MAPS Properties Limited

Walsham Grange

Inspection report

81 Bacton Road
North Walsham
Norfolk
NR28 0DN

Tel: 01692495818

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Ratings

Overall rating for this service	Requires Improvement
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

We carried out an unannounced comprehensive inspection of this service on 5 and 6 April 2016. Three breaches of legal requirements were found and a warning notice was issued in relation to one of them which involved the governance of the service. We gave the provider until 17 June 2016 to meet the legal requirements of this regulation.

We undertook this focused inspection to check that the service had undertaken changes to meet the legal requirements of this regulation. This report only covers the findings in relation to the warning notice. You can read the report from our last comprehensive inspection in April 2016, by selecting the 'all reports' link for Walsham Grange on our website at www.cqc.org.uk.

At this inspection carried out on 9 August 2016 we found that there were still considerable concerns in relation to the governance of the home. We have not changed the overall rating for this service as a result of this inspection as it was only undertaken to follow up our enforcement action. The service remains requires improvement and the domain for well-led remains inadequate.

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 with a number of communal areas. Since our last inspection in April 2016, the service had closed its Grant Hadley unit which catered for people living with dementia. Although there were still people living with dementia residing in Walsham Grange, they had moved into the main house following appropriate consultation. At the time of this inspection, 44 people were living at Walsham Grange on a permanent basis, some of whom required nursing care.

At the time of this inspection, the home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At our previous inspection in April 2016, although the manager was in post, their application to become registered with the CQC was being processed.

At this inspection carried out on 9 August 2016 the registered manager was not available and the deputy manager was managing the home in their absence. The registered manager was due to be available on 15 August 2016 and we gave them the opportunity to submit any further information in relation to the warning notice up until 5pm on that day. Additional information was submitted within the timeframe given.

At the inspection in April 2016, concerns were identified that demonstrated that the provider did not have effective systems in place to monitor the quality and safety of the service delivered. This had resulted in some people receiving a poor service.

At this inspection we saw that although some improvements had been made, the service was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which relates to governance.

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

Although additional processes had been introduced to monitor the quality and safety of the service the home delivered, these were not wholly effective. The service had failed to appropriately manage the concerns highlighted in this report. These included a lack of suitably trained and supported staff to meet people's needs in a person-centred manner and failure to mitigate the future risk of accidents and incidents reoccurring. Issues in relation to medicines administration and management had not been identified by the service. There was also a lack of clear plans to action any concerns identified where the service fell short of the required standard.

Some processes that the service had introduced had resulted in some improvements being made. This included mitigating some risk of medicine administration errors and the identification and management of the risks associated with the building, environment, working practices and adverse events.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Inadequate

The service was not well-led.

The auditing system in place to monitor the quality and safety of the service was not wholly effective and some issues identified on our previous inspection in April 2016 were still evident.

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.

We undertook an unannounced focused inspection of Walsham Grange on 9 August 2016. This was carried out to check that requirements of a warning notice, issued after our comprehensive inspection in April 2016, had been met. The warning notice had been issued as the service was not meeting all legal requirements in relation to the governance of the service .

The inspection was carried out by two inspectors.

During our visit we spoke with two people who used the service. We also spoke with the deputy manager and three care staff. We looked at a number of records and audits in relation to the monitoring of the quality and safety of the service. In addition, we reviewed the care and support records for two people and the medicines administration and associated records for eight people.

Inadequate

Is the service well-led?

Our findings

At our previous inspection carried out on 5 and 6 April 2016, we found that the systems to monitor the quality and safety of the service were either not effective or were not in place. This resulted in some people experiencing poor care and support. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We subsequently served the registered person with a warning notice informing them that they had to comply with this regulation by 17 June 2016. At this inspection carried out on 9 August, we found that the necessary improvements had not been made and that the provider was still in breach of this regulation.

The concerns found during the inspection in April 2016 included the management and administration of people's medicines, the staff response times for people requesting assistance and staff training, support and supervisions. In addition, concerns were identified relating to accidents and incidents and the risks associated with the building, environment and working practices. The service's system to monitor the quality and safety of the service was not effective.

At this inspection carried out on 9 August 2016 we found continued concerns in relation to the governance of the home. Although some systems had been introduced to monitor the quality and safety of the service, these were not always effective.

Each staff member we spoke with told us there were not enough staff to meet people's needs. One staff member told us that they had to rush when they assisted people. Another staff member explained that care was provided to the people who used the service but that they did not have time to chat with people. One person who used the service told us. "There are definitely not enough staff." The service had also received a complaint in regards to the poor call bell response times. The service had not identified these issues. Although a dependency tool was used to calculate staffing levels, no system was in place to audit whether people's needs were being met safely and in a timely and person-centred manner.

