individual basis and depended on each person's needs.

Using medicines safely

- Staff did not always have all the information they needed to administer medicines safely. Medicines administration record (MAR) charts did not always contain details such as what time a medicine should be taken or how many tablets to take. In one case, the name of the medicine was not present so it was unclear what staff were signing for, and for another person the dose they should take was incorrectly recorded on one MAR. This increased the risk of overdose or other errors especially if people needed to move to other services such as hospitals. After the inspection, the registered manager sent us evidence that they had improved the level of detail on MARs.
- People's care plans contained information about their medicines, including what they were prescribed for. However, for one person the only information about where their medicines were stored was "in a container" which was not specific enough for healthcare providers or new staff to find the medicines in an emergency.
- Medicines were not always appropriately recorded. One person whose care plan stated they needed staff to prompt them with medicines did not have a MAR and staff were not recording in daily notes whether they prompted the person to take their medicines. This meant there was no record of whether the person received the support they needed with medicines. There were also gaps in two people's MARs meaning we could not be sure they were receiving their medicines as prescribed.

Because risks arising from people's care needs and medicines management were not fully addressed, people were at increased 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

● People felt safe using the service and knew how to report any concerns about their safety. One person said, "I feel safe and comfortable. Staff do a very good job."

● The provider had a safeguarding policy in place and staff knew how to access this. Staff did not always know the correct procedures to follow when reporting a safeguarding concern. Two staff told us they would discuss the concerns with people or their relatives, which might present a risk of compromising safeguarding investigations. However, all staff knew they should report the concerns to the registered manager in the first instance.

Learning lessons when things go wrong

● At the time of our inspection, the service had not experienced any significant incidents. The registered manager told us staff documented minor incidents in people's daily notes, which were reviewed monthly. Because the service was small this allowed them to have sufficient oversight and identify any trends, but they also had an incident recording system they would be able to use to help them learn from any significant incidents.

● However, the service did not have a written accident and incident reporting policy in place. This meant there was a risk that the provider's system would become less effective as the service expanded, particularly if staff were not aware of the process.

Staffing and recruitment

● The provider did not carry out all of the checks required by law to help ensure staff they recruited were suitable for the role. Although they did complete several checks such as proof of identity and criminal record checks, they did not obtain a full employment history for each candidate since leaving full time education, which is a regulatory requirement.

● There were enough staff to care for people safely and the provider had systems to ensure people received their scheduled visits. People told us staff arrived on time and stayed as long as they needed them to. There were arrangements to cover staff absence and the registered manager was able to carry out visits to people if they needed cover at short notice.

Preventing and controlling infection

● Staff followed infection control procedures to reduce the risk of people acquiring infections. Policies covering areas such as hygienic food preparation and hand washing were clearly written and followed best practice guidance.

● People told us staff followed good hygiene practices including hand washing, using personal protective equipment (PPE) such as gloves, and preparing food safely to prevent cross-contamination.

● There were supplies of PPE at the office that staff could access when they needed it.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This was the service's first inspection. At this inspection this key question is rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty. We checked whether the service was working within the principles of the MCA.

- People who had capacity to consent told us staff always asked for their consent before providing care.
- Staff received training in the MCA and understood the main principles around mental capacity, consent and the law.
- The provider could not always demonstrate that they only provided care with people's consent or followed the correct legal procedures to ensure their care was in their best interests. None of the three people whose care plans we reviewed had provided a signature or other indication that they consented to their care being provided as planned, even in cases where the provider had carried out an assessment showing the person had capacity to consent. Two people's care plans stated a relative had legal authorisation to consent on their behalf, but there was no documentary evidence of this. One care plan also made reference to a decision not to attempt resuscitation in the event of cardiac arrest but there was no evidence to show this decision had been made by an appropriate medical professional.

There was a risk that people would receive care that was inappropriate for them because there were insufficient safeguards to ensure their care was in their best interests. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- The provider had an assessment process that helped them decide which staff were the best match for each person in terms of their skills, personality and experience.

● The provider referred to appropriate standards and guidance to enable them to keep up to date with current best practice.

