MAPS Properties Limited

Walsham Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Walsham Grange is a residential care home providing personal care to 53 people aged 65 and over. The service can support up to 75 people. The home is an adapted building set across two floors.

People's experience of using this service and what we found
Individual risks relating to people's health and wellbeing had not always been identified or planned for. Where risks had been identified, appropriate action was not always taken to minimise the risk of harm. Staff did not have a good understating of what constitutes abuse and how to report concerns. Learning did not take place after incidents and people's care records were not always reviewed after an accident. Environmental risks were not always identified or well-managed.

Medicines were not managed in a safe way. People were not given their medicines as prescribed and there was insufficient written information about people's medicines. There were poor practices relating to caring for people living with diabetes.

There were insufficient numbers of staff to support people safely and recruitment records were not always complete.

Staff did not always observe good practices around infection prevention and control and there was a malodour in some parts of the home.

Assessments of people's care needs were not detailed and failed to identify the level of care people required.

New staff did not receive thorough inductions and staff had not completed all of their training set by the provider. The training staff had received was not sufficient for them to carry out their role effectively. Staff received regular supervision, but some appraisals were overdue.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Mental capacity assessments were not always carried out and consent was not always sought from people's authorised representatives.

There was poor assessment of people's nutritional needs. Where people had been identified as being at risk of not maintaining a good nutritional intake, people did not receive the appropriate support. Staff did not always work collaboratively with other healthcare professionals to ensure people received timely care. We did however see some good practice in this area too.

Staff did not always treat people in a respectful way and uphold people's dignity. Staff did not spend time to

speak with people of engage people in activities. People's communication and diverse needs had not been assessed.

People care was not planned in a person-centred way and care records were not up to date. There was no record of people's life histories. People's end of life wishes were not recorded.

There was a lack of systems in place to monitor and assess the quality and safety of service being delivered. Audits that were carried out were ineffective at identifying shortfalls and where shortfalls had been identified, timely action was not taken.

The form used to gain people's views about the service was not sufficient as it did not give people the opportunity to provide feedback across all areas of the service. The registered manager had implemented feedback forms for relatives and was awaiting the responses.

Notifiable incidents were not always reported to CQC as required by law.

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 23 November 2017).

Why we inspected
The inspection was prompted in part due to concerns received about medicines, safeguarding concerns and people's care records. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to safe care and treatment, staffing, need for consent, meeting nutritional and hydration needs, dignity and respect, person-centred care and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Walsham Grange

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.

Inspection team
On the first day of the inspection, the inspection team consisted of two inspectors, a medicines inspector and an assistant inspector. The last two days of the inspection were carried out by one inspector.

Service and service type
Walsham Grange is a 'care home'. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Walsham Grange can accommodate up to 75 people, at the time of our inspection 53 people were living in the service.

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
Before the inspection we reviewed the information that we held about the service and registered provider. This included any notifications and safeguarding information that the service had told us about. Statutory notifications are information that the service is legally required to tell us about and include significant events such as accidents, injuries and safeguarding notifications. We also contacted the local authority and safeguarding team for feedback about the service.

During the inspection

During the inspection we looked at eight people's care files, 14 people's medicine records, four staff recruitment files and a range of documents relating to the day to day running and oversight of the service. We spoke with two people who lived in the service, four relatives, the registered manager, deputy manager, five members of care staff, one of which was a regular member of agency staff, a member of kitchen staff and one visiting healthcare professional.

After the inspection
We continued to seek clarification from the registered manager to validate evidence found.

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.

Systems and processes to safeguard people from the risk of abuse

● Staff did not have a good understanding of what constituted abuse. Staff did not know what outside agencies they could report concerns of abuse to.

Using medicines safely

● There was a system in place for ordering and giving people their medicines as prescribed. Medicines given by staff were recorded on Medicine Administration Record (MAR) charts.

● We noted there were some gaps and numerical discrepancies on the MAR charts for oral medicines, which indicated people did not always receive their medicines as prescribed. There were also gaps on charts relating to medicines prescribed for external application such as creams and emollients.

● Observations of staff giving people their medicines showed that they did not follow safe or hygienic procedures. At the time of inspection, members of staff handling and administering people's medicines including the administration of insulin by injection had not recently been assessed for their competency to give people their medicines safely. We spoke with the registered manager who told us they would arrange for the district nurses to administer people's insulin.

● Oral medicines were stored securely. However, monitoring records for the temperatures at which medicines were stored were not always completed. Medicines prescribed for external application such as creams and emollients stored in people's rooms were not secured so they could be accessed by people who could have caused themselves accidental harm.

