Maple Health UK Limited

Maple House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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.

About the service
Maple House is a residential care home providing personal care and accommodation to 5 people at the time of the inspection. The service can support up to 5 people.

People's experience of using this service and what we found
Right Support: The model of care and setting did not maximise people's choice, control, and independence. 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. Staff were not adequately trained and did not always have the skills, knowledge and competence required. This included the routine and disproportionate use of non-recognised and unsafe physical restraint.

Right Care: Care was not consistently person-centred, or always provided in a way which promotes people's dignity, privacy, and human rights. People were at avoidable risk of harm, through poor management of incidents and safeguarding concerns. Staff did not recognise or act appropriately on poor practice. There were safety issues relating to medicines management, fire, and infection prevention control. Suitable risk assessments were not always in place, and some care records were out of date.

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive, and empowered lives. Governance and oversight measures were either not in place or ineffective to ensure the safety and quality of the service. There were multiple indicators of a closed staff culture, which included leaders, placing people at the ongoing risk of receiving poor 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 good (published 2 August 2018).

Why we inspected
The inspection was prompted in part due to concerns received about the unsafe use of physical restraint. A decision was made for us to inspect and examine those risks.

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.

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

Enforcement
We have identified breaches in relation to person-centred care, dignity and respect, the need for consent, safe care and treatment, safeguarding, governance, staffing and recruitment. Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

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 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
This inspector was completed by 2 inspectors and 1 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Maple House 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 House 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 28 September 2023 and ended on 11 October 2023. We visited the location's service on 28 September 2023 and 4 October 2023.

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 spoke with 4 relatives and 1 person about the care and support provided. We observed support in shared area of the service. We spoke with 6 members of staff including support workers, senior support workers, the care team leader, the registered manager, and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed 3 people's care plans and risk assessments, and a variety of medication records. We reviewed incidents and safeguarding matters for the service. We looked at staff files in relation to recruitment and staff supervision. We also looked at documents for oversight of the service, such as policies, procedures, and audits.

Inadequate

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- The provider had failed to keep people safe from the risk of avoidable harm, and staff did not understand how to protect people from abuse. Multiple incident reports showed staff using ad hoc, disproportionate and 'non-recognised' restraint without legal authority. This was contrary to national best practice guidance and the provider's safeguarding policy. Staff had either not received training in physical restraint or had last received the training in 2019. There was no restraint policy in place, and no detailed risk assessments to guide staff. The service did not always record the use of restrictions on people's freedom and managers did not review the use of restrictions to look for ways to reduce them.
- There were indicators of a poor and closed staff culture, with allegations of bullying, violence, and sexual misconduct or inappropriate personal relationships amongst some staff, contrary to the provider's own conflict of interest policy. This had the potential to directly impact people using the service. We reviewed 3 people's care plans which showed they all had sexual safety risk factors. Leaders had not acted to identify and mitigate the impact of inappropriate staff conduct in front of people, including where this was a known trigger for extreme anxiety and distress. This placed people at significant risk of harm.
- There was no effective investigation of incidents and safeguarding matters, and no action plans or analysis of themes and trends. This meant there were no lessons learned to reduce the risk of reoccurrence, including no credible vision for proactive restraint reduction, and poor practice continued. There was a blame culture at leadership level, placing the responsibility for the service's normalised unsafe practices on outside stakeholders. When safeguarding referrals were made to the local authority, the forms were poorly completed and lacked detail on the severity of the incidents they related to.

Systems and processes had not been established or operated effectively to protect people using the service from the risk of abuse or neglect. This placed people at risk of harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We raised our urgent concerns with the provider relating to the unsafe use of physical restraint. We also reported this to the police, and to the local authority safeguarding team.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

- Leaders failed to assess or act on known risks to people's safety and welfare. Risk assessments in relation to areas such as physical restraint, choking and fire safety were poor or not in place. Personal Emergency Evacuation Plan ('PEEPs') lacked sufficient detail on how to support people to safely leave the building in the event of a fire, including how to reduce distress or the potential impact of sedative medicines on people.

A person at risk of choking who had been referred to the Speech and Language Therapy team had no choking risk assessment in place.

● Staff did not consistently manage the safety of the living environment and equipment in it through checks and action to minimise risk. The provider's own audits had identified multiple fire doors which were not working correctly since April 2023, but no action had been taken to repair them. This placed people at an increased potential risk of fire and smoke spreading throughout the building in an emergency, including those with reduced mobility.

