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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 5 and 6 April 2016 and was unannounced. It was carried out in response to concerns raised with the Care Quality Commission (CQC) and to establish whether improvements had been made since our last inspection.

Walsham Grange provides residential and nursing care for up to 75 people, some of whom may be living with dementia. Accommodation is over two floors and there is a separate wing called the Grant Hadley unit to cater for those people living with dementia. At the time of our inspection, 54 people were living at Walsham Grange on a permanent basis.

There was a manager in post who had been appointed in February 2016. At the time of our inspection, the manager had submitted an application to the CQC to become a registered manager; their application was being processed. 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.

We last inspected this service on 28 and 30 April 2015 where we found that the service was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was in breach of the regulations for person-centred care, need for consent and good governance. The service was also in breach of the Care Quality Commission (Registration) Regulations 2009. This was because they had failed their legal obligations to report events to the CQC that affect people's safety.

Following the inspection in April 2015, the service sent us a plan to tell us about the actions they were going to take to meet the above regulations.

At our inspection in April 2016, we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The service had appointed a new manager who had only been in post since February 2016. Although the manager had an open approach with us and told us the areas of the service that required improvement, the provider's quality monitoring audits had not identified the issues highlighted in this report.

Medication management was not consistently safe. People did not always receive their medicines as the prescriber intended. The service had failed to maintain accurate and full records in relation to medicines administration and management.

The people who used the service, staff and visitors to the home were not protected from the risk of harm as the service was unable to produce risk assessments for the environment. Accidents and incidents were recorded and the manager had an overview of these. However, no formal analysis was completed in order to

identify contributing factors or trends. This potentially put people at risk of harm. Individual risks to people had been identified, assessed and reviewed on a regular basis.

Staff knew how to identify and report potential abuse. The service had appropriately liaised with other agencies to manage identified concerns. However, the service did not always have the knowledge to take appropriate action to investigate those concerns and required guidance.

People's social and leisure needs were not consistently met. Although staff interacted with the people they supported on a regular basis, little activities took place and some people told us there wasn't enough to keep them occupied or stimulated.

People received enough to eat and drink and could request this anytime. People's nutritional needs were met. However, the mealtime experience was sometimes chaotic and disorganised within the nursing and residential area of the home.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. People told us they had been involved in the planning of their care although this had not been consistently documented. People had not always formally given their consent to receive care and support although staff always gained consent before assisting people. People's capacity to make decisions had not always been assessed. Where best interests decisions had been made on behalf of people who lacked capacity, these had been recorded following appropriate consultation with others. The service had made appropriate applications to the supervisory body for consideration of depriving a number of people of their liberty.

The service had completed recruitment checks to ensure that those that were employed were safe to work with older people. However, there wasn't always enough staff to meet people's needs. People told us they sometimes had to wait for assistance.

Although staff demonstrated the appropriate skills and knowledge to care for the people they supported, they had not been regularly or consistently trained. Staff had mixed views on whether they felt supported in their roles and supervision sessions had not been completed on a regular basis.

People told us staff were kind, caring and respectful. However, there were two occasions during our inspection where people became distressed and staff did not provide timely reassurance and comfort. We saw that staff spoke over one person on another occasion.

People's dignity and privacy was maintained and they received choice in their day to day living. However, people's independence was not always promoted.

People's needs had been identified, assessed and reviewed on a regular basis. Their care plans were individual to them and accurate. Staff had enough information to be able to care for the people they supported. However, people did not always have care plans in place to support them with their specific medical needs although they had access to a variety of healthcare professionals.

There was a new management team in place and people had mixed opinions on the visibility and approachability of them. Some staff did not feel they were supportive.

Regular meetings had taken place to give people the opportunity to make suggestions and feedback on the service. The service had sent out questionnaires to gain people's opinions and any concerns raised with the

service had been fully investigated and addressed.

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.

People's health and wellbeing was at risk as they did not consistently receive their medicines as the prescriber intended.The service had failed to ensure there were enough staff to meet people's needs in a timely manner.

The service could not demonstrate that they had identified and managed the risks associated with the building and adverse events. This potentially put people at risk of harm.

