Laycraft Ltd

Maplin House

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

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
Maplin House is a residential care home and was providing accommodation and personal care to eight people at the time of the inspection. The service can support up to 16 people living with a learning disability and/or autism.

People's experience of using this service and what we found
Not all risks to people's safety were assessed, mitigated and up to date to ensure they were kept safe. Improvements were required to ensure the security of medicines. Though there were the required numbers of staff on duty, one of these was undertaking training which meant there were not enough numbers of staff deployed to meet people's care and support needs. People were not always supported to be independent and make decisions.

Quality assurance arrangements were in place to monitor the quality of the service provided. Whilst there was evidence available to demonstrate improvements had been made since our last inspection to the service in September 2021, The quality assurance system had not identified issues found during our inspection. This needed to be embedded into the service's day to day ongoing monitoring.

Suitable arrangements were in place to ensure the right staff were employed at the service. People told us they had no concerns and that the service was a safe place to live. Interactions between people using the service and staff were relaxed and comfortable. The service was clean and odour free. This inspection highlighted lessons had been learned and improvements made since our last inspection in September 2021.

The service was not able to fully demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right Support:
• The service was a large residential property that comprised of 12 bedrooms within the local residential area. There were no visible signs to reflect from the outside, to show Maplin House was a care home. Most people had lived together at Maplin House for many years.
• People had their own rooms which had been personalised. People were able to use communal areas as they wished and to have privacy for themselves. However, the décor of the service required significant improvement.
• Improvements were needed to promote and develop some people's independence and to support them to

be better involved in making choices and decisions about the running of the home.

Right Care:
• Staff were caring and treated people as individuals. Better support was required to enable and facilitate people using the service to access the local community.
• Staff knew people well and understood how to communicate with each person.

Right culture:
• The ethos of the service was family orientated and we saw that people were comfortable and liked where they lived.
• There was a stable team of staff at Maplin House, of whom various staff members had worked at the service for a significant period of time. This meant people using the service received consistent care from staff who knew them well.

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

Rating at last inspection and update
The last rating for this service was Inadequate [published 12 October 2021].

The service has been in Special Measures since March 2021. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated Inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

We have found evidence that the provider needs to continue to make improvements and to imbed continued learning.

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support, right care, right culture and to check compliance with the Warning Notices issued in September 2021.

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.

Follow up
We will continue to monitor information we receive about the service until we 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 well-Led findings below.

Maplin House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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
Maplin 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. Maplin 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
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 sought information from the Local Authority. We reviewed information we had received about the service since it was registered. We used this information to plan our

inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with three members of staff and the registered manager. We reviewed four people's care files and two staff personnel files, including information about staff training and supervision data. We looked at the service's medication practices and information relating to the service's quality assurance arrangements.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed additional information relating to the service's quality assurance arrangements. We contacted two people's relatives so that we could talk to them about their experience of the care provided for their family member. We were able to speak with one relative.

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 the last inspection this key question was rated as Inadequate. At this inspection this key question has now improved to 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.

At our last inspection to the service in September 2021, the provider's recruitment practices were not safe. This was a continued breach of Regulation 19 [Fit and proper persons] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We issued a Warning Notice on 14 September 2021. Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 19.

Staffing and recruitment
• Suitable arrangements were in place to ensure the right staff were employed at the service. Since our last inspection in September 2021, relevant checks had been completed for one member of staff who had been reemployed and records were obtained where previous shortfalls had been identified.
• Staff told us staffing levels were appropriate to meet people's needs. This was confirmed as accurate by people using the service. Comments included, "There are always staff here" and, "Yes, enough staff." The registered manager confirmed they were not experiencing any workforce challenges which had a negative impact on service delivery.
• However, when we arrived at Maplin House, one member of staff who was rostered on duty was observed having an online meeting in the conservatory with their Qualifications and Credit Framework [QCF] assessor as part of ongoing distance learning. This meant there was only one member of care staff on duty instead of two to meet people's care and support needs. The registered manager told us this would be reviewed going forward.

Systems and processes to safeguard people from the risk of abuse
• We discussed safety with people using the service. People told us they had no concerns and that the service was a safe place to live. Interactions between people using the service and staff were relaxed and comfortable. People confirmed if they had concerns, they would talk to staff. One person told us, "I love it here, if I was worried I would tell someone."
• A relative confirmed they had no concerns relating to the safety of their family member. They told us, "Absolutely 100% X is safe at Maplin House."
• Staff demonstrated a satisfactory understanding and awareness of the different types of abuse, how to respond appropriately where abuse was suspected and how to escalate concerns about a person's safety to the management team and external agencies, such as the Local Authority and Care Quality Commission.
• The registered manager was aware of their responsibility to notify us and the Local Authority of any allegations or incidents of abuse at the earliest opportunity.

