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, which can accommodate up to 63 people. At the time of our inspection there were 49 people using the service. The service supports people across three floors, one of which specialises in supporting people who are living with dementia, and one of which provides nursing care.

People's experience of using this service and what we found
Robust systems were not fully in place to manage and mitigate risks to people. The manager was in the process of implementing processes and procedures, but they needed to become embedded and sustained.

Some key information was missing from some people's care plans. We have made a recommendation around this. Some staff were not sure what to do in the event of a fire. We have made a recommendation around this. Some areas of the environment were not always safe for people. The manager addressed this immediately following our feedback.

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.

Staff helped to keep people safe from the risk of avoidable harm. There were enough staff on duty to provide safe care to people. There had been changes within the staff team which had made some people feel unsettled. The manager had safe recruitment procedures in place. People received their medicines as prescribed. Some areas of the service required maintenance work, and the manager had a home improvement plan in place.

Audits had identified some issues we found on inspection, but not all. We received positive feedback about the manager and the ongoing changes to the service. Relatives gave mixed feedback about the quality of communication with the home. The manager and provider were open and transparent and committed to continuous improvement.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 8 April 2021) and there was a breach of regulation 12 (safe care and treatment). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulation 12. However, systems were not fully in place to manage risk which was a new breach of regulation 17 (good governance).

At our last inspection we recommended that the provider reviews their safeguarding procedures in line with best practice guidance. At this inspection we found the provider had made improvements.

The last rating for this service was requires improvement. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions safe and well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last comprehensive inspection to calculate the overall rating.

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

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 have found evidence that the provider needs to make improvements. 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 The Maple Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 a breach in relation to systems and processes to manage risk. Please see the action we have told the provider to take at the end of this report.

We have made recommendations around reviewing people's care plans and reviewing staff knowledge and competency in the event of a fire.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 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
Two inspectors and an Expert by Experience carried out the inspection. 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 and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Maple Care Home is a care home with 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 CQC 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 the inspection, the service had a manager who was in the process of becoming registered with the CQC.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 31 August 2022 and ended on 9 September 2022. We visited the service on 31 August 2022.

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 sought feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with five people who used the service and 12 relatives about their experience of the care provided. We spoke with 14 members of staff including the manager, a nurse, senior care workers, care workers, kitchen staff and the maintenance person. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included six people's care records, three staff recruitment files and multiple medication records. A variety of documents relating to the management of the service, including policies, training records, maintenance records and quality assurance documents were also reviewed.

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. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection, 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12. However, further improvements were needed to ensure risk was consistently and robustly managed, and positive changes sustained.

● Risks to people were not always robustly managed. However, the manager had only been in post a short period of time and had identified areas for improvement. The manager had implemented action plans around identified risks. Actions needed to be completed and changes needed to become embedded and maintained.
● The manager and senior staff were in the process of reviewing and re-writing people's care plans and risk assessments. Some key areas contained robust and person-centred information. However, other areas lacked important information around risk. For example, one person was at risk of developing pressure ulcers, but did not have a care plan in place around this to help support staff keep this person safe.

We recommend the provider reviews people's care plans and risk assessments to ensure all key information around risk is recorded and there is sufficient information for staff to help them manage those risks.

● Some staff were still not confident in the event of a fire. The manager had carried out a fire drill in July 2022 and identified this. The manager told us weekly fire drills were to be implemented in response. However, these had not started at the time of our inspection. Staff comments included, "I wouldn't know what to do if there was a fire" and, "I haven't had fire training or done a mock evacuation."

We recommend the provider reviews staff competency and knowledge around fire procedures to ensure all staff are confident in the event of a fire.

● The environment was not always safe for people. Cleaning products had been stored in cupboards which were accessible to people who may not understand the risks posed by the products. The manager had previously addressed this with staff, but staff had not embedded the practice of storing cleaning products safely. The manager addressed this with staff again immediately after our feedback.

● The manager had introduced new systems and processes for monitoring risk. For example, recording weekly weights and daily monitoring of fluid intake, where appropriate. These systems were new and needed to become embedded into staff practice.

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.

Systems and processes to safeguard people from the risk of abuse

At our last inspection we recommended the provider review their safeguarding procedures in line with current best practice. The provider had made improvements.

