Review of compliance

Maple Health UK Limited Maple Lodge	
Region:	East
Location address:	247a Berechurch Hall Road Colchester Essex CO2 9NP
Type of service:	Care home service without nursing
Date of Publication:	May 2012
Overview of the service:	Maple Lodge is a small residential home for five people with learning and physical disabilities and who may have autism.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Maple Lodge was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 12 - Requirements relating to workers
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 26 March 2012, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

The people who lived at Maple Lodge had different ways of communicating such as through words and sounds, gestures and body language. They did not respond to many of the questions that we asked them. We saw that people were engaged in different activities and were supported and respected by the staff team during our visit.

What we found about the standards we reviewed and how well Maple Lodge was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

The provider is not compliant with this outcome. Whilst we saw that people were respected and offered choice during our visit by the staff, there was little evidence in the systems and processes to show that people had a person centred service which met their diverse and complex needs.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The provider is not compliant with this outcome. People who use the service cannot be assured that they will have personalised care and support that meets their needs and protects their rights.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The provider is not complaint with this outcome. People cannot be assured that they will be restrained in a safe, lawful and non excessive way.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

The provider is compliant with this outcome. People using the service are cared for by staff who have been safely recruited.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider is not compliant with this outcome. The home does not regularly assess and monitor the quality of the service it provides to ensure that people receive a good quality service.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are moderate concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
The people who lived at Maple Lodge had different ways of communicating such as through words and sounds, gestures and body language. They did not respond to many of the questions that we asked them. However, we saw people interacting with staff in a positive and relaxed way.

Other evidence
The deputy manager told us that people were more involved than they had been previously in making decisions and choices about their lives. People were involved in assisting with household tasks such as shopping and cleaning their rooms, deciding on meals, community activities and time spent with their family. We saw that a weekly calendar of activities had been put in place for one person to provide them with focus and structure so that they knew which activity they would be doing on any given day.

Some people who used the service could make choices about everyday things, for example what they wanted to do and where they wanted to go. However, for other people this was more complex, as making the smallest of choices could be difficult. Shopping for clothes for some people was difficult but with support they were encouraged to make appropriate choices whilst still keeping their individuality.

We saw pictures and photos around the home to assist with communication and understanding, but no one had their own individual communication system such as their own pictures or words to help them express themselves. We were told that communication passports were being developed so that when people go out they are able to be better understood by people they met in the community.

We were told by the staff that one person used Makaton sign language but that they had not received any training to engage well with this person or encourage them to use Makaton to make their needs known. The staff had requested this but we did not see this was on the planned training programme.

Some of the care plans we saw provided a profile of the person, their spoken language and religion, their funeral plans and some details about their emotional and sexual health. They were signed by people using the service. However, we were told that people who use the service were not involved in any aspect of the content of the plans or in reviewing them. They were also not in a style that people could understand.

Specialist support had been provided for people with regards to sexuality and sexual relationship issues which had helped them understand and manage, with support, their feelings and emotions. We were told that the staff were not qualified or comfortable in discussing these issues with people and so it was important for specialist support to be provided. A referral had been made to a specialist community nurse to do a session for the staff on sexual awareness.

We saw that the staff involved people who used the service in day to day activities, communicated in a clear and respectful way and offered choices so that people could be in control of making decisions for themselves with support.

Our judgement
The provider is not compliant with this outcome. Whilst we saw that people were respected and offered choice during our visit by the staff, there was little evidence in the systems and processes to show that people had a person centred service which met their diverse and complex needs.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
The people who lived at Maple Lodge had different ways of communicating such as through words and sounds, gestures and body language. They did not respond to many of the questions that we asked them. One person told us that they liked going out a lot and they liked having a beer.

Other evidence
Maple Lodge provides care and intensive support for five men with high support needs. Three people needed one to one support, two people needed two to one support and all had two to one support when outside of the home. People did a range of activities which included going to college and clubs, playing on the Wii, arts and crafts, going to leisure world, playing football and pool, pub lunches, kareoke, woodwork and cycling. Listening to music and watching DVD's was very popular. Most people had contact with their family on a regular basis.

During our visit we looked at two people's care plans. These included a personal profile with photo, support plan, details of medical and professional visits, Mental Capacity Act assessments for capacity around meals and meal times, restraint, future planning, religion, personal development, community access and dealing with finance. There were details on the need to infringe a person's rights for medication, personal care tasks and behaviour and risk assessments for mobility, meal preparation, emotional moods and social activities. The health action plans were not dated and no input from the person's whose plan it was. We saw one health action plan that was in Widget symbols and we were told that the person could not understand it because they do not

use Widget symbols.

The care plans were difficult to read, repetitive and confusing. They were not in an accessible format to enable an individual to understand them. It was difficult to gain an understanding of someone's up to date care and support needs from their care plans which could mean staff not having current, relevant and important information about that person's changing needs. Staff had signed to say they had read the care plans when they first started work.

Meetings and reviews of care plans had taken place in 2010 and 2011 with the person using the service being present. One review had included an advocate.