Staff support: induction, training, skills and experience
● People and relatives felt staff were sufficiently skilled and knowledgeable to carry out their roles competently. Staff were happy with the induction and training they received.
● Staff received appropriate training that was relevant to the needs of people who used the service. For staff who did not have previous care experience, this included the Care Certificate, a national qualification covering the knowledge and skills required to provide adult social care.
● Staff received the support they needed to carry out their jobs. Staff told us they received supervision regularly but could access informal support when required. One member of staff said the staff team could get together in the office to discuss and resolve any problems when necessary.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they received the support they needed to eat and drink enough and were happy with the meals they ate with this support.
● Staff recorded what people ate and drank so their records could be monitored to ensure they had enough. If there were concerns about people's dietary intake, staff recorded people's weight to make sure it remained at a healthy level.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider worked with other agencies to ensure staff knew how to support people's healthcare needs. For example, the local district nursing team trained staff on catheter care to support one person's needs.
● There was information in people's care plans about their healthcare needs and the medicines they used, which the provider would be able to share with other agencies in an emergency.
● The provider supported people to make referrals to appropriate services as needed to meet their healthcare needs.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This was the service's first inspection. At this inspection this key question is rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff took the time to build supportive relationships with people. One person told us, "You can have a laugh and a joke with them." Another person's relative said, "The staff are really helpful and show an interest in who we are as people. They are very polite and courteous." Staff spoke about the importance of making people comfortable and being able to laugh together.
- Because there was a small staff team, there was a good level of consistency in staffing so people got to see the same staff most of the time. People told us this helped them build up good relationships with staff.

Supporting people to express their views and be involved in making decisions about their care

- Staff offered people opportunities to express their views. They received training on how to enable people to do this when they experienced barriers in communication, such as dementia. People told us staff were familiar with their likes and dislikes but still offered them choices about each aspect of their care.
- People were involved in making decisions about their care plans. A relative told us how the registered manager sat down with them and their family member to discuss what should be included in the care plan. We saw evidence of these discussions in people's files, and the care plans took into account people's views about the care and support they needed. This meant people were involved as partners in their own care.
- People received the information they needed about the service in the form of a service user guide. There was information about what the service could and could not offer and how to access further help and support. This helped people to make decisions about their care.

Respecting and promoting people's privacy, dignity and independence

- People and relatives said staff promoted privacy and dignity at all times. One person told us, "[Staff] treat you with dignity and respect." A relative said, "Staff treat people with dignity, no question about that. We all get on fine." Staff showed a good awareness of how to promote privacy and dignity when supporting people with personal care.
- Staff promoted people's independence. One person's relative told us, "[Relative] prefers to be very independent, but it's not that easy. They respect her independence and offer to let her do things herself." They explained how staff involved the person in more complex tasks by breaking them down into stages and allowing the person to complete specific steps of the process independently. This was also reflected in people's care plans so staff knew in advance what tasks people would benefit from being helped to do independently.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This was the service's first inspection. At this inspection this key question is rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans contained information about people's individual care needs and the support they needed to meet them. This included information about healthcare conditions and symptom management, mobility and use of equipment, personal care and continence management. People told us staff gave them all the support they needed to meet their care needs.
- However, some of the information in care plans was out of date or incomplete, which meant there was a risk of staff providing inappropriate care based on incorrect information. Much of the information in people's care plans had been taken from local authority assessments and had not been reviewed in light of their current care arrangements. For example, one person's care plan referred to what they would like to happen when they came out of hospital, which had already happened by the time they started to use this service.
- It also became apparent during our discussions with the registered manager and staff that important information about people's care had not always been captured in care plans. For instance, the registered manager told us one person liked to put their own meals in the oven but staff needed to prompt them to use the microwave instead of the conventional oven. This was not mentioned in the care plan. We judged that this was not having a significant impact on people at the time of our inspection because of the consistency of the staff team and the positive feedback we received from people and their relatives. However, as the provider planned to recruit new staff and expand the service the risk of people receiving inappropriate care could increase. We discussed this with the registered manager, who told us they would work on improving the level of detail in care plans and contacted us after the inspection to tell us they had done this.
- People's care plans took into account their individual needs and preferences around their personal care. A relative told us the service was "very accommodating" and gave examples of when visit times were adjusted to suit their relative's plans.
- Although the provider asked about people's diverse characteristics such as cultural and religious needs as part of their assessment process, it was not always clear whether these were considered when planning people's care.

We recommend that the provider takes action to ensure, in line with best practice guidance, that people's needs around equality and diversity are considered as part of the care planning process.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability,

impairment or sensory loss and in some circumstances to their carers.

● Staff used various communication techniques to help them support people who experienced barriers in communication. For example, one person was deaf and their relative told us, "Staff write things down for her to read – they still manage to have a laugh together that way."