People were protected from the risk of abuse as staff had been safely recruited, understood the procedures for safeguarding people and had raised concerns.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service had not consistently assessed people's capacity as required by the Mental Capacity Act (MCA) 2005. Consent had sometimes been given by people's relatives when the service had no evidence they had the legal authority to do so.

People did not always receive care and support from staff who had been fully trained although they demonstrated the skills required.

Although people's nutritional needs were met, some people experienced a poor mealtime experience.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not consistently receive the support they needed, at the time they needed it, when they felt distressed or upset. People's dignity and independence wasn't always promoted.

People told us they had been involved in the planning of their care. They told us the staff that supported them were kind and

helpful.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's social and leisure needs were not always met.

Although the service had procedures in place to robustly address complaints, people did not always feel comfortable in raising concerns.

Some care plans were in place that gave staff information on how to support people. However, some people did not have care plans in place to meet their health needs.

Is the service well-led?

Inadequate

The service was not well-led.

Quality monitoring audits had failed to recognise the issues highlighted in this report. However, the manager was able to demonstrate they were aware of some of the concerns and had begun to address them.

The service had failed to keep accurate and complete records in relation to the people who used the service.

The management team promoted an open and transparent culture and welcomed feedback on the service which was appropriately responded to.

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.

The inspection took place on 5 and 6 April 2016 and was unannounced. The inspection was carried out by two inspectors, a pharmacist inspector and a specialist advisor. The specialist advisor was a registered general nurse and had experience of working in services for older people and those living with dementia.

Before we carried out the inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us in the last year. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. We also contacted the local safeguarding team and quality assurance team for their views on the service. We also looked at the action plan the provider had sent us after their last inspection in April 2015.

During our inspection we observed the care and support provided to the people who used the service. We carried this out in the two dining rooms, a lounge and the conservatory. We spoke with six people who used the service and three relatives. We also spoke with the manager, deputy manager, care coordinator, a nurse, two senior care assistants, a cook, two care assistants and two agency workers. The agency workers were not employed by the provider but had worked regularly within the home.

We viewed the care records for six people and the medicines records for nineteen people who used the service. We tracked the care and support four people received. We also looked at records in relation to the management of the home. These included minutes from meetings, three staff recruitment files, survey results and staff training records.

Requires Improvement

Is the service safe?

Our findings

Our pharmacist inspector looked at how information in medication administration record (MAR) charts and care notes for people living in the service supported the safe handling of their medicines.

People living in the service were not always receiving their medicines as prescribed. When we looked at MAR charts they did not show that medicines had been given as intended by prescribers, as there were gaps in the records. This included insulin given by injection for the management of diabetes due the morning of the inspection. We identified for one person that there had been delays in the administration of a painkilling patch and for another delays between receipt of their medicines at the home and when they were first given to the person. For another person, some of their medicines had not been administered because they had not been made available to administer or had not been obtained in time. This placed people's health and wellbeing at risk.

We observed staff giving people their medicines and noted that they followed safe procedures, however, a nurse on duty told us that the morning medicine round was often lengthy due to interruptions by other staff and telephone calls.

There was a lack of supporting information that would have enabled staff handling and administering people's medicines to do so safely and consistently. This included a lack of personal identification and information about known allergies and medicine sensitivities for some people. There was a lack of written information on people's preferences about having their medicines given to them. For people prescribed painkilling medicines and who were unable to talk about their pain there were no pain assessment tools to enable staff to give them their painkillers consistently. There were additional charts to record the application and removal of skin patches; however these were not always completed. There were also additional charts for people prescribed the anticoagulant medicine warfarin but some had been inaccurately completed. For a person self-administering some of their medicines there had been no recorded assessment of the risks around this. When people were prescribed medicines on a when required basis, there was a lack of written information available to show staff how and when to administer these medicines and no records about why they were needed when used. Therefore people may not have had these medicines administered consistently and appropriately.

Oral medicines were stored safely for the protection of people who used the service. However, in one area of the home there were no recent records showing that medicines requiring refrigeration had been stored at correct temperatures. In areas where people were living with dementia, medicines prescribed for external application were not safely stored so these medicines could have been accessed by people placing them at risk of harm.