● There was some guidance to show staff how people preferred to have their medicines given to them. However, for people who were given their medicines prepared in food or drink, written information about this was inconsistent and advice had not always been taken from a pharmacist to ensure it was safe to do so. A member of staff we spoke with told us how they gave a person their medicines, but this was inconsistent with the written information available.

● There was guidance to help staff give people their medicines prescribed on a when required basis for some but not for all medicines prescribed in this way. Some of the written information lacked sufficient detail to enable staff to give people these medicines consistently and appropriately and some changes to medicine doses had not been included. In addition, there were not always clear records showing why the use of the medicines was justified on each occasion. For people who had their pain-relief medicines prescribed in this way and who were unable to tell staff about their pain there were no pain assessment tools in use.

● When people had known allergies and medicine sensitivities, information about this was sometimes written inconsistently which could have led to error.

● For people who were prescribed medicated skin patches, there were additional records in place to show the sites the patches had been applied to had been varied to reduce the potential for side effects, however,

these had not always been completed by staff.
● There was a lack of information to show staff the areas on people's bodies creams and emollients were to be applied.
● Containers of eye drops that have limited shelf-lives once opened were not handled in a way that ensured they would only be used for their limited time period. There was a risk they could be used after their expiry.
● Observations of staffs' competency in administering all other medicines had been carried out, however, only three staff had up to date training in the theoretical aspect of medication awareness.

Assessing risk, safety monitoring and management
● Individual risks to people's health and wellbeing were not always identified and planned for. We saw one person was at risk of choking; a risk assessment for this need was not in place until three months after they moved to the home.
● Two people who moved to the home were known to be at risk of developing pressure ulcers. Staff did not take the necessary action to mitigate this risk and the two people both developed pressure ulcers. We found assessments of people's skin integrity were not always carried out.
● There was poor ongoing care for people at risk of developing pressure ulcers. People were not repositioned at the frequency stipulated by their care plans and creams to maintain people's skin integrity were not applied as prescribed. Records showed staff did not thoroughly check people's skin integrity.
● During the inspection, the registered manager told us they had been informed night staff were pre-filling daily care records such as repositioning charts and personal care records. They told us they visited the service and found some people's records had already been pre-filled with times and details of care yet to be delivered. This added to our concerns that people were not receiving safe care.
● There was poor provision of care for people living with diabetes. We saw risk assessments lacked personal details such as normal ranges of blood sugar levels and what symptoms individuals would show if they were experiencing high or low blood sugar levels.
● We saw from one person's records their blood sugar levels had increased. It took staff 10 days to seek medical advice and the person was admitted to hospital for treatment.
● Some people showed behaviour that challenged others. Risk assessments in relation to this need were not person-centred and failed to describe what caused the behaviour and what reassurance or distractions people responded to.
● One person we spoke with told us staff moved them in bed using their bed sheet rather than a slide sheet which would reduce the risk of sustaining any skin tears. We noted there was no slide sheet in their room.
● Personal emergency evacuation plans (PEEPs) for people did not always have the correct information about the support people required to evacuate the home in the event of an emergency.
● Risks within the environment had not been identified and managed. We noted there was a pipe sticking out of the floor and the foam covering had come away from it which posed a danger should someone fall on it.
●We also noted a number of toiletries in one of the bathrooms and a prescribed cream for one person who had passed away. There was no risk assessment in place for leaving toiletries in the bathroom.

Preventing and controlling infection
● One member of staff told us there were not always the right size gloves available for staff and we noted there were only two sizes of gloves available on the first floor. We also saw that staff did not always wear aprons when serving food or when going in and out of the kitchen.
● An infection control audit identified that practices around handwashing were poor.
● One relative told us, "There is often a bad smell, but you do see the cleaner go around." We noted there was a malodour in some parts of the home, however the home was generally clean.
● There had been two outbreaks of diarrhoea and vomiting and one stomach bug outbreak within a three-

month period.

The above findings constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● On the second day of our inspection we noted the toiletries and cream from the bathroom had been removed.
● Utilities such as the water and gas supply were safety tested as well as fire fighting equipment and electrical items.
● The deputy manager showed us copies of risk assessments for the hot weather which detailed what action staff should take to ensure people stayed hydrated and comfortable in the extreme heat.

Staffing and recruitment
● People and relatives we spoke with told us there were not always enough staff. One person said, "You have to shout for staff, I know they do not always have staff." One person's relative told us, "I think they could do with more [staff] as you have to wait for staff to come when you call them."
● Staff we spoke with also said there were not enough staff. One staff member told us, "There are too many residents for the amount of staff." A second staff member said, "There's not enough staff, [it's] really busy in the morning."
● Our observations showed there were not sufficient numbers of staff to respond to people's needs in a timely manner.
● Assessments of people's dependency did not accurately reflect the level or care and support they required, therefore, this meant suitable numbers of staff were not provided.