Work was underway to review the care plans and make them more accessible, up to date and effective. A range of pictures, easy words and symbols to form individual communication passports were being produced so that people had information about themselves for when they needed to use health services and to be able to communicate with shopkeepers and the Police if they got lost.

We saw a range of daily diaries for three people. These included one which detailed moods, activities, food and drink, personal care, events, incidents, the temperature of the water, medication administered which was double signed by another worker and daily living skills done. Another daily diary recorded people's food and drink intake and another recorded how people felt that day and staff had been instructed to ask people everyday and record this. All were comprehensive and clear but the duplication of information was unnecessary.

Our judgement
The provider is not compliant with this outcome. People who use the service cannot be assured that they will have personalised care and support that meets their needs and protects their rights.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are major concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We saw that people were given guidance, boundaries and prompts to remind them about their language and behaviour which kept them and others around them safe.

Other evidence
The necessary safeguarding of vulnerable adults from abuse policy and procedures including the Southend Essex and Thurrock safeguarding protocols and guidance were in place. The manager and deputy manager knew how to use them

There was a high ratio of staff to people who use the service as everyone had either one to one support and, when they are outside of the home for example, needed two to one support. This ensured that people, and those around them, were kept safe and protected.

All of the staff had received safeguarding of vulnerable adults from abuse training in 2011 and new staff had received this in 2012. Staff told us that they knew what kinds of abuse to look out for and what they should do about it. We saw training certificates on staff files and staff confirmed that they had received training and it was very useful.

We saw from the training programme that eight senior staff had received Securicare restraint training in 2010 and of those eight, only four senior staff with the relevant training, were available to cover all the shifts. On the day of our visit, we spoke to the staff about what they would do if someone needed to be restrained, they told us that the deputy manager would deal with this as they were trained and knew what to do. The

deputy manager confirmed that whilst they knew how to restrain people safely, they had not received any training.

Due to people's complex needs, everyone had Mental Capacity Act assessments in place which protected their interests. People's finances were administered through Essex Guardian's and one person had their own bank account. More effective systems and processes for administering people's finance in the home such as petty cash for personal items, clothes and activities were being developed and implemented.

We saw leaflets on the board in the hall about being kept safe in easy words and pictures as well as other information for people who use the service.

On our visit, we saw that some staff were not dressed in the most appropriate way to be working with vulnerable people. We spoke to the deputy manager about this and they agreed that this needed to be dealt with.

Our judgement
The provider is not complaint with this outcome. People cannot be assured that they will be restrained in a safe, lawful and non excessive way.

Outcome 12:
Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

The provider is compliant with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
We did not talk to anyone at the service about requirements relating to workers.

Other evidence
We looked at the recruitment records for two staff. The necessary checks had been carried out prior to appointment and included an application form with employment history, relevant identification, criminal records bureau check, two references, job description, terms of employment and a completed induction programme which included all the basic requirements. The staff told us that the best things about working at Maple Lodge were the people who live there.

Staff had undertaken a range of training including manual handling, fire and health safety, food hygiene, first aid, safeguarding of vulnerable adults from abuse, mental capacity, person centred planning, challenging behaviour, infection control and risk assessments. The deputy manager told us that all staff were trained in administering medication but that a refresher course was planned for April 2012.

Staff had signed a supervision contract and we saw notes of supervision sessions undertaken during 2010/2011 and more current December 2011 and March 2012 which showed that staff were adequately supervised and supported in order to undertake the responsibilities of their role.

Our judgement
The provider is compliant with this outcome. People using the service are cared for by

staff who have been safely recruited.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are major concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not talk to anyone at the service about monitoring the quality of the service

Other evidence
The deputy manager told us that the assessment and monitoring of the service was under review. No information in relation to quality assurance or audits could be found to show that the service assessed and monitored quality and outcomes for people who lived at Maple Lodge. Very irregular house meetings took place and the notes of the last one in September 2011 were very brief providing very little opinion and views from the three people who attended.

The service had a complaints leaflet available but no complaints or comments about the service had been logged in a complaints book. Families were asked their views about the service their relative received during the yearly review meetings held but this information was not recorded elsewhere to form any part of the provider's quality assurance process.

Our judgement
The provider is not compliant with this outcome. The home does not regularly assess and monitor the quality of the service it provides to ensure that people receive a good quality
service.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: Whilst we saw during our visit that people were respected and offered choice by the staff on duty, there was little evidence in the systems and processes to show that people had a person centred service which met their diverse and complex needs.	
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People who use the service cannot be assured that they will have personalised care and support that meets their needs and protects their rights.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: People cannot be assured that they will be restrained in a safe, lawful and non excessive way.	
Accommodation for persons who require nursing or personal care	Regulation 10	Outcome 16: Assessing

	HSCA 2008 (Regulated Activities) Regulations 2010	and monitoring the quality of service provision
	How the regulation is not being met: The home does not regularly assess and monitor the quality of the service it provides to ensure that people receive a good quality service.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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