Mr & Mrs B W Wall

Walnut Villa

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

Summary of findings

Overall summary

About the service: Walnut Villa is a residential care home registered to accommodate up to six people. At the time of this inspection the service was providing personal care to six people who have a learning disability.

People's experience of using this service:
People were not protected from abuse because staff did not have the skills to recognise abuse or know how to safeguard them. Risks to people were not assessed or action taken to mitigate them. The lack of emphasis focused on protecting people from abuse compromised the care they received. There were insufficient staffing levels to ensure people received a safe and effective service. Medicine management was unsafe, and people did not always receive their medicines as prescribed.

Decisions made on people's behalf were not always in their best interests. People were cared for by staff who did not have the necessary skills and were not supported in their role by the registered manager. People were not supported by staff to prepare and cook their own meals.

The lack of emphasis focused on protecting people from abuse compromised the care they received. People could not be assured they would receive care and support specific to their needs because they were not involved in planning their care. Staff demonstrated a good understanding about promoting people's right to privacy and dignity, but this was not always put into practice.

People's lack of involvement in their care assessment did not ensure they received a service that reflected their preferences. People could not be confident their concerns would be listened to or acted on. People were supported by staff to pursue social activities although, some activities were not of people's choice.

There was no clear management structure, and no one knew who was running the home. There were no effective systems in place to monitor the quality of service provided to people. The provider did not work closely with other agencies to ensure people receive person-centred care.

Hygiene within the home was maintained to a good standard. Where an accident had occurred, action had been taken to avoid it happening again.
Staff assisted people to attend their medical appointments.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support. This should ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes. However, people living at Walnut Villa were not supported to achieve the best possible outcomes.

Rating at last inspection: The service was rated Good at the last inspection in April 2016.

Why we inspected: This was a scheduled inspection based on the previous rating.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Follow up: ongoing monitoring; possibly more about how we will follow up

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

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 effective?

Inadequate

The service was not effective

Details are in our Effective findings below.

Is the service caring?

Inadequate

The service was not caring

Details are in our Caring findings below.

Is the service responsive?

Inadequate

The service was not responsive

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Walnut Villa

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: The inspection was carried out by one adult social care inspector and one inspection manager.

Service and service type: Walnut Villa is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. The registered manager was also one of the registered providers. 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. The registered manager was not present on the day of our inspection visit.

Notice of inspection: The inspection site visit was unannounced on 3 June 2019. Our inspection visit on 7 June 2019, was announced.

What we did: We reviewed information we held about the service such as previous inspection reports and statutory notifications. A statutory notification is information about important events, which the provider is required to send us by law.

We asked the local authority and Healthwatch for any information they had which would assist our inspection. We used this information as part of our planning. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services. The local authority had shared concerns about the management of the home and the safety of people who used the service.

At the inspection visit we spoke with five people who used the service, two care staff, one of the providers and the administrator.

We looked at two care plans and risk assessments. We looked at records relating to the management of medicines and staff training.

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse
•People were not protected from abuse.
•Staff were aware that people were being abused outside of the home but did not take any action to safeguard them.
•A staff member told us if they identified people being abused they would report this to the home's administrator. They were unaware of agencies they could share their concerns with.
•With regards to the abuse that people told us about, we asked staff to make a safeguarding referral to the local authority. However, staff told us they did not know how to do this.
•After our inspection visit we made two safeguarding referrals to the local authority safeguarding team to ensure people were safeguarded from further abuse.

