Laycraft Ltd

Maplin House

Inspection report

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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 providing personal 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
The leadership, management and governance arrangements did not provide assurance the service was well-led. Quality assurance and governance arrangements were not reliable or effective in identifying shortfalls in the service and to meet regulatory requirements.

Information relating to people's individual risks were not always recorded or mitigated for the safety of people using the service. Risks relating to how Control of Substances Hazardous to Health (COSHH) items were stored, and the service's fire arrangements, did not provide enough assurance that people were safe. Suitable arrangements were not in place to ensure the safe management of medicines and this placed people at risk of harm.

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 28 November 2018).

Why we inspected
We inspected the service because there had been a recent COVID-19 outbreak at Maplin House.

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 coronavirus and other infection outbreaks effectively.

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.

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.

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.

Follow up
We will work alongside the provider and 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 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 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 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 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 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. Prior to the inspection we had spoken with the registered manager about the COVID-19 outbreak at the service at the beginning of January 2021. We took this into account when we inspected the service and made the judgements in this report.

During the inspection-
We spoke with four people who used the service about their experience of the care provided. We spoke with two 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 two people's care records and multiple medicine records. We looked at two staff files in relation to recruitment and three staff member's supervision records. Other information relating to the management and quality assurance arrangements were requested but these were unavailable.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at the provider's monthly reports and spoke with a further four members of staff.

Inadequate

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 Good. At this inspection this key question has now deteriorated to Inadequate.

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

Assessing risk, safety monitoring and management
• Risks were not routinely identified to mitigate potential risk of harm for people using the service. For example, where people had a catheter in place, risks associated with this had not been considered or documented. A catheter is a medical device used to empty the bladder and collect urine in a drainage bag. The same person's records referred to their skin integrity having been compromised. No formal pressure ulcer assessment or risk assessment had been implemented or completed. The lack of information placed people at potential risk of not receiving the correct care and support.
• Not all windows on the ground and first floor had effective restrictors in place to restrict the window from opening and preventing people from the potential risk of injury.
• Risks relating to the service's fire arrangements were not safe. Fire doors were held open, not allowing the doors to close without physical assistance, cold smoke seals were not fitted into the door or door frame to prevent the fire from spreading and areas of the service were cluttered which could act as a fuel for a potential fire.
• Fire records were available relating to monthly checks, but these had not been completed since June and October 2020; and November 2015. The service's fire risk assessment was last reviewed in 2016 and individual Personal Emergency Evacuation Plans (PEEP) were last completed in June 2016. These had not been updated to reflect if a person's needs had changed and the risks posed for those who cannot get themselves out of a building unaided. This had not been picked up by the provider or registered manager.
• Appropriate arrangements were not in place to ensure Control of Substances Hazardous to Health (COSHH) items were stored safely or securely. Cleaning products which are classed as irritants were in unlocked cupboards in the laundry room. This posed a risk that people using the service could access these items, placing them at risk of harm.

Using medicines safely; Learning lessons when things go wrong
• Suitable arrangements were not in place to ensure the proper and safe management of medicines and this placed people at potential risk of harm.
• We found omissions in the records made when medicines were administered. We found the Medicine Administration Record [MAR] for three out of eight people was blank giving no indication of whether the medicine was administered or not. However, this was a records issue as the medication was no longer within its original packaging, had been administered but not recorded as given.
• Appropriate arrangements were not in place to ensure medicines were stored securely for safekeeping. The dedicated fridge for medicines which required cold storage was unlocked and medicine which was awaiting return to the pharmacy was in the office and easily accessible to people not authorised to have access. Keys

to the medicine trolley were kept in the lock and not held securely for safekeeping by the member of staff administering medicines. This posed a risk that people may ingest medicines or misuse the medicines.
• Thickening powders to aid a person's swallowing difficulties and to minimise the risk of aspiration were not stored correctly to ensure safe storage. These were stored on the kitchen worktop and not in line with the NHS 'Patient Safety Alert: Thickening Powders' dated 2015. This posed a risk of choking by accidental ingestion of the thickening powder.
• In addition to people's medicines being stored in a Monitored Dosage System (MDS) device, medicines were also stored within their original packaging (packets and bottles). In line with good practice procedures these were not signed and dated to demonstrate when these medicines had commenced. This places people at risk of receiving medicines that are no longer required and in use.

Preventing and controlling infection
• Suitable arrangements were not in place to ensure safe prevention and infection control measures in the event of a COVID - 19 outbreak. A plan to demonstrate how appropriate measures would be put in place to isolate people who tested positive and to zone environmental areas of the service should there be an outbreak of COVID - 19, had not been considered or completed.
• Arrangements to assess current and emerging risks presented by the pandemic had not been identified for people or staff residing at Maplin House. This meant people and staff who may be at increased risk of contracting COVID - 19, for example, those with underlying health conditions, had not been assessed.
• Some areas of the service, such as, the registered managers office, one corner of the communal lounge on the ground floor and laundry room were cluttered. This meant effective cleaning could not take place.
• Cleaning schedules could not be located to evidence records and checks of compliance with the cleaning schedule.
• Though staff wore Personal Protective Equipment (PPE) in accordance with government guidelines, the designated area for taking off their PPE was not appropriate as this was located within the kitchen and there was a risk of cross-contamination.