The manager told us that staff authorised to handle and administer people's medicines had received training but that they had not recently been assessed as competent to undertake medicine-related tasks.

The service had identified and assessed the individual risks to the people who used the service. These had

been regularly reviewed. However, the manager could not tell us how they had managed the risks to people associated with the environment and work processes. When we asked for these risk assessments the manager could not produce them. In addition, the service had no plan in place in the event of any adverse incidents such as loss of power, an infectious disease outbreak or failure of the lift. We concluded that people were at risk of potential harm as the service had not taken steps to identify, assess and manage the risks associated with the environment, work processes and adverse events.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with had mixed views on whether there were enough staff to meet their needs. One person who used the service said, "There's always someone [staff] around when needed". However, another person told us, "Sometimes it takes a long time for the staff to answer bells". This person went on to explain that sometimes staff turned off their bell stating they would return to help them. However, they told us that sometimes staff did not return for up to an hour and that this was difficult for them when they were waiting to use the toilet. One relative we spoke with agreed that there were not enough staff to meet people's needs. They told us, "I was here at the weekend and there were bells going off left, right and centre. A person waited thirty minutes to go to the toilet". They told us, "I've seen people rocking in discomfort waiting to go to the toilet".

Some relatives told us that the independence of their family member wasn't always encouraged. One told us, "[Relative] should walk with their frame and exercise their hand. [Relative] could walk two weeks ago but their walking is not so good". They went on to explain that staff used a wheelchair to assist their family member to mobilise. They told us they felt staff used this as it was quicker for them. They said, "You can't fault the day staff, there's just not enough of them". We saw that another relative had raised concerns regarding the lack of physiotherapy their family member had received.

All the staff we spoke with agreed that there were not enough permanent staff and that the home relied on agency staff. They told us that this impacted on the service people received as the quality of agency staff varied. However, none of the staff felt the staffing levels had an impact on the safety of those people who used the service.

When we brought these concerns to the manager's attention, they agreed there were times when people's needs were not always met as quickly as they wished. They told us they were currently in the process of recruiting more staff to address this. They also told us they used the same agency staff as much as possible to aid continuity of care. When we asked the manager about how they ensured they had the right amount of staff, they told us this was based on people's needs. However, no formal process was in place to monitor this.We concluded that the service did not always have enough staff to consistently meet people's needs in a timely manner.These concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had procedures in place to identify and report safeguarding concerns. Staff told us what they would do if they suspected a person was at risk and knew how to report this. We saw records that showed the service had reported concerns to the local authority safeguarding team and taken actions to address concerns as required. We noted that the service had appropriately liaised with other organisations to manage the risks associated with safeguarding concerns.

The service had taken prompt and appropriate action to address concerns raised by staff. Records showed that these had been thoroughly investigated and actions taken as necessary. Accidents and incidents had

been recorded and demonstrated that each one had been investigated. Actions had been taken to reduce the likelihood of future occurrences.

Checks had been made to ensure that the staff employed by the service were safe to work in health and social care. These had been completed prior to staff commencing in their role and included the completion of a police records check. In addition, the service had requested two references from former employers and ensured staff provided a full employment history. We saw from the records we viewed that the service had made further checks if the information they received was not adequate enough to make a judgement on suitability.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in April 2015 the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service had not adhered to the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS).

At our inspection in April 2015, the service had failed to assess people's capacity on an individual basis. No records were found to show that, where staff were making decisions on behalf of people, these were made in their best interests. In addition, there was no evidence to say that people had given their consent for staff to provide care and treatment. In some cases, the service had allowed the relatives of people who used the service to sign consent agreements without having evidence that they had the legal authority to do so.

Following our inspection in April 2015, an action plan was submitted by the provider which detailed how the service would meet their legal requirements. They told us this would be completed by December 2015. At this inspection we found that some improvements had been made. However, the service needs to ensure that the principles of the MCA are consistently applied.

We looked at the care records of six people to see whether their consent for care and treatment had been obtained. We also looked to see whether the service had worked within the principles of the MCA. This included looking at the DoLS application procedures.