● Systems and processes to administer medicines safely were not always clearly in place or followed. We found 1 person's medicines profile which stated staff should crush tablets if not able to source them in liquid form but did not state what medicines this referred to. Some medicines cannot be crushed safely. There was no GP or pharmacist authorisation held on file.

● Another person had their PRN ('as required') medicine dose for supporting them when expressing distress changed by the registered manager, before consulting a healthcare prescriber. This did not ensure people's behaviour was not controlled by excessive and inappropriate use of medicines contrary to the principles of STOMP (stopping over-medication of people with a learning disability, autism or both).

● We reviewed medicines administration records (MARs) and found there were no gaps, showing medicines had been given as required. Stocks of prescribed medicines were correct according to records in the service. However, homely remedies were audited too infrequently, which meant we found a discrepancy. Staff confirmed those tablets unaccounted for had been disposed of. We also identified staff were counting down the balance of medicines for people who were not physically in the service, which posed a risk records could be confusing or inaccurate.

● The service did not consistently employ effective infection, prevention and control measures to keep people safe. Whilst some areas of the service were clean and hygienic, others were not. We identified rust to fittings and fixtures in a shared bathroom, as well as a worn toilet brush, mould to bath sealant and a cracked tile. Sofa upholstery had a rip in it, which meant it could not be effectively cleaned. We also found an inflatable plastic pool with organic matter and dirt in it. Stagnant water can act as a reservoir for harmful bacteria, placing people at risk of illness.

Systems were either not in place or robust enough to demonstrate safety was effectively managed relating to the health, safety and welfare of people. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's relatives told us they were satisfied with the cleanliness of the service. Despite the shortfalls referred to above in shared spaces, we saw people's bedrooms were clean, decorated and personalised. One person's relative said, "[Person's] is room is clean and very good." Some environmental checks were in place, including gas and electrical safety.

● We asked the registered manager to take immediate action to assess the risks we identified relating to choking and fire safety. The service also confirmed action would be taken to improve medicines practice following our feedback.

Staffing and recruitment

● There were processes in place for recruitment checks on new staff, including with the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. However, compliance with this was inconsistent. We found 1 new staff member had started work without a full employment history and before receiving 2 references. There was no risk assessment or enhanced induction to ensure they were safe and competent.

Safe recruitment checks were not completed to ensure all staff were suitable for the role. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were sufficient staff numbers deployed to support people within Maple House, but not to ensure good access to leisure activities outside of the service. We received some mixed feedback from people's relatives about staffing. One person's relative said, "I think there are enough staff." Another relative said, "[Maple House] could communicate better. I sometimes go and the staff are unfamiliar, but there are enough staff."

Visiting in care homes

● People were free to receive visitors to maintain contact with those important to them.

Inadequate

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff support: induction, training, skills and experience

- The provider failed to ensure people's care and support reflected current evidence-based guidance, standards and practice, and care was not always provided to meet people's assessed needs. Care plans were of variable quality. Whilst some parts of people's care records had a good level of detail and personalisation, other parts were of poor quality, out-of-date, or contrary to best practice. Some staff told us they had not read care plans or were not sure of people's needs.
- People were not supported by staff who had received relevant and good quality training in evidence-based practice in all areas, or fully understood the principles of training they did receive. This included training in the wide range of strengths and needs people with a learning disability and or autistic people may have, mental health needs, communication tools, positive behaviour support, trauma-informed care, human rights and all restrictive interventions. This impacted on people's needs being consistently met.
- As a result, staff were not trained or confident to carry out physical restraint, and the skill mix for doing so was incorrect. One staff member said, "Because of staff confidence, difference in height, we have quite a few female team members. It's difficult." This had led to staff being injured on occasions. Teams did not hold debriefing meetings or reflect on their practice to consider improvements in care following incidents.
- Staff did not receive support in the form of good quality supervision, appraisal, and recognition of good practice. The registered manager did not always give honest feedback on staff performance to support them to improve. For example, 1 staff member who had shown significantly poor practice during an incident received an appraisal 1 month later stating they were 'good' or 'excellent' in all areas. When allegations of a safeguarding nature were made against staff, the registered manager did not act promptly to suspend them whilst investigating concerns.
- Following our urgent concerns, the registered manager took action to book physical restraint training for staff. However, this had not been independently acted on or prioritised despite being a known risk. The registered manager confirmed to inspectors the decision not to source specific training prior to our feedback was for financial reasons.