Not all was being done to mitigate risks for people's wellbeing and safety. This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• Following the inspection, the provider confirmed window restrictors had been ordered. Measures had been taken to make sure fire doors were no longer wedged open and decluttering of the environment had taken place to mitigate fire risks to the service. Arrangements were made for an external company to revise the service's fire risk assessment. People's PEEP had been reviewed and rewritten. COSHH items were now stored securely and suitable arrangements had been put in place to ensure medicines management was safe. Cleaning schedules were newly implemented and the designated area for staff to put on and take off their PPE had been relocated.

Staffing and recruitment
• Suitable arrangements were not in place to ensure staff employed had had the appropriate checks undertaken and were suitable to work with vulnerable people.
• There was no completed application form for one member of staff. Satisfactory evidence of conduct in staff's previous employment, in the form of references, had not been received before they commenced employment and gaps in employment were not explored.
• The Adult First Check and Disclosure and Barring Service (DBS) certificate for one member of staff was issued after they started employment at the service. Staff files showing convictions relating to dishonesty offences had no risk assessments in place.

This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

•The deployment of staff was appropriate, there were enough staff to meet people's needs and staff responded to people in a timely way.
• People using the service told us there were always enough staff on duty. One person told us, "Yeah, staff are always here, they are excellent." Staff told us staffing levels were appropriate and there were enough of them to provide safe care to people living at the service. Comments included, "We have enough staff" and, "I think so, yes, there are enough staff."

Systems and processes to safeguard people from the risk of abuse
• Systems and processes to safeguard people from the risk of harm were not robust. A member of the public was found to be living at the service. This compromised the security of the premises and placed people at potential risk of harm as they had unsupervised access to the service at any time. DBS checks and a risk assessment as to the person's suitability to be at the service had not been completed. Following the inspection, we were notified by the provider that this person was no longer living there.
• People told us they felt safe and comments included, "Yes, [Name of Inspector] I feel safe here" and, "Yeah, of course I do." Observations demonstrated people had a good relationship with staff.
• Staff demonstrated an understanding and awareness of safeguarding and how to escalate concerns, citing they would inform the registered manager and external agencies, such as, the Local Authority or Care Quality Commission.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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; 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

• The 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.

• The provider's oversight of the service was not effective. The provider told us, since the start of the pandemic in March 2020, they had had limited opportunity to spend time at Maplin House. The provider completed regular monthly reports, but these were not robust and had failed to identify the concerns found as part of this inspection. These are highlighted within the 'Safe' section of this report, to drive improvement and to respond appropriately.

• The registered manager told us they were responsible for the completion of audits at the service. For example, audits relating to medicines, health and safety, infection, prevention and control measures and food hygiene. However, no audits could be located despite a search for them. The registered manager told us, it's here somewhere, where I expect it to be, it's not, things have been moved around."

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

• The registered manager's understanding of their roles and responsibilities was not reliable or effective.

• Systems for managing risk or potential risk were not identified. The findings at this inspection demonstrated a lack of understanding of some legal requirements and national guidance and recommendations. For example, the registered manager did not act in accordance with the Mental Capacity Act 2005. People's capacity to consent or, where people did not have the capacity to consent to COVID - 19 testing, was not recorded. The 'best interest' process was not being routinely followed. A 'best interest' assessment determines the person's wishes and whether any restrictions in place are in the person's best interest.

• Support for staff in the form of formal supervision was inconsistent. Staff files viewed as part of the inspection process showed no formal supervisions or appraisal for two members of staff and the third staff member had their last recorded supervision as dated May 2017. The registered manager told us, "I accept supervisions are not always formally recorded but we do a lot of face-to-face talking, we talk all of the time." Not all staff spoken with felt supported by the registered manager. These arrangements were not effective to

ensure staffs competence to carry out their roles and responsibilities were monitored.
• The registered manager confirmed they did not receive formal supervision. They told us they spoke to the provider at least five to six times a day and stated, "If [Provider] felt I needed a supervision, they would, we chew the fat all the time."
• Comments relating to teamwork and communication were variable. Comments included, "Team work here is very good" and, "Teamwork is not good, there are lots of complaints and a real lack of communication."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• 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. There were no action plans completed to evidence how issues raised and discussed were to be addressed, dates to be achieved and if these had been resolved or remained outstanding.

Effective systems were not in place to monitor the service and ensure compliance with regulatory requirements. This was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, we asked the registered manager to provide evidence of the arrangements in place for gathering people's views of the service. No information was provided to demonstrate a formal system was in place but people using the service told us they were very happy living at Maplin House and had no concerns.

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

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks for people must be assessed, recorded and mitigated to ensure their safety and wellbeing.

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 17 HSCA RA Regulations 2014 Good governance Effective arrangements were not in place to assess. monitor and improve the quality and safety of the service provided.

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 were not in place to ensure recruitment procedures were operated effectively and safely.

The enforcement action we took:

We served a Warning Notice