Care Expertise Group Limited

Maple Manor Care Home

Inspection report

3-5 Hardy Street
Nottingham
Nottinghamshire
NG7 4BB

Tel: 01159784299

Date of inspection visit:
22 July 2022

Date of publication:
12 September 2022

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
Maple Manor Care Home is a residential care home providing personal care to up to 16 people in one adapted building. The service provides support to people who require support with personal care and people with learning disabilities. At the time of our inspection there were seven people using the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right support
The service provided people with care and support in a safe environment, however improvements were required to ensure the home was always clean and well-maintained. Further work was required to ensure people were supported to personalise their rooms.
Whilst the provider worked with people to plan for when they experienced periods of distress, the guidance was not always fully implemented by staff.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People were supported to engage in meaningful activities, including support to travel wherever they needed to go.

Staff supported people with their medicines in a way that promoted their independence and achieved the best possible health outcome.

Right care
People's care, treatment and support plans did not always fully reflect their range of needs.

Staff understood how to protect people from poor care and abuse because they received and understood training on how to recognise and report abuse. Staff protected and respected people's privacy and dignity. They understood and responded to their individual needs.

The provider worked well with other agencies. People received kind and compassionate care.

Right culture
Whilst people received compassionate care, further improvements were required to ensure the staff always understood best practice in relation to specific needs people with a learning disability and/or autistic

people may have.

The provider continued to work on reducing staff turnover which supported people to receive consistent care from staff who knew them well.

Where possible, people and those important to them, including advocates, were involved in planning their care.

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 requires improvement (published 3 November 2021). The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections.

Why we inspected
This inspection was prompted by a review of the information we held about this service. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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.

The overall rating for the service has remained requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Maple Manor 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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment and good governance 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 from 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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our safe findings below.

Maple Manor 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 Health and Social Care Act 2008.

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 was completed by one inspector.

Service and service type
Maple Manor Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Maple Manor Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post. There has been no registered manager in post for over 18 months.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke to four relatives of people who use the service.

We spoke with the operations manager, manager, three support workers and a cook. We reviewed a range of records, included in part, four people's care records. We looked at two staff files in relation to recruitment, and a variety of records relating to the management of the service, including incident records and analysis.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. This increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Information about risks to people's health and wellbeing were not always comprehensive or up to date. For example, one person was at increased risk of choking, however there was no mitigation plan in place. Another person had a diagnosis of epilepsy but there was no mitigation plan on what to do in the event of a seizure. This increased the risk that in the event of emergency, staff would not know how to support people. The manager updated the risk assessments immediately, following our feedback.
- There was limited use of systems to record and manage concerns about risks. For example, one person frequently presented with distressed behaviour due to their mental health diagnosis. The person's care plan stated that all events of distress should be recorded in a behavioural chart. However, the staff did not consistently record the person's distressed behaviour. This increased the risk of staff not identifying triggers of distressed behaviour and the best ways to support the person.
- Recording of significant information regarding people's health and wellbeing, for example weight was not always accurate and Malnutrition Universal Screening Tool (MUST) for people at risk of losing weight was not always regularly reviewed.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our feedback, the provider reviewed all of the documents where shortfalls had been identified and provided us with assurances the documentation was now up to date.

Systems and processes to safeguard people from the risk of abuse

- People were protected from avoidable harm, abuse and discrimination.
- The provider had a safeguarding policy in place and the staff were aware of how to manage any safeguarding incidents.
- Staff received safeguarding training and understood signs of abuse and how to report them.
- All the relatives of people we spoke to felt confident their loved ones were cared for safely at Maple Manor Care Home.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Staffing and recruitment
● Safe recruitment processes were used to ensure only staff suitable for their role were employed at the service. Appropriate recruitment checks were carried out as standard practice.
● There were enough staff to meet people's needs and ensure their safety. The provider told us the staffing levels were based on the number and level of needs of people who used the service. The staff told us there were enough staff to support people.
● People's relatives, who frequently visited the service, told us they had no concerns about staffing levels and people did not have to wait for support.
● There were several people living at the home who received funding for additional staff support. We saw evidence of the additional support being provided in people's care logs and observed this taking place during the inspection.

Using medicines safely
● Staff responsible for administering medicines received appropriate training and managed medicines consistently and safely.
● We saw medicines were stored correctly and staff kept accurate medicines records.
● The provider had robust procedures in place to ensure people received their medicines as prescribed. Regular medicines audits took place to prevent errors.

Preventing and controlling infection
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some areas of the home, for example skirting boards and door frames in the communal areas were marked and scuffed and the taps needed descaling. This could reduce effectiveness of cleaning. We have signposted the provider to resources to develop their approach.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● 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 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.

Visiting in care homes
The provider aligned to government guidance on visiting in care home. Visitors were encouraged to present negative Covid-19 test results prior to visits taking place.

Learning lessons when things go wrong
● Staff understood their responsibility to raise any safety concerns.
● We saw evidence of incidents being recorded, investigated and reported appropriately.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained 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.

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

- Management had not always identified and managed risks to the quality of the service. For example, during our inspection we identified shortfalls in managing risks to people's health and wellbeing, such as risk of choking or weight loss.
- The provider had several audits in place, however some areas for improvements were not identified prior inspection. Whilst actions to drive improvements were taken following our feedback, these concerns had not been identified by the provider's own quality assurance processes. This increased concerns about the provider's ability to proactively learn and improve care.
- Maple Manor have been rated requires improvement for the past four inspections. The provider failed to make improvements over a prolonged period of time. For example, we identified shortfalls in the management of risks in the last three consecutive inspections.

Systems and processes in place to demonstrate safety was effectively monitored and managed were ineffective. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There is a legal requirement for the provider to have a registered manager. There has not been a registered manager in post for approximately 18 months. We are looking into this.

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

- Managers had a good understanding of the importance of equality, diversity and human rights and promoted these principles to the staff in team meetings and supervisions. However, staff did not always follow the guidance they had been given. For example, the language staff used to describe people's behaviour was not always person centred or reflective of understanding people's diverse mental health needs.
- Feedback we received about the leadership of the service was positive. One staff member said, "The mangers are very approachable and are always making sure everything is done right".
- People's relatives spoke highly about the management. One relative said, "The [manager's name] is very good. They are trying to get people more involved for example by arranging meaningful activities".

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

● Whilst there was no evidence of incidents notifiable under the duty of candour since the last inspection, the manager understood their responsibility under duty of candour.

● The manager was open and transparent and investigated concerns and complaints received in line with the provider's complaints policy.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider had involved people and their family in running of the service. People and relatives were invited to attend meetings to discuss issues that may affect them. One relative said, "They [providers] have meetings and they inform me when they are".

● Staff meetings took place. We saw minutes of the meetings which evidenced that relevant, current issues were discussed with the staff.

● The provider worked well and effectively with other agencies. For example, since the last inspection, the provider initiated regular meetings with CQC to inform of any issues and improvements in the service.

● The staff made referrals to other health care professionals promptly to ensure people received support to achieve the best outcomes. For example, we saw evidence of staff working with dieticians and mental health care professionals.

● The provider had initiated partnership working to support people with their equality characteristics. For example, when a person lacked the capacity to make a decision, the manger involved Age UK advocacy services to ensure the decision was in the person's best interest.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been always been effective in assessing, monitoring and mitigating risks to the health, safety and welfare of people using the service This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found no evidence that people had been harmed however, systems were not robust enough to demonstrate safety was being effectively managed. This placed people at risk of harm.