We viewed six care plans for people whose capacity to make decisions was in doubt. Out of these, four people had had their mental capacity assessed by the service. These were decision specific as required by the MCA. When we spoke with the manager about the other two people, they told us both needed their mental capacity to make decisions assessed as there was doubt over this. They told us this would be completed following our inspection. Where the service had made best interests decisions on people's behalf, records showed who had been involved in these decisions, what they were and the rationale for them.

The service had made applications to the supervisory body for consideration of depriving a number of people of their liberty. These were appropriate and had been assessed on an individual basis. However, one application had been made without first assessing if the person had capacity to make the decision for themselves. This meant the service had not followed the requirements of the MCA.

We concluded that the service had made improvements in it's adherence to the MCA although further improvements are required to ensure consistency.

Out of the five people we spoke with about being involved in decisions about their care, four told us staff consulted them on their plan of care. They told us staff asked for their consent before assisting them with care and support.

We asked the people who used the service whether they felt the staff that supported them had the right skills and knowledge for their role. There was a mixed response. One person told us they, "Felt quite confident" in the staff while another said they had confidence in some but not others.

The staff we spoke with told us there were gaps in their training. They told us they didn't always have their training refreshed on a regular basis. When we looked at the training records for staff there were a number of staff whose training had expired. For example, 60% of staff were overdue for their fire awareness and moving and handling training. We saw that 70% of staff had not completed safeguarding training in the time specified by the provider. Staff did not receive training to meet people's specific needs although training was available to support people living with dementia. The manager told us that staff had not recently been assessed to ensure they were competent in administering medicines. We noted that up to date best practice guidance was available in paper form to staff in the care offices. We also saw that staff reacted to a fire alarm that sounded while we were present in the home. Staff took action quickly and effectively.

When we spoke with staff about how supported they felt in their role, there was a mixed response. One staff member told us they got, "No support at all". Another staff member said the manager was, "Not hugely approachable, I've probably only had about two conversations with them". However, others said the manager was approachable and supported them. When we looked at the supervision and appraisal record which the manager provided for us, one staff member had not received a supervision meeting since July 2014 whilst seven had not had one for over ten months. However, staff told us they had regular group supervisions where they could raise concerns. We concluded that not all staff felt supported in their role or received the support they wished for.

These concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people who used the service had a mixed opinion on the quality and choice of food provided. One person said, "Very good, straight-forward food. Every day you get something different". Another person told us, "I think that we get a bit spoilt. You don't get the same thing – you get a variety". However, two of the people we spoke with were not so complimentary. When we asked one person if the food was to their taste they told us it was adequate. The same person didn't feel they got a sufficient choice of food. A fourth person agreed that there wasn't much choice and told us the food was not up to the standard they expected. However, everyone agreed that the quantity was good and that food and drink was available anytime they wanted it.

When we spoke to the cook about people's specialist dietary needs they knew who required what type of diet. They could describe the different types of diet and could give us examples of what types of food would be suitable for people. They knew people's likes and dislikes as up to date information was available to them.

We observed a number of mealtimes during our inspection. We saw that people who were on specialist diets received appropriate food and that fluid was available. We saw that those people that required assistance received the help they needed.

Although the lunchtime experience for people living in the Grant Hadley wing was sociable and pleasurable,

lunch served within the nursing and residential wings was chaotic and disorganised. We saw that some people on a table received their main course while others had to wait. We observed that one person had to wait thirty minutes for their main course whilst another waited for fifty-five minutes. When one of these people received their meal it was only lukewarm. They told the inspector they liked their food hot. We saw that when the staff member assisted this person to eat, they did not offer a hot alternative or explain what the meal was.

On both days of our inspection we observed that ancillary staff walked through the dining room a number of times. This was because the dining room led through to another part of the home. One carried cleaning equipment whilst another came through with a trolley of clean laundry. The receptionist walked through the area as well as a number of carers. This caused a chaotic and intrusive atmosphere within the dining room. We concluded that people received enough to eat and drink and that specialist dietary needs were met. However, improvements are required to ensure people receive food in a timely manner and that it is at the temperature of their liking. The service needs to ensure that the mealtime experience is protected from interuptions and that it provides a relaxed and calm atmosphere.

