MAPS Properties Limited

Walsham Grange

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection was unannounced and took place on 28 and 30 April 2015.

Walsham Grange provides care and accommodation for up to 75 people who may require nursing or dementia care. On the days of this inspection there were 52 people living at this home. The home is divided into two units, the nursing wing and the Grant Hadley wing that provides support for up to 12 people living with dementia.

This service is required to have a registered manager in day to day charge of the home and one was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Some areas of the home were not safe and hygienic. Razors were found left in communal bathrooms and these posed a risk to people. Areas of the kitchen were dirty with spillages not cleaned up. Cups and beakers were heavily stained.

People and their relatives were not always involved in the assessment, planning and review of their care. People's

Summary of findings

care plans were not focused on the needs of each individual. Some care records were not kept up to date to demonstrate that people received the care and support they needed when they required it.

The registered manager had not notified the Care Quality Commission about significant events affecting the care and welfare of people living at the home.

There were enough staff available apart from first thing in the morning when we noted that people needed to wait up to 20 minutes for assistance. Activity co-ordinators had been employed recently and were spending time assessing what activities people would enjoy taking part in. Care records did not reflect people's interests and hobbies.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The principles of the MCA had not been applied when assessing if a person should be deprived of their liberty and an individual approach was not being taken. Best interests' decision making processes were not in place.

People were provided with a varied diet and choices, special diets and preferences were catered for.

People were not always referred to by staff in a dignified way, with some staff referring to people by their room number rather than by their name. Staff were kind and polite when speaking to people.

Staff had started to work with people who agreed, to explore and write their personal history so that staff understood the person and their life choices better.

The complaints procedure was not clearly displayed and known to people. Those complaints received had been investigated and responded to the satisfaction of the complainant.

Staff felt well supported by senior staff although some described a blame culture existing within the service. Staff meetings took place but supervision sessions had not been and there were plans to restart them so that information could be shared within the staff group.

People and their relatives were asked for their views about the quality of the service but these were not always acted on in order to make improvements. Quality audits were taking place but did not always identify shortfalls in the service.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 consistently safe.

Razors were left in communal bathrooms putting people at risk. Areas of the kitchen, cups and beakers were not clean and hygienic. Some foods were left uncovered for long periods.

People felt safe and staff understood how to protect people from abuse and what to do if they suspected abuse was happening.

Safe medication practices were in place.

There were sufficient staff employed although people had to wait long periods for assistance during the morning.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had received training about supporting people living with dementia but they were unable to demonstrate a good understanding of dementia and how it affected the support they needed to offer people.

Where people lacked capacity to make decisions for themselves, the service had not followed the principles of the Mental Capacity Act best interests decision making process. The service could not demonstrate that they were acting in people's best interests.

People could choose what they had to eat from a range of options.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their relatives were not always involved in developing their care plans based on their choices and preferences. People were not always involved in decision making.

People were not always treated with dignity and respect. Some staff referred to people by their room number rather than by name.

People were treated in a kindly way and staff were polite when speaking with them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records were not kept up to date to show whether people had eaten, drunk or been re-positioned. Care plans were not person-centred.

Summary of findings

People did not know how to complain and the complaints procedure was not clearly displayed in the home.

Work was underway to develop information books with people that documented their life history.

Is the service well-led?

Requires Improvement 

The service was not consistently well-led.

The Care Quality Commission was not always notified about significant events that occurred at the service.

Quality audits were taking place but had failed to identify some of the concerns found during the inspection.

People and their relatives were asked for their views about the quality of the service but the service was not acting on their feedback.

Staff described a blame culture where the registered manager was not visible throughout the home

Walsham Grange

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 28 and 30 April 2015 and was unannounced. This inspection was completed by two inspectors.

Before the inspection we looked at the information we held about this service. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed notifications that had been sent to us by the service. These are reports required by law, such as the death of a person, safeguarding, accidents or injuries. We were also in contact with the local authority quality monitoring and safeguarding teams to seek their views about the quality of the service provided to people.

We spoke with eight people who lived at the home and three visitors. We also 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 also spoke with 11 staff including the director of the company, registered manager, deputy manager, nurses, care staff, activity co-ordinator and catering staff.

