Autism Anglia

Walnut House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Walnut House is a residential care home providing care and support to four people. The service provides support to people with a learning disabilities and or autistic people. At the time of our inspection the service was fully occupied. Walnut House is a house, with bedrooms across the ground and first floor, and shared facilities for people to use. Access to the service was via a side gate, attached to another location under the same provider.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Right support: The condition of the care environment was poor. This did not demonstrate value placed on the care experienced by people. Care records did not demonstrate people were involved in the development of these documents, or that their individual wishes and preferences were consistently reflected. People's dignity, privacy and human rights were not being consistently upheld, particularly in relation to the implementation of the Mental Capacity Act (2005). Staff did not always 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. Gaps in staff training did not ensure staff had the necessary skills, knowledge and expertise to safely meet people's needs.

Right care: People were not always supported to have maximum choice and control of their lives. Staff did not always 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. Gaps in staff training did not ensure staff had the necessary skills, knowledge and expertise to safely meet people's needs. Care records did not demonstrate people were involved in the development of these documents, or that their individual wishes and preferences were consistently reflected.

Right culture: Members of the provider team visited the service but did not complete meaningful reviews to support ongoing improvement of the service. Inspection findings highlighted that where shortfalls were being identified, timely action was not being taken to address these and make improvements to the quality of people's care or the condition of the care environment. The provider was unable to demonstrate their own plans for the implementation of Right Support, Right Care, Right Culture and associated specialist training into their ways of working and service provision. Overall, there has been a deterioration in the service's rating, and breaches of the regulations were identified.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update: The last rating for this service was good (published 26 July 2019.

Why we inspected
This inspection was carried out because of concerns identified about two other locations under this provider. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this report.

Enforcement and Recommendations
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, which will help inform when we next inspect.

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Walnut House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Both days of inspection were completed by 2 CQC inspectors.

Service and service type
Walnut House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Walnut House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a newly registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 29 November 2022 and ended on 05 December 2022. We visited the location's service on both dates. Written feedback was given after each visit to the service.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used information gathered as part of monitoring activity that took place on 05 July 2022 to help plan the inspection and inform our judgements. We liaised with the local authority quality assurance team, and reviewed information we held on our system about the service. We used all this information to plan our inspection.

During the inspection
We spoke with 8 members of staff including the registered manager, deputy manager, team leader, care staff including a member of bank and a member of agency staff. Some of the staff we spoke with work at night time. We spoke with 4 people living at the service and observed care provided in communal areas.

We reviewed a range of records, including four people's care records in full, and their medication records. We looked at staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We continued to seek clarification from the provider to validate evidence found. We spoke with 3 people's relatives by telephone, about their experiences of the care provided. We liaised with stakeholders after our inspection visits.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Security arrangements in place at the service were found to be poor, this placed people at risk of leaving the service, and wider site without staff knowledge. All the people living at the service had Deprivation of Liberty Safeguards (DoLS) applications in place, due to the risk of "Leaving the home unsupported."
- The condition of the service was in a poor state of disrepair throughout. No improvements were made between our first and second inspection visits. Even where incidents had occurred linked to the condition of the environment, timely improvements were not being made.
- Management plans in place for those people living with epilepsy, including where monitoring equipment was used was poor. There was a lack of action taken in response to our feedback following our first day of inspection.
- People's care records contained out of date, or contradictory information. This did not ensure staff, including unfamiliar agency staff had access to relevant information relating to individual risks and support needs. Staff also told us some documents were not on file as they had not been printed off.
- People's care records stated for knives, cleaning products and other risk items to be stored securely. Items such as knives and cleaning products were found to be accessible without staff supervision. From speaking with staff, it was unclear if this level of restricted access was required and had not been risk assessed on an individual basis.

Risks relating to the health and welfare of people were not always assessed and managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After our inspection, the service confirmed the person had been medically reviewed, and no longer required an epilepsy monitor to be in place.

Using medicines safely

- We identified a medicine error, where medicine had been given to a person incorrectly, but this incident had not been treated as an error, and the required processes followed to reduce the risk of reoccurrence.
- The management of tablets needing to be returned to the pharmacy was poor. Clear records to account for tablets not consumed, safe storage arrangements and records of disposal or returning to the pharmacy needed to be addressed.
- We identified concerns in relation to the safe storage of people's prescribed creams. Arrangements in place did not ensure creams in use remained in date or were safe to use.
- Staff were not following the provider's homely remedy policy. Items such as olive oil ear drops, and

creams were not being labelled to ensure items were used correctly and with the intended person living at the service.
● From reviewing the service's training records, two staff had out of date, or overdue medicine competency checks to monitor the safety of their practice.

Risks relating to the management of people's medicines and the associated risks were identified. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were not assured that the provider was using Personal Protective Equipment (PPE) effectively and safely. Staff were observed supporting people without wearing appropriate PPE to keep themselves and others safe.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Areas of the home were heavily damaged and stained. These areas were no longer able to be adequately cleaned to reduce risk of infection.
● Whilst in date, we were not assured that the provider's infection prevention and control policy was being implemented into staff practice.

Risks relating to infection, prevention and control were identified. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections.
● We were somewhat assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were somewhat assured that the provider was admitting people safely to the service.
● We were somewhat assured that the provider was responding effectively to risks and signs of infection.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Visiting in care homes
● People were able to receive regular visits from relatives and friends within the service, as well as having meetings and attending social events out in the local community.