Assessing risk, safety monitoring and management
• Risks to people's safety and wellbeing were assessed and recorded for people currently living at Maplin House.
• However, no risk assessments were recorded for one person who was admitted to the service for respite care since our last inspection to the service in September 2021. Risks were not identified to mitigate the risk or potential harm for this person, for example, in relation to catheter care, skin integrity and moving and handling. This meant we could not be assured staff had all information required to manage the person's risks in a safe and effective way. The registered manager acknowledged this was an oversight and would not happen again.
• Staff showed an understanding and knowledge of people's individual risks and how to ensure their safety and wellbeing.
• Risks relating to the service's fire arrangements were monitored and included individual Personal Emergency Evacuation Plans (PEEP) for people using the service.
• The service's fire risk assessment dated February 2021 detailed there were areas for improvement. The action plan was blank giving no indication if the works highlighted had been actioned or not. This was discussed with the registered manager, and they confirmed the actions highlighted were completed.

Using medicines safely
• We looked at the Medication Administration Records [MAR] for each person living at the service. These were in good order, provided an account of medicines used and demonstrated people were given their medicines as specified by the prescriber.
• During the inspection the medication room was not always locked. The keys to the medication room were left in the lock and the dedicated fridge used for keeping medicines cold was not locked. This meant there was a potential risk, people not authorised could access the medication in the fridge. We brought this to the attention of the registered manager. They told us they would remind staff of the importance to keep people safe and monitor this going forward.
• Suitable arrangements were in place to ensure staff who administered medication were trained and competent to undertake this task safely and to an acceptable standard.

At our last inspection to the service in September 2021, the provider's arrangements for testing staff for COVID-19, was not in line with the Department of Health and Social Care published guidance. This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We issued a Warning Notice on 14 September 2021. Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 12.

Preventing and controlling infection
• We were assured the provider was preventing visitors from catching and spreading infections.
• We were assured the provider was admitting people safely to the service.
• We were assured the provider was using Personal Protective Equipment [PPE] effectively and safely. Staff confirmed there were always enough supplies of PPE available. Staff were observed to wear PPE in line with government guidance.
• We were assured the provider was accessing testing for people using the service and staff. Since our last inspection to the service in September 2021, the registered manager had introduced a robust system for COVID-19 testing for staff and people using the service. Visitors to Maplin House were not allowed entry unless they had proof of a negative lateral flow test.
• We were assured the provider was promoting safety through the layout and hygiene practices of the premises and that infection outbreaks could be managed.

Learning lessons when things go wrong

• This inspection highlighted lessons had been learned and improvements made since our last inspection in September 2021. The provider's arrangements relating to recruitment practices and risk management had improved, though further improvements were still required. The registered manager had introduced a robust system to ensure staff were tested for COVID-19 in line with government guidance.

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 the last inspection this key question was rated as Inadequate. At this inspection this key question has now improved to 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.

At our last inspection to the service in September 2021, the provider's quality assurance arrangements were not effective or reliable to ensure compliance with regulatory requirements. This was a continued breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We issued a Warning Notice on 14 September 2021. Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 17.

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

- Audit arrangements were in place to monitor the quality of the service provided in key areas and at regular intervals. However, though there was evidence available to demonstrate improvements had been made since our last inspection to the service in September 2021, these arrangements required improvement and embedding as they had not identified the issues found during our inspection.
- Since our last inspection in September 2021, the registered manager had completed an annual quality assurance report. The registered manager acted on their duty of candour and was honest to portray the service's current poor rating and ongoing scrutiny from the Local Authority.
- Whilst positive comments were recorded on the annual quality assurance report, the main emphasis of the report focused on the outcome of surveys completed by people using the service, relatives and staff. The report provided little or no review and evaluation of the service's overall quality assurance arrangements to demonstrate this was in line with the organisation's visions and values, both at service and provider level.
- The service's environment remained tired and worn, with many areas requiring improvement to the décor. The registered manager with support from the Local Authority, had implemented a Service Improvement Plan detailing where improvements were required, actions taken or to be taken and the date for completion. It was positive to note that a plan for refurbishment of Maplin House is planned throughout 2022.
- One relative told us staff put people's needs and wishes at the heart of everything they did. A family member told us, "Staff treat X as if they are a real person. I find the staff are very good, X wouldn't get that anywhere else. I do feel the care and attention X gets is second to none."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully

considering their equality characteristics
• The registered manager understood the importance of their role and responsibilities.
• Staff were positive about the registered manager and confirmed they had seen an improvement on how the service was run and managed.
• Since our last inspection to the service in September 2021, arrangements were in place for gathering relatives' views about the quality of service provided at Maplin House. Most comments recorded were positive. Comments included, "I consider my relative to be generally well cared for. Staff are helpful and caring. I could not wish for better care for my relative." and, "The care is excellent and that's the most important thing." Where negative comments were recorded, these related to the lack of community access for people using the service and the décor of the service. There was no action plan detailing how these areas were to be addressed and monitored.
• Staff meetings were held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service. Meeting minutes were evident but did not include an action plan detailing how areas for improvement highlighted were to be addressed and monitored.

Working in partnership with others
• Information available showed the service worked in partnership with key healthcare and adult social care organisations.