● Care plans included information about people's communication needs and how staff should make sure they were understood.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Staff supported people to meet their social and emotional needs. Staff were aware of the risk of people becoming lonely if they did not have family members with them throughout the day and told us how they made the effort to maintain social conversation during care visits. For each person who used the service, the provider gathered information about the people who were important to them and whether they needed support to maintain contact with them.

● Care plans did not contain information about people's hobbies, interests or life history. Although people fed back that staff took the time to get to know them well, this meant new staff would not have the information they needed to engage people in conversations about things that were important to them and help prevent them from feeling isolated and bored. We discussed this with the registered manager, who told us they would consider how best to capture this information.

Improving care quality in response to complaints or concerns

● People told us they would feel confident making a complaint if they needed to and knew how to do so. One person said, "The manager told me to call if I have any problems." Another person's relative said, "The manager has good problem solving skills and will sort out any issues before they become complaints."

● The service had not yet received any formal complaints, but there was a clear complaints policy which people had a copy of along with a blank complaint form they could complete if they needed to.

End of life care and support

● At the time of our visit, the service was not yet providing end of life care as part of their services. However, the provider was planning to develop this and had plans to access relevant advice and training for staff.

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.

This was the service's first inspection. At this inspection this key question is rated 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.

Continuous learning and improving care

- The provider's audits and checks were not always effective in identifying improvements that were required. For example, their care plan audits had not identified the problems we found with missing or out of date information. After the inspection, the provider contacted us to tell us how they were addressing this issue. We will follow this up at our next inspection.
- The registered manager carried out weekly checks of medicines records. However, they had not identified the problems we found with the lack of information about medicines and administration records for some people. After the inspection, the provider sent us evidence that they had started to address this.
- The registered manager carried out regular spot checks to ensure staff were providing high quality care to people. People and their relatives confirmed they were kept informed and understood the purpose of these visits. Staff felt this helped them to ensure they were providing the best quality care they could.
- We saw examples of when the registered manager identified issues with the quality of care and addressed them, for example when spot checks showed a need for extra staff training or supervision.

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

- People told us the registered manager was "approachable and kind" and "very nice, approachable and helpful." A relative said they were "always willing to go the extra mile." Staff told us the registered manager was supportive and caring towards them.
- The service had an open and inclusive culture. People, staff and relatives felt they could always express their views to the management because they would be listened to and would not be judged unfairly.
- The registered manager told us it was important to them that the service maintained a person-centred culture that made people feel valued. They gave examples of how they did this, such as calling a person during their hospital admission to check how they were feeling and provide some stimulation.

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; Working in partnership with others

- People, staff and relatives told us the registered manager was open and honest with them. We saw examples of this in notes from staff meetings, where the registered manager discussed their plans for the service.
- The provider worked closely with the local authority that commissioned care for people who used the service. This included communicating with them about anything that went wrong. The local authority carried out visits to the service to check the quality of care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Staff had the information they needed to be clear about their roles and do their jobs well. The registered manager used various methods of sharing information such as staff meetings, memos and text messages.

● The registered manager carried out assessments to ensure staff were competent before they were allowed to carry out complex or risky tasks such as administering medicines. If they identified any issues they communicated these to staff so they knew what they needed to improve.

● Staff had regular opportunities to discuss risks to the service and to agree what their duties were in terms of reducing the risks.

● At the time of our inspection, there were no formal arrangements in place to ensure the service was appropriately led and managed if the registered manager unexpectedly had to take time off. However, the provider was aware of this issue and was in the process of recruiting full-time office staff and training existing staff into more senior roles.

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

● Staff had regular opportunities to express their views and contribute to the running of the service.

● The provider engaged and involved people and their relatives as fully as possible. People confirmed the registered manager contacted them regularly to seek their views about the service. The registered manager also asked people to complete feedback forms to help them assess the quality of the service and carried out visits to people's homes to check they were happy with their care. The feedback they received was positive.

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
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure care and treatment of service users was only provided with the consent of the relevant person or, where the service user was unable to give consent, that they acted in accordance with the 2005 Act. Regulation 11 (1)(2)(3).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure care and treatment was provided in a safe way for service users, by assessing such risks, doing all that was reasonably practicable to mitigate the risks, and ensuring the proper and safe management of medicines. Regulation 12 (1)(2)(a)(b)(g).