The records we looked at included staff rotas, Mental Capacity Act and Deprivation of Liberty Safeguard assessments and applications, and the care records for 15 people including eight care plans, medication records and records of people requiring their food and fluid intake to be recorded.

Is the service safe?

Our findings

During our inspection we found that people were not always protected from potential harm associated with the environment. We saw disposable razors left out in the communal bathrooms and also in the unlocked cupboards within them. These items posed a risk of harm to people and we brought our concerns immediately to the attention of the registered manager, who undertook to have the items removed. We later went back to the bathrooms and confirmed that the items had either been removed or locked away in the cupboards and the keys removed from the locks. There were no risk assessments in place for the storage of items such as razors in the communal bathrooms.

We found that some areas of the kitchen were not clean and hygienic, with spillages not being cleared immediately resulting in dirty trolleys and work surfaces. Plastic beakers and cups were in use but were heavily stained. We brought this to the registered manager's attention and most of the cups were removed. However, we later saw other stained cups being used for people. We saw that some foods, such as butter, marmalade and jugs of milk were left uncovered on work surfaces and trays and this meant that the food products were not stored correctly. On the second day of our inspection we found that the kitchen had been deep cleaned and all beakers and cups replaced. All food items had also been stored correctly.

These matters were addressed during the inspection but we were not able to test that compliance was maintained.

All of the people we spoke with told us they felt safe living at this home. They told us that they trusted the staff. One person said, "I am alright. The staff are nice and I feel safe." Another person told us, "I feel very safe and don't have any worries." A person's relative said, "I don't have any concerns about safety and think all the staff are competent."

All of the staff we spoke with had an understanding about safeguarding people from abuse. They told us that they received regular updates to their training about this. During discussions, staff were able to demonstrate that they knew how to recognise the signs of possible abuse and would report it appropriately. Staff told us they felt confident about raising any concerns with the management team. They knew there was a safeguarding policy at the home and could tell us what was in it.

The recruitment records of staff working at the service showed that the correct checks had been made by the company to make sure that the staff they employed were of good character. We spoke with staff who had recently been recruited and they confirmed that the required checks had been completed before they started working at the home.

Assessments of people's needs took into consideration the risks to which people were exposed in respect of mobility and falls, moving and handling, pressure area care and nutrition. However, we saw that for one person the assessment in respect of the risk of them developing a pressure ulcer had been incorrectly calculated. This meant that they may not receive the care they needed to ensure their safety. We observed people being assisted to move and saw that this was done safely.

People told us that they felt that there were enough staff although they said that they were always busy. One person told us, "They come to you when they can." They told us that they had to wait, 'quite a long time' on occasions but they understood that this was because staff were trying to respond to everyone. They said that the longest waits were usually first thing in the morning. One relative whose family member lived in the Grant Hadley wing told us, "There are always staff about. It seems there are as many staff as there are patients."

The registered manager told us that the required number of staff during the day were two qualified nurses, two team leaders and nine care staff. The number of care staff reduced to eight during the afternoon and evening. Night cover was one qualified nurse, one team leader and three to four care staff. These levels complied with the rotas that were provided to us and to those staff that were on duty on the days of our inspection. In addition, there were two activities coordinators, catering and housekeeping staff employed.

Staff told us that they felt there were adequate numbers of them on duty to meet people's needs in a timely way. They said that any shortfalls in the staffing numbers were usually covered within the staff team. However, agency staff would be used if necessary. Staff spoke about mornings and meal times being more rushed and that there were delays in attending to people in a timely way. For example, we noted that call bells rang for up to 20 minutes between 9am and 10am, when people were being assisted to get up, before they were responded to. For the rest of the day they were answered in a more timely way.

Is the service safe?

We saw people being offered their medicines and asked if they would like to take them at that time. One person told us, “I let the staff look after my medicines otherwise I would forget.”

We looked at the arrangements for the ordering, storing, recording and administering of medicines and found that these were safe. We saw that the records of stock held corresponded to the medicines in cupboards and trolleys. Oral medicines were stored safely but medicines for external use were seen in communal bathrooms. When this was brought to the registered manager’s attention they dealt with it immediately. We checked the systems in place in respect of controlled drugs and found these were safe. We saw that medicines were audited each week by two nurses to ensure that there were no errors.