The above findings constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Recruitment files were not complete. The employment history for two staff members was incomplete and there was no application form for one member of staff. There was only one file with any interview notes.
● We saw that appropriate background checks had been completed before staff commenced their employment. This included a Disclosure and Barring Service (DBS) check and two references.

Learning lessons when things go wrong
● No learning took place after the three outbreaks of contagious illnesses. There was also no formal analysis or learning from serious individual incidents.
● Accidents and incidents were reviewed on a monthly basis and any actions taken were documented, however, we noted from one person's care records that a review of their care was not completed after every fall. We also noted a lack of detail about incidents on the monthly analysis.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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 people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People's mental capacity was not always assessed. We saw one person had not had their capacity assessed but there was a best interest decision in place for the use of a call mat.
- A second person's care records showed they had a DoLS care plan in place, but their mental capacity had not been assessed. A further document in their care records showed they had fluctuating capacity, but no further information was provided. For example, if they were able to make any decisions or if their capacity fluctuated throughout the day.
- One member of staff told us the MCA and DoLS training they received did not provide them with the knowledge to carry out detailed capacity assessments and best interest decisions.
- We saw there were a number of conditions on one person's DoLS authorisation, these were stipulated to ensure the person was being deprived of their liberty in the least restrictive way. We looked at the person's daily care notes from the day the authorisation was granted and noted none of the conditions had been met.
- One person had appointed a Lasting Power of Attorney (LPOA), the registered manager told us they did not have a copy of the document which showed who held LPOA.
- A second person had appointed a LPOA and had a best interest decision in place about receiving care and treatment. There was nothing to show the LPOA had been consulted about this decision. We also saw that a

family member without authorisation to make decisions on the person's behalf had been asked for verbal consent to take photos of the person for their care records.
● Due to the lack of sufficient individual information about people's capacity, we could not be assured every practicable step had been taken to promote people's independence in relation to making decisions about their care and treatment.

The above findings constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff support: induction, training, skills and experience
● New staff did not receive comprehensive inductions and there were no records of staff inductions. The deputy manger confirmed inductions were not recorded. A member of staff we spoke with told us, "My induction was good, I had a good induction, shadow shifts for a week. Now they are not getting good inductions, they need the staff, so they bring them in."
● Some staff we spoke with told us they did not receive training pertinent to their role. One staff member said, "Staff don't have the training to deal with high need service users or dementia." They added they had not received any dementia training. A second staff member told us, "There is a lot [of staff] that don't know what they are doing, they rely on other staff." A third staff member told us they had not had any training in behaviour that challenged.
● Care staff we spoke with did not have a good understating of safeguarding, the MCA or DoLS.
● We noted from the training matrix that staff had not completed all of the training set by the provider. This included fire awareness, food safety, end of life care, diabetes and pressure ulcer prevention.

The above findings constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Staff received regular supervision with the registered manager. Supervision is a meeting with a senior member of staff for staff to discuss their performance and development opportunities. Staff also had an annual appraisal. We noted that some staff were overdue their annual appraisal.

Supporting people to eat and drink enough to maintain a balanced diet
● Risks relating to people's nutritional intake were not adequately assessed and mitigated. One person's care record stated they needed to be weighed weekly, their records showed they had only been weighed once since moving to the home. An assessment of their nutritional risk had not been carried out until two months after their admission.
● Their care plan stated they should be offered snacks between meals. We looked at their food intake charts and showed these were not being offered. We were unable to ascertain if this had an impact on them due to the lack of information about their weight.
● We were concerned that the nutritional risk had not been calculated for a second person correctly, as this involved knowing the person's height. The nutritional risk assessment had been calculated but the person's height was not on the document. It stated they were overweight but to offer the person high calorie snacks. Although the rationale for this was not clear, we did not see staff offering these. The fluid intake charts for this person were also not complete.
● We looked at the food charts for one person who was diabetic. We saw staff were not supporting them to follow a diabetic diet and they had eaten chocolate cake twice in one day.
● We observed the lunchtime meal and noted this was disorganised. People were not served their meal at the same time and we saw some people had finished their meal before others had been served theirs.
● We noted people were being given their tea time meal at 4pm. This was only a few hours after people had

finished their lunchtime meal.