People had access to a variety of healthcare professionals to assist them in maintaining their health and wellbeing. We saw from the care plans we viewed that the service had promptly requested assistance for people's healthcare needs.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in April 2015 the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people, and where appropriate, their relatives had not been involved in the planning of their care.

Following our inspection in April 2015, an action plan was submitted by the provider which detailed how the service would meet their legal requirements. They told us this would be completed by December 2015. At this inspection we found that some improvements had been made. However, more robust recording of people's involvement in their care planning was required.

At the inspection in April 2016 although we saw no records to show people had been involved in the planning of their care, most people we spoke with told us they had been involved. One person said, "Yes, they talk to you and if I felt that I wasn't getting enough of something, I can speak to them". Another person told us, "If I don't like something, I'll tell them and they won't do it again". When we spoke with senior staff about this, they told us they involved people and their relatives as much as possible. One staff member said, "When they are in, I go and say hello to the family. I go through the care plans with them". When we discussed this with the manager, they agreed that care plans did not show that people had been involved in their care planning. They told us that they wanted to improve the involvement of people and, where appropriate, their relatives in the care planning process.

During our inspection we saw that staff mostly supported people in a kind, compassionate and respectful manner. However, there were two separate occasions where staff did not respond to people's distress in a way that reassured those people. We saw one person becoming distressed and asking for help. We saw that, although there were a number of staff around, this person was ignored. We saw one staff member make eye contact with the person but did not offer assistance or comfort. On the second occasion, we saw that when another person showed signs of discomfort, one staff member spent a short while with this person trying to comfort and reassure them. They demonstrated warmth and gave the person an explanation to the questions they were asking. However, this person continued to be distressed and no further attempt was made to relieve the person's concerns.

On another occasion we saw that staff spoke over the person they were assisting. We observed that they did not refer to the person by their name or include them in the conversation. We heard the staff members discussing the personal care needs of this person in front of them. However, on other occasions we saw that staff members reacted kindly to people's needs and wishes. For example, we saw one staff member warmly explain to a person where their family member was. We saw that the staff member had made eye contact with the person, smiled and held their hand. The tone of their voice was upbeat and kind. We saw that the person reacted positively to the staff member's approach by returning a smile.

However, most people we spoke with told us that staff were caring. One person who used the service told us staff were kind and that they listened to them. Another person said, "Staff are nice". A third person said, "We have a natter, talk in general. Staff will help you with anything you ask them to". The relatives we spoke with

agreed. One described the staff as, "Kind and attentive". However, one person who used the service felt the caring nature of the staff varied amongst them.

When we asked staff how they assisted people to maintain their dignity, they were able to give us examples of the steps they took to promote this. During our inspection we saw that people received assistance with their personal care in private. However, twice during our inspection we had to find staff members to assist one person who was removing their clothes in a communal area. Once staff became aware of this, they ensured the person received support in private before returning back to the communal area. We also saw that staff supported this person to change into clean clothes after lunch due to food debris.

We concluded that the people who used the service did not always receive care and support in a way that promoted their dignity or promptly relieved their discomfort and improvements are needed with regard to this.

Most people we spoke with told us they felt able to talk to the staff that supported them. They told us the staff were helpful. One person said, "[Staff] are very good and will sort things out for you". Another person said, "If I need anything, they come and ask me, they walk through to see if anyone needs anything". People were offered choice and we saw examples of this during our inspection.

The home had no restrictions on visiting hours and people's friends and relatives could come and go as they pleased. We saw that the home had an area where visitors could make refreshments. During our inspection we saw that family members were able to visit over mealtimes if they wished.

Requires Improvement

Is the service responsive?

Our findings

When we asked people if they felt their needs were being met, we had a mixed response. Most people felt staff supported them to meet their needs however one person did not agree. This person told us they didn't feel their social needs were being met. The relatives we spoke with felt the home did meet the needs of their family members in most aspects of their lives. However, people's needs were not met in a timely manner. This included assistance with emotional support, their lunchtime meal and personal care. We saw that people had to wait for assistance and that they did not receive the care and support required when they needed it.