● Staff helped to keep people safe from the risk of avoidable harm. Staff had received training in safeguarding and knew what to do if they had any concerns. Staff told us the manager would act on any concerns straight away.
● Staff recorded all incidents and took appropriate action. The manager reviewed incidents and looked for trends.
● Most people felt safe living at the service. One person told us, "I feel safe here and I am happy to raise concerns when I have them."

Staffing and recruitment
● There were enough staff on duty to provide safe care to people. The manager adjusted staffing levels based on feedback from staff and observations.
● There had been some changes within the staff team and some agency staff had been used in the service. People and relatives told us this made them feel unsettled, and staff did not always know their needs. People and relatives said, "I feel very unsettled and I am tired of explaining my needs to the staff" and, "Some staff provide good care, but others don't seem to know the residents."
● The manager had safe recruitment procedures in place and carried out appropriate pre-employment checks.

Using medicines safely
● Medicines were managed safely, and people received their medicines as prescribed.
● Staff stored most medicines appropriately. However, some people were prescribed thickener which was put in their fluids to reduce the risk of choking. Staff had not stored this securely and this was potentially accessible to others. The manager addressed this immediately after our feedback and assured us this would now be kept in a locked container.
● Staff did not always clearly record why medicines prescribed on a 'when required' basis had been administered. Staff did not record whether 'when required' medicines were effective. The manager

introduced these additional records immediately following our feedback.
● The manager had implemented detailed risk assessments and care plans for people who self-administered their medicines. The manager supported this practice, where appropriate, to encourage independence. They had robustly considered the risks involved and provided guidance for staff to follow.

Preventing and controlling infection
● We were somewhat assured that the provider was using PPE effectively and safely. PPE was not always disposed of in appropriate bins. The manager rectified this immediately after our feedback.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some areas of the service required maintenance work or refurbishment. The manager had implemented a home improvement plan to address these issues.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● 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.
● The provider did not have any visiting restrictions in place at the time of our inspection.

Learning lessons when things go wrong
● The manager learnt lessons when things went wrong. They had implemented multiple action plans since coming into post. The manager and provider were committed to continuous learning and improvement.
● The manager carried out a 'lessons learnt' exercise following incidents. They then communicated lessons learnt to staff in handovers, meetings and supervisions.

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

- The manager and provider had not fully adopted effective and robust systems to ensure risk was suitably managed. Further improvements were required, including around risk management, fire safety and the safety of the environment.

Systems had not been established to fully manage risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager had produced several action plans to help drive improvements. The provider had commissioned an external quality audit which was due to take place shortly. Positive changes were therefore ongoing, but these needed to be completed and maintained.

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

- The manager and provider had created a positive culture within the service. One staff member told us, "Things are improving and staff, I think, are becoming happier." The positive culture and ongoing improvements needed to become embedded throughout the service and sustained.
- We received positive feedback about the new manager. Staff comments included, "I don't think we could have a better manager; she is doing a fantastic job. She wants things done in a certain way which is always in the residents' best interests" and, "The management now is spot on. The manager is putting things in order and moving things forward in a good way."
- Most relatives told us they would recommend the service and there was a pleasant atmosphere. Feedback from relatives included, "The staff are lovely and approachable" and, "It's a friendly place."

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

- Generally, the manager and provider engaged well with people using the service. Residents' meetings were held, and people were asked for their views.
- We received mixed feedback from relatives about communication with the service. One relative told us, "I'm kept well updated and we get letters from [the provider]." However, one relative told us, "It's left for me

to find out what's happening. They don't tell me or update me."
● The manager had increased communication and engagement with staff. They held regular meetings and supervisions. Staff told us the manager was approachable and would act on any concerns straight away.
● The manager and the provider worked well with other professionals. Both the manager and provider were welcoming and open throughout the inspection process. Professionals spoke positively about the manager and the positive direction the service was going in.

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 provider and manager understood their responsibility to be open and honest when things went wrong. Most relatives told us they were notified straight away about any incidents. Relative comments included, "[Person] has had a couple of falls and they've phoned me up straight away" and, "If anything had happened to [person], they ring me up."
● The manager ensured that lessons learnt were communicated to staff. The provider told us learning from incidents would be shared openly with their other services to help improve outcomes for people.

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 17 HSCA RA Regulations 2014 Good governance Systems had not been established to fully manage risks to the health, safety and welfare of people using the service. Regulation 17(1) and (2)(b)