Laycraft Ltd

Maplin House

Inspection report

117-119 Church Road
Shoeburyness
Southend On Sea
Essex
SS3 9EY

Tel: 01702297494

Date of inspection visit:
07 September 2021

Date of publication:
19 October 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Maplin House is a residential care home and was providing care to eight people who have a learning disability, physical disability and/or living with dementia. The care home can accommodate up to 16 people in one adapted building.

People's experience of using this service and what we found
There was a lack of understanding and familiarisation with the COVID-19 national testing guidance as set out by the Department of Health and Social Care to keep service users and staff safe. The arrangements to prevent visitors from catching and spreading infections were not being followed. Recruitment practices continued to not be safe and operated in line with regulatory requirements. Staff rosters were not accurately maintained to determine the numbers of staff on duty on any given day or the hours worked. Some aspects of fire safety remained outstanding from our previous inspection to the service in February 2021. Although some improvements were noted since our last inspection in February 2021, quality assurance arrangements remain unreliable as the above shortfalls were not identified.

Information relating to people's individual risks were now recorded and mitigated for the safety of people using the service. Suitable arrangements were in place to ensure the safe management of medicines. People told us they felt safe and interactions between staff and people using the service were relaxed and comfortable. The service was clean, and staff wore appropriate Personal Protective Equipment [PPE].

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 10 March 2021] and there were three breaches of regulation. 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 not all of the improvements had been made and the provider remained in breach of these regulations.

Why we inspected
We undertook this focused inspection to check whether the Warning Notices we previously served in relation to Regulation 17 [Good governance] and Regulation 19 [Fit and proper persons employed] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. We also reviewed concerns raised by the Local Authority following an announced quality monitoring visit to Maplin House in July 2021. The overall rating for the service has remained Inadequate.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to COVID-19 testing for staff employed at the service at this inspection and continued breaches relating to the provider's governance arrangements and recruitment practices.

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 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 work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

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
This was a focused inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 17 [Good governance] and Regulation 19 [Fit and proper persons employed] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and to review additional concerns raised by the Local Authority following their announced quality monitoring visit to Maplin House in July 2021.

As part of this inspection we also 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 or personal care as a single package under one contractual agreement. 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 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 the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We sought feedback from the Local Authority. We took this into account when we inspected the service and made the judgements in this report. We used all of this

information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with three members of staff and the registered manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at three staff files in relation to recruitment and reviewed information relating to staff's induction and training. Other information relating to the management and quality assurance arrangements were also viewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at the provider's monthly reports and reviewed staff information relating to COVID-19 testing.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same.

This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection
• The provider and registered manager demonstrated a lack of understanding and familiarisation with the COVID-19 national testing guidance as set out by the Department of Health and Social Care to keep service users and staff safe and to contain any potential outbreaks.
• The guidance states the regular testing pattern for staff is a once weekly Polymerase Chain Reaction [PCR] and twice weekly rapid lateral flow test. Information provided showed six out of seven members of staff last completed a PCR test in June 2021 and there was no evidence of a PCR test for three members of staff. Information demonstrated there were significant gaps between staff members rapid lateral flow tests, and these were not being undertaken twice weekly.
• We were not assured the provider was preventing visitors from catching and spreading infections. The Department of Health and Social Care published guidance ['Testing for Professionals Visiting Care Homes'] on their website concerning COVID-19 testing for professionals visiting a care service. Staff employed at the service failed to ask the inspector for proof of a negative COVID-19 when they first arrived at Maplin House on 7 September 2021. The purpose of this was to demonstrate and provide evidence that the inspector was following the governments and Care Quality Commission's testing regime, therefore helping to keep service users and staff safe.
• There was no evidence of fire drills having taken place for both day and night staff employed at Maplin House since August 2015. This is important as it allows staff to practice evacuation procedures and to ensure they are fully aware of what to do in the event of a fire emergency.

This was a continued breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• We were assured that the provider was using PPE effectively and promoting safety through the layout and hygiene practices of the premises. Staff were observed to wear appropriate PPE, such as masks, gloves, aprons and using hand sanitiser. The designated area for staff to take off and dispose of their PPE was located appropriately.
• Most staff and all people using the service had been double vaccinated against COVID-19.
• We were assured that the provider's infection prevention and control policy was up to date.

Staffing and recruitment; Learning lessons when things go wrong
• At our previous inspection to the service in February 2021, recruitment practices were not safe and had not been operated in line with regulatory requirements. We served a Warning Notice on 11 February 2021, whereby the provider was required to be compliant by the 19 February 2021. At this inspection we found recruitment practices remained unsafe and lessons had not been learned to make the required improvements.
• Evidence of conduct from a new recruit, in the form of a written reference, was not sought or considered for all newly employed staff.
• The Disclosure and Barring Service [DBS] status for one member of staff was not received prior to them commencing employment at Maplin House. No information was recorded or available to demonstrate the 'Adult First' or 'Update Service' had been checked. The 'Adult First' check is a service that allows an individual to be checked against the adults' barring list. The 'Update Service' check allows organisations to see if any relevant information had been identified about an individual since their DBS certificate was last issued. A risk assessment was not completed or considered to assess and manage the risks relating to them commencing employment prior to receiving the outcome of their DBS status.
• No staff personnel file was available for one member of staff who was reemployed at Maplin House in May 2021 following an 18-month period of absence. The registered manager confirmed no updated recruitment checks were completed for this person.