At the time of our inspection, the home had recently had a vacancy develop for the role of activities coordinator. The manager told us this vacancy was due to be advertised shortly. However, the service had not made other arrangements in the interim and people told us the home lacked activities and social interaction. One person said, "There are some activities but I haven't been asked what I like to do". Another person told us, "I get bored". One relative we spoke with said there are no activities within the home. When we discussed this with the manager, they told us no actions had been taken to address the lack of activities and acknowledged this needed to be addressed.

During our two day inspection we saw few activities taking place. We saw that people had received a hairdressing service and that one person had had their nails done. However, we did see that staff interacted with the people they supported. We saw that an out of date activities planner was on display within the home which could have caused confusion for those who used the service, particularly those living with dementia. People could have been expecting to take part in an activity when it was not due to take place. From the care plans we viewed, we saw that people's leisure and social needs had not been consistently assessed or recorded.

We concluded that, although people received social interaction, they were not consistently supported to follow their interests and take part in social activities.

Although people told us they knew how to raise concerns, not everyone was comfortable in doing so. While one person told us, "I'd complain to the staff if I didn't like something and we'd talk it over", another person told us they would not feel comfortable raising issues. A third person who used the service told us they had had reason to complain in the past and that it hadn't been resolved to their satisfaction. They told us, "I've complained but nothing has changed". However, when we viewed the complaints records we saw that the service had thoroughly investigated any concerns that had been raised with them. We saw that prompt meetings had been arranged with complainants and issues investigated appropriately. During our inspection, we saw that a formal complaint had been recently received by the service. We saw that the manager had immediately made contact with the complainant and a meeting had been arranged three days after receiving the letter of complaint.

We concluded that all concerns received by the service had been robustly investigated and appropriate actions taken. However, people did not always feel comfortable in raising any worries or concerns they may

have.

We viewed the care records of six people to see that their individual needs had been identified, assessed and regularly reviewed by the service. We found that care plans were securely stored to maintain confidentiality but still easily accessible for staff. We saw that people's needs had been assessed prior to admission into the home. This ensured that the home could safely and appropriately meet people's needs and gave people the opportunity to discuss their expectations, wishes and preferences.

The care plans we viewed contained accurate information and had been regularly reviewed. We saw that they were individual to the person and gave staff information on the best way to support that person. However, we noted that some people did not have care plans in place for their specific medical needs. For example, the service had identified these and some information was available for staff to help them assist people. However, there was a lack of information on how staff could fully support people to feel well and prevent deterioration in their health or wellbeing. Nevertheless, when we spoke with staff they demonstrated they knew the people they supported well. They could tell us about the people who lived at Walsham Grange, what their preferences were and how they spent their day.

At the time of our inspection, two people who used the service required additional support. We saw that this was being delivered as required. In addition, the service had liaised with other health professionals to ensure that both people received the care and support they required. We saw that a detailed and accurate care plan was in place for one of these people in regards to the additional support they required. This gave staff detailed information on how best to support this person.We saw that one person who had complex health needs was receiving care as required in relation to their medical conditions. Care plans were in place to support this person with their individual conditions and we saw that care was delivered as planned. The service had supported this person to take preventative measures, and liaised with health professionals, to ensure they remained well.

Inadequate

Is the service well-led?

Our findings

At our last inspection in April 2015 the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the home's quality monitoring system had failed to identify issues within the service. The provider was also in breach of this regulation due to a closed and critical culture that had failed to respond to feedback received on the service. In addition, the service had failed to maintain up to date records.

Following our inspection in April 2015, an action plan was submitted by the provider which detailed how the service would meet their legal requirements. They told us this would be completed by December 2015. At this inspection we found that although some improvements had been made we found additional concerns and breaches of regulations that had not been identified by the providers quality assurance system. The meant that there is a repeated breach of this regulation.