The above findings constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● A member of kitchen staff told us staff kept them informed of people's dietary needs. They also had a good knowledge of people's individual nutritional needs.
● People we spoke with gave us varied reviews about the quality of the food. One person told us, "Lunch is good, but tea can be poor…They just give what they have and is easy." A second person said, "[I] love [the food], it is nice, have cooked food. Plenty of it, if you want more, you can ask. There is a list and you can tick what you want."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments of people's needs were not thorough and did not contain sufficient detail about people's physical and psychological wellbeing.
● Records showed information about people's care needs had been shared by referring agencies, but this had not been taken into account during the assessment process. Therefore, the level of care people required was not put in place upon their arrival at the home.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff did not always work collaboratively with other agencies to provide consistent and timely care. Records showed there was a delay in seeking medical advice for one person's high blood sugar levels and no medical advice had been sought for a second person in relation to the same matter.
● One healthcare professional we spoke with told us staff did not always follow advice and would not always identify changes in people's care needs.
● We did see some good practice around involving other healthcare professionals where there were concerns about people's health and wellbeing. For example, we saw there was regular contact with the dementia intensive support team for one person who showed behaviour that challenged.

Adapting service, design, decoration to meet people's needs
● There was some signage around the home to help people navigate their way around the home independently.
● People were able to personalise their rooms with their belongings and photos.
● There were several communal areas where people could spend time with others.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- Staff did not always treat people in a caring and respectful way. One person told us, "Some of the night staff can be blunt, they will tell you to wait and then leave."
- We heard one staff member speaking with one person who was very distressed and was living with dementia. The staff member asked the person why they were shouting, in a stern manner.
- We noted that staff missed opportunities to engage with people. For example, we saw staff sitting in people's rooms writing notes but not making any conversation with them.
- People's diverse needs were not met as these were not planned for and documented in their care records. We were concerned that staff we spoke with did not know people's individual care needs and relied on reading people's care records.
- People were not encouraged to express their views about their care. People's communication needs had not been assessed and it was unclear what decisions people were able to make for themselves.
- One member of staff told us they did not have time to speak with people. They said, "We do not have time to care for people, it is like a factory. Sometimes you can just cry when people say, 'can you sit with me?' and you cannot, you do make time where you can."
- Staff also told us people did not always get a choice of what to wear.
- People were not cared for in a way that upheld their privacy and dignity. One relative told us their family member had faeces under their fingernails and they had to ask staff to clean them. We also observed that some people's personal appearance appeared unkempt.
- We saw one person was in their en suite, a member of staff took their meal to them while they were not fully clothed, they then placed the person's meal on a table which was next to a used commode.
- A second person who had been distressed most of the morning on the first day of our inspection had been woken up for their lunchtime meal. We saw they were not supported to sit up-right and a member of staff was leaning over them trying to get the person to eat. This did not uphold the person's dignity.
- People's independence was not always promoted. We saw one person liked to read, but we noted their glasses were so dirty, it would have made it difficult for them to read.
- We observed people were not offered clothes protectors to wear when having their lunch. We observed one person being supported with their lunchtime meal and food was dropping on their clothes.

The above findings constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated

Activities) 2014.

● We had received mixed feedback from people and their relatives about the care provided, and we received some positive comments. One person told us, "[The staff] do anything I ask, I would be happy to ask if I need help." A relative we spoke with said, "[The staff] are all polite when you see them."

Requires Improvement

Is the service responsive?

Our findings

Our findings
Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Staff were not responsive to people's needs. We saw one person was very distressed on the first floor. Two of the inspection team went to see the person, while we were with them, a member of staff walked past the room without checking on the person. One of the inspection team went to find a member of staff. We told the member of staff about the person, but they did not proceed to go to them.
- There was nothing in this person's care plan about the distress they experienced and how staff should support them to manage this.
- People's care was not personalised to their needs. One person was hard of hearing but there was no mention of how to meet this need in their care records. People's preferences about how they liked their care to be delivered was not documented.
- There was a delay in planning people's care needs after they moved to the home. Some people had been living in the home for over two months before their care was planned for and risk assessed.
- People's care records did not contain the most up to date information about their care needs. One person's choking risk assessment showed they did not need assistance with eating, but we saw staff supporting the person with their meals.
- People's care files did not contain any information about their personal histories. Knowing about people's personal histories helps staff to engage people in conversation and reminiscence has been shown to improve the wellbeing of people living with dementia.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- There was a lack of detailed information about people's communication needs and no consideration had been given to the use of alternative ways of communicating with people.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People and staff we spoke with told us there was little activity provision. One person told us, "[We've] not had any activities for weeks, if there is something, you just sit there, nothing interesting." One member of staff explained, "They do have activities, but not everyone can get to them, I feel they need more and more to relate to them. They just sit and do nothing."