We observed a qualified nurse administer medicines to people receiving nursing care and a senior care staff to those people receiving residential care. Both staff followed safe procedures for the administration of medicines. All staff received training from an outside provider and their competence was assessed before they were able to administer medicines unsupervised. All staff handling medicines received regular refresher training on an annual basis.

Is the service effective?

Our findings

The Care Quality Commission is required by law to monitor the use of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and report on its findings each year. The service had submitted applications for authorisation to deprive all people of their liberty with the exception of one person. We were told this had been done because people were prevented from leaving the home to maintain their safety, however all applications must be assessed on an individual basis. We were aware of three incidents where people had left the Grant Hadley unit unaccompanied and this had placed them at significant risk on two of the three occasions. This had resulted in a risk assessment being developed so that contributing factors were identified and the risk of it happening again was reduced. These people did not have a DoLS authorisation in place.

The care plans we looked at showed that, where necessary, people's mental capacity to make decisions had been assessed. However, where they lacked capacity to make decisions, people did not have records within their files to show that when staff were making decisions on their behalf they were being made in their best interests, following the principles of the Mental Capacity Act 2005. We discussed this with the deputy manager, who told us that they had developed a process that would assess and record best interests decisions. This was so that staff acted in accordance with the person's safety and well-being and in line with their known preferences. These processes had not been introduced at the time of this inspection. Some of the staff we spoke with did not understand their role in making decisions in the best interests of the person.

We looked at four people's care plans to determine whether consent to care and treatment had been obtained. One care plan had no consent recorded and a further three contained consents given by their relatives. The registered manager did not know whether the relatives had the legal authority to make decisions on behalf of the person. We could see no involvement of the person being recorded within their care plans. The people we spoke with did not think that they had been involved in the writing of their care plans.

This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the people we spoke with said that generally they were satisfied with the care they received. A group of people chatting at the dining table said that they were well cared for. One person told us, "We get everything we need. We have no complaints." One person's relative said, "My [family member] gets well cared for. They are always clean and wear clean clothes." However, another family raised concerns with us about the personal care their family member received and the lack of communication from the registered manager and senior care assistants. They told us they had spoken with the deputy manager about this and would be contacting the director of the company.

Staff could explain what care, support and treatment people required and how this was delivered. However, a significant number of the people using the service were living with dementia and we found that some care staff only had a basic understanding about this condition. They could not tell us about the impact of different types of dementia and only described the condition as people not being able to remember things. However, according to the training plan provided to us, 13 staff had attended dementia training in the week preceding our inspection, some of whom we spoke with during this inspection and this told to us that the training had not been effective for all staff.

The training plan showed that staff received core training and regular updates to refresh their knowledge, for example in moving and handling and first aid. All new staff members completed a fully recorded induction programme. We saw that staff also received training relevant to their role, for example medication, dignity in care and end of life care. Staff members also had the opportunity to gain a national qualification, such as a National Vocational Qualification or a Diploma, at level two or three in health and social care.

Staff told us they felt well supported by the deputy manager and qualified nurses and that supervisions had recently recommenced after falling behind so that they could discuss their development needs. The deputy manager showed us a supervision record that set out when and how frequently staff would receive either supervision or an annual appraisal.

Those people who were able to speak with us told us they were free to make decisions around all aspects of daily living. One person told us, "We can do as we please. Everything is good here." Another person said, "You eat

Is the service effective?

what you like, you do what you like. I'm happy here." People also told us that staff asked for permission before providing support and we saw this happen for the most part. However, at lunchtime we observed staff placing clothes protectors over people's heads without asking them or warning them that they were about to do so.

People who were assessed as at risk of not receiving enough to eat and drink were served their meals on a red tray to alert staff that assistance was required to help them eat well. Information was also available to staff about any special diets that may be required, such as soft or diabetic.

People told us they enjoyed their food. One person said, "The staff are lovely and the food is good. What else would I need?" Another person told us, "The food is good and you get enough." They said they could choose what they wanted to eat and were aware that there were always alternatives available. We noted that the alternatives were not shown on the menu board in the dining room so that people could see what the options were each day.