The service had systems in place to monitor the quality of the service that was delivered. However, these were not fully effective. We saw from the records we viewed that, all except one of the quality monitoring audits had not been completed since November 2015. These included audits around infection control and prevention and health and safety. The catering audit had not been completed since July 2015 and no audits were available to show that the service had monitored the completion of people's care plans. No system was in place to monitor the staffing levels to ensure that there were enough staff in place to meet people's needs. In addition, the service had failed to implement processes to ensure staff were suitably skilled, trained and competent in their roles. The service had also failed to prepare and plan for the recent changes in management. When we brought this to the attention of the manager, they confirmed that no recent audits had taken place. The lack of audits and effective monitoring of the service meant that the areas of concern that we identified had not been identified by the provider, or had been identified but action had not been taken to make improvements.

In addition, the service had failed to maintain an accurate, complete and contemporaneous record in respect of each person. This included keeping a record of the care and treatment provided to them, information about their medicines and of decisions taken in relation to the care and treatment provided. This meant that staff did not have accurate guidance to enable them to meet people's needs effectively.

The manager told us they looked at accident and incident records on a regular basis but not on a weekly basis as required by the provider. The manager demonstrated they had an understanding of the accidents that had occurred. They gave us an example of where a pattern had been identified and actions taken to reduce the likelihood of future harm to people. However, there was no formal analysis of accidents and incidents. This meant that, should the manager be absent, there was no system in place for other staff to identify trends and take appropriate action to reduce the risk of further occurrences.

As a consequence of these findings the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in April 2015 the provider was also in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because the provider had failed to report significant events that affect people's safety. These are called statutory notifications and the provider is required by law to keep the CQC advised of such events.

Since our inspection in April 2015 and from the information we hold about this service, we know that the service has made improvements and submitted statutory notifications as required.

At the time of our inspection, the manager had submitted an application to become registered with the Care Quality Commission (CQC) and this was being processed. The manager had been in post since February 2016 but had previously worked for the provider for some years. They told us they felt supported in their role and was open in their approach with us. They told us they were aware that improvements to the service were required and explained the challenges they currently faced. The manager had identified some of the issues highlighted in this report and was able to talk us through their plan of action to address these. The people we spoke with had a mixed opinion on the visibility and approachability of the management team. When we asked one person who used the service if they saw the manager very often they said, "Not a lot" although they added that they felt things were improving under the new manager. Another person told us that when they had raised a concern with the manager they didn't find them helpful. One relative told us that they didn't know who the manager was. When we discussed this with the staff, they were divided in their opinion. Two told us they didn't find the manager supportive and had had little conversation with them. However, all the other staff we spoke with told us the management team was approachable and had an 'open door' policy.

The service had given people the opportunity to discuss the service and make suggestions. We saw from the records we viewed that regular meetings had taken place. We saw that meetings had been held with the people who used the service, their relatives and staff. The minutes from these meetings demonstrated that the service was encouraging an open and honest culture. This was done by discussing the changes planned and acknowledging the current challenges the service was experiencing. We saw that some of the relatives of people who used the service had suggested forming a 'Friends of Walsham Grange' group to support the service and assist in fundraising events. From the minutes of meetings we viewed we saw that this suggestion had been encouraged by the service and that the group was now in place.

In response to the inspection in April 2015, the service had introduced questionnaires to gain feedback on the service. A 'suggestion box' had also been installed in the foyer and we saw that suggestions had been responded to. These were on display in the home so people could see what action the service had taken. Questionnaires had been sent out to the people who used the service, their relatives and healthcare professionals in October 2015 and these were mostly positive in their response. Out of the 23 received, six commented on the poor choice and quality of the meals provided by the service. However, we saw from the minutes of meetings subsequently held, that this had been acknowledged and that the menu was under review.

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 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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe care and treatment The service had failed to protect people against risks by doing all that is practicable to mitigate any such risks. Regulation 12(1) and (2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA 2008 (RA) Regulations 2014: Staffing The service had failed to ensure there were enough suitably qualified, competent, skilled and experienced staff deployed to meet people's needs. Regulation 18(1) and (2)(a)

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good governance The service had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. Regulation 17(1) and (2)(a)(b)(f) The service did not maintain an accurate and complete record in respect of each person who used the service. This included a record of the care and treatment provided and of decisions taken in relation to the care and treatment provided. Regulation 17(2)(c)

The enforcement action we took:

Warning notice