This is a breach of Regulation 13, Safeguarding service users from abuse, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
•People were at risk of harm because staff were not made aware of the potential risk to people or how to protect them.
•We looked at two risk assessments that were out of date and did not reflect people's current needs.
•A staff member told us that risk assessments did not provide relevant information about how to reduce the risk to people.
•One person had reduced mobility and their bedroom was on the first floor. They told us, "The staff help me up the stairs." However, there was no risk assessment in place to tell staff how to safely support the person with their mobility.
•Staff told us there were no personal emergency evacuation plans (PEEP) in place, to tell them what support each person would need to leave the building safely in an emergency. The provider confirmed that PEEPs were not in place.
•Since our inspection visit the provider has sent us copies of the PEEPs they have put in place after our inspection visit.
•One person who used the service until recently was supported by staff when leaving the home. The provider told us the person had been assessed to have capacity and was now accessing their local community alone. The provider was unable to provide evidence of the mental capacity assessment or to demonstrate that a risk assessment had been carried out to ensure the person's safety when they left the home.

Using medicines safely
•People could not be assured they would receive their medicines as directed by the prescriber.

•A medication administration record (MAR) showed a person had been prescribed treatment for constipation. This medicine should only be administered when needed. However, the MAR showed this medicine had been administered every day. The staff member who administered medicines was unable to explain why this medicine was given to the person every day.
•We observed prescribed medicines in cabinets that were not identified on the MAR. Staff were unable to confirm whether or not these medicines were still in use. However, the provider told us that these medicines had been discontinued. This placed people at risk of receiving medicines that were no longer needed.
•A staff member told us they had not seen any written procedures to support their understanding about how to manage 'when required' medicines or homely remedies in use. When required medicines are prescribed to only be given when needed.
•We found that not all staff who assisted people to take their medicines had received medication training. This meant the provider was unable to demonstrate that all the staff had the skills to assist people to take their prescribed treatment safely.
•Staff told us that medicines competency assessments were not carried out to review their medicines practices.

This is a breach of Regulation 12, Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
•There were insufficient staffing levels provided at all times to ensure people's needs were met safely.
•We received concerns from the local authority that staff were not always present in the home.
•The provider told us that people were left in the home alone.
•The provider told us one person required support when they went out in the community. However, this person was left on their own in the home.
•We spoke with the local authority who told us that the provider had been funded to provide 24-hour care. This meant people were placed at potential risk of harm.

This is a breach of Regulation 18, Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Staff told us that before they started working in the home safety checks were carried out to ensure their suitability. We saw evidence of the undertaking of Disclosure Barring Service (DBS) check. DBS checks helps the provider to make safe recruitment decisions.

Preventing and controlling infection
•There were no formal systems in place to ensure the cleanliness of the home. However, we observed that all areas of the home were clean and tidy.
•There were no domestic staff employed. The care staff were responsible for maintaining hygiene standards within the home.
•People who used the service were not encouraged or supported by staff to clean their bedroom. Discussions with staff confirmed that people may not have had the opportunity to develop the skills to undertake domestic duties because staff always carried out these tasks.

Learning lessons when things go wrong
•A staff member told us about an accident where a person had fallen on the doorstep. They told us that a ramp was installed to reduce the risk of this happening again.

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

Inadequate: There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•We spoke with five people who used the service. They told us they were not involved in any meetings relating to them or the care they received. This placed people at risk of not receiving care and support specific to their needs.
•We looked at two people's care records that contained care assessments. However, these were out of date and did not reflect people's current needs.
•A staff member told us the information in care assessments did not reflect people's needs. They told us they were reliant on the provider or the administrator to tell them how best to meet people's needs.
•A staff member raised concerns about the lack of consistency of care and support delivered by each member of staff.

This is a breach of Regulation 9, Person-centred care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
•One person who used the service told us their relative made all the decisions in relation to their care and support and the provider confirmed this. This was of concern because the provider told us the person had capacity to make their own decisions.
•A staff member told us that the decisions made by a relative was not always in the person's best interests. The person told us this was making them anxious and ill.
•The provider was unable to demonstrate that people who made decisions on people's behalf had power of attorney.
•A power of attorney is a written authorisation to represent or act on another's behalf in private affairs, business, or some other legal matter.