Staffing and recruitment
● We reviewed rotas and other information provided by the service and identified times where there were not sufficient staff to keep people safe during the day. We found examples of where incidents had happened as a result of either not enough staff on shift to manage the associated risks, or the skills and abilities to meet people's individual assessed needs.
● Support in place for unfamiliar agency staff was unsafe. We observed an agency staff member, who was new to the service, and did not know the local area, to take a person into town alone. This placed the agency staff member and person at risk.
● From reviewing rotas, staff were often working a day shift then the night shift. Whilst the night shift was treated as a 'sleep in shift' arrangements in place did not offer staff sufficient time to rest.
● We reviewed the service's supervision records and identified gaps of up to four months with no record of supervision in place. We checked with the registered manager who confirmed they were behind in the completion of staff supervision.

● There was poor completion of the provider's mandatory training to ensure staff had the skills and knowledge required to meet their roles and responsibilities. This included training relating to autism and epilepsy.

Sufficient levels of suitably trained staff were not always in place to keep people safe. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely to the service, with relevant checks including Disclosure and Barring Service (DBS) checks in place, to ensure staff were suitable to work with vulnerable people. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.)

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
● We found the service was not always working within the principles of the MCA as some of people's capacity assessments were out of date, and not being reviewed, which did not ensure people's changing needs and abilities were being recognised and acted on.
● Where restrictive practices, such as use of assistive technology were in use, corresponding mental capacity assessments were not completed to ensure staff implemented least restrictive options in line with the principles of the MCA.
● We identified examples of blanket risk management, rather than ensuring risks were assessed on an individual basis.
● Not all staff had completed MCA training or refresher courses, to support their knowledge and understanding of its implementation into their ways of working
● We reviewed the service's DoLS register, and an application had been made for each person to be deprived of their liberty. None of these requests had been authorised. As one person accessed the local community without staff support, it was evident the need for DoLS applications was not being kept under regular review by the registered manager.

We would recommend improvements are made to the monitoring and reviewing of people's MCA and DoLS applications to ensure these remain up to date and relevant.

Systems and processes to safeguard people from the risk of abuse
● From reviewing the service's accident and incident records, we identified examples of safeguarding incidents which had not been reported to the local authority or to CQC in line with the registered provider and manager's regulatory responsibilities.
● We found examples of incidents which had resulted in people living at the service or staff being placed at risk, yet no changes had been made to practice or approach to reduce the risk of reoccurrence, and to maintain people's safety.
● People and their relatives told us they felt safe and liked living at the service. Relatives were complimentary about the regular care staff, and felt they were familiar with people's support needs.

Learning lessons when things go wrong

● Part of the reason for inspecting this service, was due to concerns identified about two other locations under this provider. Findings from this inspection do not demonstrate the provider or registered manager have learnt lessons from recent inspections, to implement change and drive improvement at this service.

● Where incidents and accidents had happened, the provider and registered manager were not completing any form of analysis to determine whether there were themes or trends emerging. This did not ensure timely measures were being implemented to reduce the risk of reoccurrence.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Concerns regarding the condition of the care environment, and the need for areas of refurbishment were identified at the last inspection completed in 2019. No changes or improvements had subsequently been made, and the overall condition of the care environment had further deteriorated.
- There was poor reporting arrangements in place by the registered manager and provider. Accident and incident records identified events which had not been referred to the local authority safeguarding team and notified to CQC.
- There was a lack of learning from incidents. The provider and registered manager did not complete thematic reviews and analysis to look for patterns within incidents and were not ensuring the correct level of action was being taken in response to keep people safe.
- There was poor engagement in the inspection process by the provider. We gave feedback after day one of the inspection. A member of the provider team visited the service between day one and two, so was fully aware of our inspection feedback and areas of concern identified. No action was taken in response to make improvements, and we have not received any further assurances from the provider since our final inspection visit.
- Quality audits were not identifying risks and shortfalls in the service, including areas of concern identified as an outcome of this inspection. For example, staff were not completing records relating to the health and safety checks they were responsible for.
- Poor performance by staff in relation to the use of personal protective equipment was not addressed between our first and second inspections to maintain people's safety. There was a lack of managerial oversight to ensure staff were regularly completing supervision and maintaining compliance with their training and competency checks.
- There was a lack of recognition of the seriousness of risk and the need to take timely action to keep people safe and medically well by the registered manager, in response to our feedback.
- Where feedback on the running of the service was sourced by the provider, this was of poor quality. We reviewed a recent report following responses to questionnaires sent to relatives. The report was found to be derogatory, by referring to people living at the service as "Children" rather than adults, and where concerns had been raised, did not contain an action plan of how these concerns would be addressed.
- No relatives knew who the registered manager or deputy manager for the service were when asked or

could tell us who they could contact within the provider team. This did not demonstrate regular contact and open lines of communication were in place between the service, provider and people's relatives.
● For the size of the service, the registered manager was unfamiliar with events which had happened at the service and was unable to access accident records on the provider's electronic system, on the day of our inspection. This did not ensure sufficient managerial oversight of the running of the service and management of incidents and accidents.

The provider had poor governance and oversight arrangements in place to maintain people's safety, quality of life, standards of care provision and drive improvement at the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Each person living at the service was involved in community-based activities, and one person had been supported to secure employment.
● The staff told us they worked well together as a team and felt well supported by the registered manager and deputy manager.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care provider did not always ensure that people and the care environment were consistently kept safe. Risks to people were not well managed, including with medicines management and infection, prevention and control. Regulation 12 (1) (2) (a) (b) (d) (g) (h)

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider did not have good governance and leadership arrangements in place. Audits and quality checks were not consistently identifying risks and shortfalls. There was a lack of provider level oversight of the safe running of the service. Regulation 17 (1) (2) (a) (b)

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The care provider was not ensuring there were sufficient staff, with the necessary skills, training and oversight of their performance to meet people's care and support needs. Regulation 18 (1) (2) (a)

The enforcement action we took:

Warning notice.