We spoke with the chef who described the choices and special diets that were available and how they were recorded. They described how they were kept informed of any special dietary needs and preferences. They said they spoke with people to understand their likes and dislikes so that they received food they enjoyed. We were told that several people ate a vegetarian diet and there was always an appropriate option available to them.

People told us they were able to see their GP when they needed to. One person said, "The staff call the doctor when I need to see him. It is very good." A visiting health professional was seen during out inspection but was unable to speak with us. Care records showed that people were supported to maintain good health, have access to healthcare services and receive on-going healthcare support. There was information about the input from people's GP, district nurses, consultants, speech and language therapists and chiropodists. We saw that referrals were made in a timely way.

Is the service caring?

Our findings

Whilst we heard staff offering people choices around their daily living, there was no evidence that people had been involved in developing their own care plans.

Some of the care plans we looked at showed that the person's relatives had signed agreement with risk assessments although there was no evidence within the care records to show they had the legal authority to do so. There was no evidence that people had been consulted about the care their loved one needed. Two visitors told us, "We have never been spoken to about what care [family member] needs. They have never asked us. They have never reviewed the care plan with us and we didn't know what was in it until recently." Another relative said, "I wasn't involved in my [family member's] care planning. It all happened very quickly." A further relative we spoke with told us, "I wasn't involved in the care planning. Nor am I involved in any of my [family member's] reviews." This meant that there was little evidence that people, with support of their family, had expressed their views and been actively involved in making decisions about their care, treatment and support.

We were aware that the relatives and other agencies of a person admitted to the service for a period of respite care had provided detailed information to the service on admission. However, the service did not use this information to develop an appropriate care plan and the person did not receive the care they needed.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with were all complimentary about the staff. One person said, "The staff are all lovely and I get well looked after. All of the staff are very kind." One person's relative told us, "The staff are all excellent. They work extremely hard and are always so busy. They are very kind and always smiling."

We observed how staff interacted with people and saw that for the majority of the time people were treated with dignity and respect. People were asked quietly whether they needed to go to the bathroom. We noted that all personal care was delivered behind closed doors.

However, during our inspection when we asked some staff about individual people and their needs, they referred to people as room numbers rather than by their names. This did not promote people's dignity. At lunchtime we also saw on seven out of ten occasions that people had clothes protectors placed over them without staff asking if it was alright to do so first. This did not promote people's choice or dignity.

We observed staff treating people in a kind and compassionate way. Staff were polite at all times. We heard laughter throughout the day and people appeared relaxed and happy in the company of staff.

Staff encouraged people to be as independent as possible and to make choices as much as they could. Gentle encouragement and support was given as necessary. Staff were seen to respect the decisions people made.

Is the service responsive?

Our findings

Care plans were in place but they did not provide person-centred information to guide staff about how the person should be cared for. The information provided was variable in its level of detail about what was important to people and what activities they enjoyed. We were told that people should have their needs reviewed within two days of admission but this had not always been carried out as described.

We found that people's care plans mostly reflected what had been documented according to their needs and risk assessments. However, we found that there was inadequate record keeping and monitoring of records. Some people at risk of developing pressure ulcers had charts to record when they were repositioned but there were significant gaps in them. For example, one person should have been repositioned every two hours but we found gaps of five hours in the record. Another person who required three hourly turns had gaps in their record of six hours. The qualified nurse was unable to explain why there were gaps but felt sure that the care staff would have repositioned the people as required.

Four of the care plans that we reviewed showed that the people had needs in respect of eating and drinking. The fluid charts showed significant shortfalls in relation to how much the person had drunk during the day in comparison to what they needed. The qualified nurse stated that they were sure the person had been given enough to drink but that care staff had forgotten to record this. Staff were unable to say with certainty who was responsible for monitoring repositioning and fluid charts.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Because the care plans were not person-centred they were not always tailored to meet the specific needs of people, especially in relation to their social, psychological and emotional needs. For example, in one person's care plan, under 'social and leisure needs' there was an entry written by staff as 'no hobbies'. This person was living with dementia. Another care plan stated that a person's interests were 'writing letters' but no hobbies or other interests were recorded.

We spoke with one of the activities co-ordinators and also with the deputy manager. We were told that work had recently started on developing information booklets containing the person's life history and the sorts of activities and past times they liked to take part in. The deputy manager told us that the project would also include developing a specific care plan to keep in the main care plan records so that all staff were aware of this aspect of the person's care needs.