● One person told us they sometimes felt isolated, "Yes, you can [feel bored], you just watch the world go by. It can be lonely."
● We saw from one person's care records they liked listening to the radio and their care plan stated which stations they liked to listen to and to ensure they had a newspaper every day. We did not see they had a newspaper and never saw their radio was on.

End of life care and support
● Not everyone had a care plan in place which detailed their end of life wishes and preferences. The one end of life care plan we saw was written in a person-centred way.

The above findings constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Improving care quality in response to complaints or concerns
● People and relatives told us they felt able to raise any concerns and knew how to complain.
● All complaints apart from one had been logged. Complaints were investigated and thorough responses were provided by the deputy manager and apologies were offered for any shortfalls found.

Inadequate

Is the service well-led?

Our findings

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 requires improvement. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was no robust schedule in place to monitor and assess the quality and safety of the service. The registered manager had been working for the provider as the regional manager prior to their current role as registered manager at Walsham Grange. They also failed to carry out any audits in their capacity as the regional manager.
- The few audits that were carried out were sporadic and did not focus on the areas of the service which had clearly deteriorated.
- We looked at the audits and saw they were ineffective at identifying shortfalls, for example, the home environment audit failed to note some of the concerns we found within the environment.
- Where the audits did identify areas for improvement, remedial action was not taken in a timely manner. In addition, two different activities audits had been carried out and gave different timescales for shortfalls to be remedied.
- Whilst people's medicines were audited, a number of concerns continued to be found. There was no comprehensive action plan in place to address this. The registered manager was not aware that staff only one member of staff was competent to administer insulin until we raised this during the inspection.
- A monthly incident analysis was carried out, but descriptions of the incidents were not sufficiently detailed. For example, descriptions of injuries sustained after a fall were not detailed, therefore, we could not be assured reviews of accidents and incidents could identify any shortfalls regarding actions taken and care provided post-incident.
- No checks of people's care records took place. One member of staff told us, "Paperwork is never reviewed like fluid charts, we fill them in, put them in a folder, nothing is done with it, sometimes there's no point in doing it." A member of staff told us a senior member of staff at the end of each shift used to check and document whether all of the daily records relating to people's care had been completed. They told us the registered manager stopped this practice.
- Clear and detailed records were not kept in relation to people's ongoing care and treatment.
- During the inspection, the registered manager told us they had been informed night staff were pre-filling daily care records such as repositioning charts and personal care records. They told us they visited the service and found some people's records had already been pre-filled with times and details of care yet to be delivered. This added to our concerns that people were not receiving safe care.
- Confidential information was not stored securely. During our inspection we found a confidential document relating to a member of staff in the health and safety folder.

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

● Some of the staff we spoke with told us the morale within the staff team was low. One staff member told us, "There is an atmosphere of push the blame down, filters down to the care staff."

● Our observations showed that staff did not have the time to spend talking with people or engaging them in activities. The care provided was task-focussed which did not lend itself to achieving good outcomes for people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The registered manager had implemented daily feedback sheets where people were asked about their views. However, the questions were not tailored to gather in-depth feedback from the perspective of someone who lived there. The questions were worded as though people were just visiting the service.

The above findings constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The registered manager told us they had recently send out surveys to people's relatives and were awaiting their responses.

● Staff had regular meetings. Records showed agenda items included staff training and activities 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

● We were not always informed of notifiable incidents. We were not notified of four safeguarding incidents and a serious injury.

The above findings constitute a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Working in partnership with others

● The provider and management team continued to liaise with the local authority and safeguarding to make improvements.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Commission of reportable incidents. Regulation 18 (1) (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that the care people received was appropriate, met their needs and reflected their preferences. Regulation 9 (1) (3) (a) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people were treated with respect and have their dignity and privacy upheld. Regulation 10 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure accurate and effective assessments of risks to the health and safety of people using the service. The provider had also failed to do all that is reasonably practicable to mitigate any such risks. People's medicines were not managed in a safe way. There were poor practices in relation to the prevention and control of infection. Regulation 12 (1) (2) (a) (b) (c) (f) (g) (h) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure the nutritional and hydration needs of people were consistently met. Regulation 14 (1) (2) (a) (b) (4) (a) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement systems and processes that effectively assess, monitor and determine risks to people or maintain accurate, complete up to date records. Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider failed to ensure adequate numbers of staff to meet people's needs.

The provider failed to ensure staff received adequate support and training and that staff had the knowledge and skills to perform the role expected of them.

Regulation 18 (1) (2) (a)