This is a breach of Regulation 11, Need for consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•People can only be deprived of their liberty to receive care and treatment with appropriate legal authority.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
•We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
•The provider told us that no one had a DoLS in place. However, one person told us they were not allowed to go out alone. The provider had not considered a best interest decision or a DoLS in this instance.
•We received several concerns from a member of the public about the safety of one person leaving the home without staff support. The provider could not demonstrate they had carried out a mental capacity assessment or that this had been risk assessed. Since our inspection visit we have been informed that an application for an urgent DoLS has been submitted to the local authority for this person.

Staff support: induction, training, skills and experience
•We looked at how the provider supported new staff into their role.
•One staff member told us they had only been working in the home for four days. This was of concern because on the day of the inspection they were in charge of running the home alongside another staff member. This meant that the provider could not demonstrate that new staff were adequately supported in their role.
•People could not be confident that staff would have the appropriate skills to care for them.
•Staff told us they had access to training. However, the training programme showed that staff did not always undertake relevant training with regards to their role. For example, medication, mental capacity act and deprivation of liberty safeguards.
•A staff member told us they received one to one supervision sessions by the administrator who also delivered training. This is of concern because the provider was unable to demonstrate that the administrator had the skills to deliver training.

This is a breach of Regulation 18 Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
•One person who used the service told us, "The staff buy and cook all the meals."
•People told us they had a choice of meals and were able to have snacks when they wanted.
•A staff member said people should be encouraged to cook their own meals and with staff support they would be able to do this. However, they told us there was a long-standing practice of doing everything for people which had deskilled them.

Staff working with other agencies to provide consistent, effective, timely care
•The provider did not work effectively with other relevant agencies to ensure people received effective care.
•One person who used the service told us about the abuse they endured outside of the home. However, the provider did not work with the local authority to safeguard the person.
•One person raised concerns about the decisions their relative made on their behalf. However, the provider had not considered allocating an independent advocate for the person.
•The provider had difficulty with funding sufficient staffing levels to ensure people received the right support. However, they did not ask the local authority to reassess people's needs in view of obtaining the necessary funds to increase the staffing levels. This placed people at risk of inadequate care and support.

Supporting people to live healthier lives, access healthcare services and support
•A care record showed what support a person required to maintain their continence needs. However, their last continence assessment was carried out in 2017. The provider told us they were guided by the person's relative about how to manage the person's continence and not by a continence advisor. This meant the

person was not necessarily getting the appropriate support which compromised their dignity.
•People told us when needed, staff supported them to attend medical appointments.
•The provider told us that people had access to routine health checks such as ophthalmic and dentists and the records we looked at confirmed this.

Adapting service, design, decoration to meet people's needs
•The home was a normal domestic dwelling and was in keeping with the local community.
•There was a ramp access to the property. The property was situated on two floors, the first floor was accessed by stairs.
•The property was not entirely suitable for people with reduced mobility and this applied to one person who used the service. They told us they required staff support to help them on the stairs.
•One person told us, "My bedroom is comfortable and warm in the winter."
•Bedrooms were decorated to reflect the individual's style and interests. All bedrooms were equipped with a washbasin. Bedroom doors were fitted with a privacy lock.

Inadequate

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

Inadequate:People were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls and some regulations were not met.

Ensuring people are well treated and supported; respecting equality and diversity
•People were at risk of not receiving the appropriate care and support.
•People told us they were not involved in any decisions about the care and support they required.
•People were not protected from abuse and this compromised their safety, welfare and the quality of care they received.
•Discussions with staff identified that people's independence was not encouraged. People were therefore, reliant on staff to do tasks they may be able to do themselves.
•We observed that one person was anxious and crying about an incident that had occurred that day. However, staff did not demonstrate the skills to reassure the person or to mitigate the risk of the incident happening again.

Supporting people to express their views and be involved in making decisions about their care
•People told us they were never asked about their views in relation to their care. They told us they were not involved in planning their care.
•We looked at two care records and these did not reflect the person's current needs and did not show they were involved in planning their care. This meant people could not be assured they would receive care and support specific to their needs.