The provider had failed to ensure sufficient numbers of suitably qualified, competent, and skilled staff were deployed to ensure safe, good quality care. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Staff did not consistently demonstrate best practice for assessing mental capacity, supporting decision-making and best interest decision-making. Some decisions were made contrary to people's best interests. For example, the registered manager made a best interests decision for a person to be restrained by staff using techniques staff were not trained in.
● There was no oversight system for DoLS, and we found DoLS application outcomes had not been notified to the CQC as required by law. We found conditions relating to DoLS were not always met, including a condition explicitly stating non-recognised restraint methods must not be used.

Suitable arrangements were not in place to gain consent from people using the service or those acting on their behalf or to act in accordance with the requirements of the Mental Capacity Act 2005. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care plans recorded some information on capacity and consent. The registered manager told us DoLS had been applied for at the service when needed.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were referred to health care professionals to support their wellbeing and help them to live healthy lives, such as the specialist epilepsy nurse, the GP, and physiotherapy. One person's relative told us, [Staff] acknowledged my feedback about my [person's] doctor's appointment and make the appropriate referrals." Another relative said, "I am quite sure [my person] gets regular appointments with GP and health services."
● People had health actions plans / health passports which were used by health and social care professionals to support them in the way they needed. However, outside of health-related referrals, the service did not always demonstrate good partnership working with other stakeholders, which impacted on joined up care and good outcomes for people.

Supporting people to eat and drink enough to maintain a balanced diet
● People received support to eat and drink enough to maintain a balanced diet. One person's relative told us, "[Staff] try to do home cooking and [my person] always has a roast dinner on Sunday." Another person's relative said, "I am happy [my person] gets a good diet. [Staff] are monitoring [person's] diet, and we are checking [person's] weight." People were involved in choosing their food, shopping, and planning their meals, and staff encouraged healthy eating.

Adapting service, design, decoration to meet people's needs

● The service was in good decorative order in most areas, and people had personalised their rooms. One person showed us their bedroom which showed their interest in sports. Another person frequently visited an art café had created artwork which was displayed on their bedroom door. There was access to a shared outside space, including use of a hot tub.

Inadequate

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence

- The provider failed to put in place systems, processes, and resources to enable staff to provide a caring service. This included poor training, staff deployment and ineffective supervision, leaving staff to provide intuitive care. There was a lack of provider oversight and action was not taken to address known risks and shortfalls in the service, including multiple closed culture warning signs. This meant staff did not respect and promote people's privacy, dignity, and autonomy at all times.
- Staff did not ensure people were protected from exposure to any environmental factors they would find stressful. People were at risk of degrading and uncompassionate treatment when distressed and at risk of self-harm. Staff had not escalated these very serious concerns to external authorities, through whistle-blowing or safeguarding channels. There was limited understanding or evidence of emotional support and reassurance for people following incidents or restraint.
- Whilst staff spoke warmly about the people they supported, care plan records contained demeaning and disrespectful language to describe people, which could impact on their confidence, well-being, and self-esteem. This included stating how "[Person] will try to play staff off against one another to get [their] own way" and how another person would, "…manipulate a situation to get what [person] wants." People were described as "very argumentative", "demanding" and having "violent and aggressive behaviours" such as "lashing out at staff."

The provider failed to support people in a respectful and dignified way. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some care plans were clear in guiding staff how to support and promote people's independence, for example, setting out how they would like to be supported with their personal care.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- Staff supported people to maintain links with those that are important to them. One person's relative said, "The staff are very responsible nice people, and they do a lot." Another relative said, "The staff are very pleasant and helpful." Whilst we received positive feedback from people's relatives, there was significant variation in people's quality of life depending on their level of support needs and how staff responded to them.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to 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; 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 did not always speak knowledgably about tailoring the level of support to individual's needs and people's changing needs were not always responded to in a person-centred way. We spoke with 1 staff member who was not aware a person they were supporting was autistic. This meant they would not be able to provide personalised support. Some care records made inappropriate blanket statements which did not reflect best practice models of care, such as stating an autistic person, 'lacked empathy towards others.'
- Plans for maintenance and redecoration were not tailored to all people's needs and preferences living at Maple House. For example, one health and safety audit stated there were no plans to decorate a shared space until 1 person moved out.
- Changes to routines and preferred leisure activities were not always planned or well managed, including the social and emotional impact of this on people. Whilst some people enjoyed meaningful leisure time, others did not have choice and control, were subject to disproportionate restriction and excluded from having the best possible quality of life. One staff member said, "We do the best we can and have been calling out for help."