This was a continued breach of Regulation 19 [Fit and proper persons employed] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• The Local Authority completed an announced quality monitoring visit to Maplin House prior to our inspection. The Local Authority did not feel there were enough staff available to meet people's needs and this compromised positive interactions between staff and people using the service and staff's ability to initiate meaningful social activities. Following the visit, action was taken to employ an additional member of staff on shift throughout the day.
• Staff rosters were not accurately maintained to determine the numbers of staff on duty on any given day or the hours worked. For example, one member of staff told us they had completed three to four shifts each week in recent weeks to cover staff shortages, including 'sleeping-in' duties. This member of staff was not rostered on the rotas viewed from 1 August 2021 onwards.

We recommend the provider consider current guidance relating to the rostering of all staff employed at the service.

Systems and processes to safeguard people from the risk of abuse
• People told us they felt safe and comments included, "I feel safe living here" and, "I feel safe."
• Interactions between staff and people using the service were relaxed and comfortable.
• The incidence of safeguarding concerns at Maplin House was very low. The registered manager was aware of their role and responsibilities to safeguard people using the service from abuse and knew how to escalate concerns to the Local Authority or Care Quality Commission.
• The staff training summary demonstrated all but one member of staff had up to date safeguarding training.

Assessing risk, safety monitoring and management
• At our previous inspection to the service in February 2021, suitable arrangements were not in place. Risks were not always identified or robust to mitigate the risk or potential risk of harm for people using the service. Additionally, other safety concerns were identified relating to the premises.
• At this inspection risks for people were identified and recorded in relation to their care and support needs.

For example, in relation to feeding tubes, catheter's and pressure ulcers. Staff had a good knowledge of people and the risks associated with their care needs.
• Individual Personal Emergency Evacuation Plans [PEEP] for people using the service had been revised and updated since our last inspection.
• Restrictors used to restrict the window from opening too wide were in place and fire doors were no longer wedged open. Steps had been taken to declutter the premises, therefore minimising the potential risk of fire.

Using medicines safely
• At our previous inspection to the service in February 2021, suitable arrangements were not in place to ensure the proper and safe management of medicines.
• At this inspection, 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.
• Medication audits were completed at regular intervals and demonstrated a good level of compliance.

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.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice, we previously served relating to the provider's quality assurance arrangements.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same.

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

• At our previous inspection to the service in February 2021, your arrangements to assess and monitor the service were not effective. This meant there were missed opportunities to mitigate risks and to make sure people living at the service remained safe. Audits to help identify where improvements were required could not be located.

• At this inspection we found improvements had been made to the service's medicines management and most actions required to the service's premises to keep people safe had been addressed. Individual risks to people's safety and wellbeing were recorded.

• Systems and processes to assess, monitor and improve the quality and safety of the service, such as regular audits were now being completed at regular intervals. The provider's monthly reports were marginally more detailed than previously evidenced. However, these arrangements failed to identify the concerns found as part of this inspection and highlighted within the 'Safe' section of this report. Although there have been some improvements, there remain significant shortfalls in the monitoring and actions taken to ensure people are safe.

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

• At our previous inspection to the service in February 2021, your arrangements to assess current and emerging risks presented by the pandemic had not been identified for people living at Maplin House or for staff employed at the service. The impact of COVID-19 on individuals who may be disproportionately at risk of COVID-19 had not been considered. At this inspection we found this remained outstanding and had not been addressed.

• At our previous inspection to the service in February 2021, not all doors examined had cold smoke seals [intumescent strips] fitted into the door or frame to help seal the gap around the door and contain any potential fire and prevent it from spreading. Where cold smoke seals were fitted these had been painted over and therefore making them less effective to work properly. This remained outstanding from our

previous inspection in February 2021.
• At our previous inspection to the service in February 2021, arrangements were not in place for gathering people's and staff's view of the service. The Local Authority completed an announced quality monitoring visit to Maplin House prior to our inspection and found this had not been addressed and remained outstanding. At this inspection, the registered manager confirmed this was accurate.

This was a continued breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

• Staff meetings were held to give staff the opportunity to express their views and opinions on the day-to-day running of the service.

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

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider must ensure the risk of preventing and controlling the spread of infections is undertaken and risks to people's safety assessed and mitigated.

The enforcement action we took:

We served a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective arrangements must be in place to assess, monitor and mitigate risks for people using the service and to ensure compliance with regulatory requirements.

The enforcement action we took:

We served a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Suitable arrangements must be in place to ensure recruitment procedures are operated effectively.

The enforcement action we took:

We served a Warning Notice