Staff had either not received or were overdue training in what the provider deemed mandatory. For example, out of the eight senior staff, only two had received up to date training in moving and handling. None had received training in equality and diversity and person-centred care. The provider had supplied us with three different sets of information in relation to staff training, all of which were different to each other. This meant there was no accurate information available on staff training. The service had not identified this and had no system in place to effectively audit and plan staff training.

At our inspection in April 2016, staff told us that they had not received regular supervision sessions. At this inspection senior staff told us that they had now received this however other staff members had not. We saw records that confirmed this. The service had not ensured that staff received appropriate and ongoing supervision to ensure competency within their role.

Although the service had introduced a system to record and analyse accidents and incidents, this had not been fully effective. During the inspection, we saw that there had been over 30 accidents and incidents

involving people who used the service during the month of July 2016. Records showed that appropriate immediate action had been taken to ensure the wellbeing of people. However, only a few accidents or incidents had been reviewed and actioned by the registered manager. The provider's procedures stated that all accidents or incidents needed to be reviewed by the manager. Out of the incidents for July, eleven involved medicine administration errors. None of the records relating to these incidents demonstrated what action had been taken to mitigate the risk of future occurrences. When we discussed this with the deputy manager, they were not able to explain what actions had taken place as a result. We concluded that the system the service had in place to record, analyse and mitigate risk in relation to accidents and incidents was not effective.

The service had an audit in place to review the medicines administration and management within the home but this had failed to identify concerns that were found during our inspection on 9 August 2016. A medicines audit had been completed by a senior carer on the day of our inspection but it was unclear as to which person's medicines it related to and what actions were to be taken as a result. When we discussed this with the deputy manager they told us that all medicines for the people living in a certain area of the home were included in the audit each month.

Although some medicine administration and management audits had been completed for June, July and August 2016, there were no associated action plans and it was not clear whether concerns that had been identified had since been rectified. For one person who used the service, staff had failed to identify that this person had not received the amount of pain relief that was prescribed. It was noted that five separate staff members had administered pain relief to this person however this error had not been identified or actioned. The service had also failed to assess this person's pain until some days after the medicines error had been identified. We also saw that not all people had information in place to assist staff in administering medicines that were needed on an 'as required' basis. The system the provider had in place to audit medicine administration and management was therefore not effective at identifying concerns and ensuring people's health and wellbeing.

These concerns meant that the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had previously warned the provider that there was a lack of systems in place to effectively monitor the quality of the service provided. The provider had taken some steps to action this and had introduced processes to address concerns identified at the April 2016 inspection. A number of action plans were in place to address the concerns highlighted.

At our inspection in April 2016, a number of concerns were identified in relation to medicines administration and management. Although the medicines audit that the provider had introduced had not been wholly effective, some improvements were identified at this inspection. At our inspection in April 2016, we saw that medicine administration record (MAR) charts for people did not record why medicines that were only needed on an 'as required' basis had been administered. At this inspection we saw that this had been recorded.

The service had also introduced a system to ensure that people's medicines were received in good time to administer them. At our previous inspection, one person's medicines had not been received in time for them to be administered putting the person's health and wellbeing at risk. This had been rectified at this inspection. We also noted that steps had been taken to securely store topical creams. They were no longer accessible to people helping to protect them from potential harm from their misuse or accidental ingestion.

Additional steps had also been taken to improve the safe administration and management of people's medicines. The staff we spoke with told us that they were now interrupted less whilst administering people's medicines therefore reducing the risk of an error occurring. They told us they wore a red tabard to assist with this and that they were more aware of the consequences of being interrupted whilst completing the task. They told us they had enough time to administer medicines. Although records showed that not all staff had received up to date training in medicines administration, staff told us that they had had their competency to administer medicines assessed. This was confirmed by the records we viewed and on speaking with the deputy manager. In addition, the service had also introduced a senior carer on each night shift to assist with medicines management and administration.

The risks to people in relation to the building, environment and working practices had been identified, assessed and appropriate control measures introduced. The potential impact on people in the event of adverse incidents such as fire or power failure had also been identified and assessed. The service had an emergency plan in place that gave staff information to assist in reducing the risk of harm to people in the event of such incidents. In addition, the service had assessed the risk for each individual in the event of an evacuation and put plans in place to address this.

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 has 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:

Notice of Proposal