People were not supported in a way that was personalised and specifically tailored to meet their needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some of the people living at Maple House were supported to participate in their chosen social and leisure interests on a regular basis One person's relative told us, "[Person] loves to go out and about to football, shopping for food, swimming and bike rides."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Care plans recorded people's communication needs, and there was information available in accessible formats, such as 'Easy Read'. We saw evidence of information being communicated in a way people preferred, such as a holiday countdown calendar. There were visual structures including photographs which

helped people know what was likely to happen during the day and who would be supporting them. One person's relative said, "What works well is that [Maple House] have an activity chart with pictures of staff on duty. It tells you where they are going and who with. I think this is important."

Improving care quality in response to complaints or concerns

● The registered manager told us there had been no recent complaints at Maple House, but a complaints policy was in place in case required. One person's relative said, "We have our differences, but we work it out between us. I have never made a complaint."

End of life care and support

● All of the people living at Maple House at the time of inspection were young adults, and there was no one receiving end of life care. Information was recorded in some people's care plans on areas such as religious beliefs and who to contact in case of serious illness, where they chose to discuss this.

Inadequate

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 good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Management and staff did not put people's needs and wishes at the heart of everything they did, including a failure to respond to known risks. Many decisions were directly to benefit staff or for financial reasons, and did not consider people's preferences, needs or best interests. This included the failure to address deficits in physical restraint training, or to replace vital safety equipment such as fire door mechanisms. When the provider did not promptly receive funding from 1 commissioning authority, they stated they would withdraw safe staffing of a person's care with little notice in response.
- Staff did not feel able to raise concerns with managers without fear of what might happen as a result. We saw comments from staff who stated when they had raised concerns they had been removed from the rota. The registered manager was aware of the formation of staff cliques. This was a significant closed culture risk, reducing the ability of staff to speak up safely. Managers did not set a culture that valued reflection, learning and improvement.
- The service was not being provided in a way which is compliant with the CQC's Right Support, Right Care, Right Culture guidance, or other national best practice guidelines to meet people's needs in this type of specialist setting.

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

- The provider failed to understand their legal responsibility to keep people safe from the risk of harm and did not take accountability and apologise when things went wrong, instead blaming other stakeholders. The registered manager was unable to confirm a duty of candour policy was in place for the service and was unable to meet their duty of candour responsibilities as some incidents were not being identified. This meant they could not be acted upon openly and transparently.

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

- Governance processes were not effective in helping to hold staff to account, keep people safe, protect people's rights and provide good quality care and support. Audits were inappropriately delegated to staff without the skills and competence to complete them, which meant areas of concern were missed or not acted upon appropriately. This includes disrespectful language not identified in care plan audits, as well as concerns with infection control, medicines, and fire safety. There was no effective management oversight of incidents and safeguarding concerns, and no formal audits of daily care notes to check for any issues or

triggers to distress.
● Policies and plans were not always tailored to the service. For example, the business continuity plan referred to another service and the risk of isolation from the mainland caused by high tide which was not relevant at Maple House. This placed people at risk in the event of an emergency, as there was insufficient guidance for staff.
● Improvements from issues identified at previous inspections were still ongoing. For example, we found gaps in records of water temperatures at our 2018 inspection. At this inspection there were none recorded for the last 3 months.
● Basic regulatory requirements were not met, such as ensuring statutory notifications were sent to the CQC for police incidents, DoLS application outcomes, serious injuries, and safeguarding matters. This is a legal requirement to ensure the CQC has oversight of any risks at the service. The provider had also failed to display its CQC rating on the company website.

The provider had failed to ensure there were effective systems in place to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff and relatives told us they found the registered manager supportive. One person's relative said, "The manager has everything in order." Meetings and surveys took place to involve people living at Maple House to share their views.

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 11 HSCA RA Regulations 2014 Need for consent Suitable arrangements were not in place to gain consent from people using the service or those acting on their behalf or to act in accordance with the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment checks were not completed to ensure all staff were suitable for the role.