The activities coordinator showed us some of the activities that had recently been developed at the home. These included music events, quizzes, games and competitions. On the afternoon of the inspection a film was being shown in the main lounge. Both activities coordinators were engaged in one to one activities with people, including those living in the Grant Hadley unit. Some people were more engaged in the activities than others, but there was a lively atmosphere in one of the lounges where activities were taking place.

None of the people we spoke with were sure how to make a complaint. People we spoke with told us they did not see the registered manager very much and said they would probably complain to the staff. Relatives we spoke with were also unsure how they could make a complaint but thought they would probably speak with the registered manager.

Although we were told that the complaints procedure was available in the entrance hall it had been removed and the only other copy was available within a book that was kept open on pages other than the complaints procedure. This meant that people would not know that there was a complaints procedure available for them to use. We raised the matter with the registered manager and arrangements were put in hand to post out a copy to all relatives and to place a copy in each person's room.

The registered manager told us that 10 complaints had been investigated by the service since August 2014. We looked at the complaints log and saw that the investigations had been completed to the satisfaction of the complainant, with action taken to address shortfalls in the service where they were identified.

Is the service well-led?

Our findings

The registered manager has not consistently kept the Care Quality Commission (CQC) advised of significant events at the service. These are called notifications and the registered manager is required by law to keep the Care Quality Commission advised of events such as allegations of suspected abuse and incidents reported to the police.

This was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We spoke with staff about the culture of the home and received mixed views. Two members of staff thought it was relatively positive whilst other staff told us they did not feel encouraged to raise new suggestions about how the quality of the service could be improved. Some staff also told us that they felt there was a 'blame culture' at times when things did not go right.

The care staff we spoke with told us that they felt well supported by the qualified nurses and the deputy manager. They told us that they could go to see the registered manager but usually chose not to do so as they had better relationships with the deputy manager and qualified nurses. Staff told us that the registered manager was not visible throughout the home very much and tended to stay in the office. They said that they felt that this meant the registered manager did not have a very good idea about what was going on.

We noted that audits were in place for issues such as infection control, medication, dignity, environment and catering. However, some of these audits had failed to identify some of the shortfalls seen during the inspection such as dangerous items left in communal areas, lack of information in care plans and the state of the kitchen and utensils. Immediate action was taken to remedy these issues as soon as they were raised with the registered manager but there is concern that improvements may not be sustained.

The service was conducting a relative satisfaction survey at the time of this inspection and only a few responses had been received to date. We therefore looked at the results of the previous survey and this showed that there were shortfalls in keeping people's relatives advised about what was taking place in the home. The results were undated and the action plan did not respond to all the issues raised. Issues identified at the time of the last satisfaction survey remained unresolved and people and their relatives had not been listened to. For example, relatives not being involved in planning the care of their loved ones.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The qualified nurses we spoke with told us that they wished they had more time to lead and supervise the staff. They said that this was especially the case at lunch time. They told us that they were often too busy administering medicines to supervise staff and ensure that people's nutritional needs were being met.

Staff told us that they had received appraisals but these had been some time ago and thought that it had been well over a year. Supervision sessions had not been taking place in line with the providers procedures and this had not been addressed by the registered manager. We spoke with the deputy manager, who showed us a supervision and appraisal plan for each member of staff that had recently been developed.

There was a residents' survey recently completed and we were aware that many had been completed with the assistance of the activities coordinator. The levels of satisfaction recorded were high, particularly in respect of choice and quality of meals and this reflected what people told us during the course of this inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who use services and others were not protected against the risks associated with person centred care because relevant people were not involved in assessing and planning how care needs should be met. Regulation 9 (3)(a)(b)(c)(d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services and others were not protected against the risks associated with good governance because relevant records were not kept up to date. Regulation 17 (2)(d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered persons failed in their legal obligations because they did not advise the Care Quality Commission of events affecting the care and welfare of people. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	People who use services and others were not protected against the risks associated with need for consent because people were not asked for their consent to care and treatment. Regulation 11.
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services and others were not protected against the risks associated with good governance because feedback from people and their relatives was not acted on. Regulation 17 (2)(e).