Respecting and promoting people's privacy, dignity and independence
•Discussions with staff and the care records we looked at identified a person's dignity had been compromised because appropriate action had not been taken to manage their continence needs.
•We received a complaint about staff breaching a person's confidentiality by sharing personal information with a person who is not a relative and has not got power of attorney. Although this concern was shared with the provider, they continued to breach confidential information.
•People told us that staff always knocked on their bedroom door before entering their room.
•A staff member demonstrated a good understanding of the importance of promoting people's rights to privacy.
•One person told us they needed minimal support with their personal care needs and confirmed that when staff assisted them, this was carried out in manner that preserved their privacy and dignity.

Inadequate

Is the service responsive?

Our findings

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

Inadequate: Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•People did not have choice or control over their life. For example, one person told us, "I am (age) and I don't want to go to the day centre anymore." However, staff had not listened to them.
•Another person told us they would like to have a job. However, this had not been explored by the provider.
•Discussions with staff identified that people were not provided with the opportunity of gaining employment or access to further education.
•One person told us that staff at the home had taken them to Barmouth and they had enjoyed their time away. They told us about their excitement about their plans to go to Blackpool.
•The provider was unaware of the Accessible Information Standards (AIS).
•The AIS was introduced by the government in 2016, to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS.
•We found that information relating to people who used the service was not in a format they could understand.
•The provider had not considered providing information in other formats such as pictorial or audio to promote people's understanding.

Improving care quality in response to complaints or concerns
•People told us about their concerns and told us they had made the provider aware. However, the provider was unable to demonstrate what action had been taken to resolve them. This meant people could not be confident that their concerns would be listened to, taken seriously or acted on.

End of life care and support
•At the time of our inspection no one was receiving end of life care.

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
•The provider was also the registered manager. One of the providers told us the registered manager had retired six months ago. However, we had not be informed of the registered manager's retirement, or provided with details of who was running the home.
•On the second day of our visit the administrator told us the registered manager had not retired and occasionally came into the home.
•The registered manager is responsible for the day to day charge of the carrying on of the regulated activity. However, people who used the service and staff told us that the registered manager did not run the home.
•It was unclear who was managing the home as staff referred to the administrator as the manager.

This is a breach of regulation 14, Notice of absence Care Quality (Registration) Regulations 2009.

•The provider was unable to assist us with the inspection and referred us to the administrator.
•On the first day of our inspection visit the home was being managed by the two care workers, one of whom had only been in post four days.
•Staff told us there were no systems in place to monitor the quality and safety of the service provided. The provider was unable to demonstrate what systems were in place to ensure people received a safe and effective service.
•There were no systems in place to ensure staff had the skills to recognise abuse and how to safeguard people from this.
•There were no monitoring systems to ensure the safe management of medicines and to ensure people received their medicines has prescribed.
•The provider did not have systems in place to ensure adequate staffing levels were provided at all times to ensure people received the relevant support when needed. At times people were left in the home without any staff present.
•The provider did not have quality monitoring systems in place to ensure people's rights of choice and independence were promoted.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility
•The provider demonstrated a good understanding of people's individual needs. However, the service people received was compromised because staff told us they did not have access to up to date information about how to safely meet people's needs.

•The provider did not have an understanding of duty of candour. For example, no action was taken when people in their care had been abused outside of the home and people remained at risk of abuse.
•The provider had not taken any action to review the risk assessment and care plan of a person who had sustained a fall. This meant the person remained at risk of further falls.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•People were not involved in decisions about their care and the support they required. For example, people told us they were not involved in planning their care.
•People were not supported by staff to promote their independence. For example, all the people we spoke with said that staff did the food shopping and cooked their meals. They told us staff did all the cleaning and the laundry.

Continuous learning and improving care
•The provider was unable to say what action would be taken in the future to improve the quality of the service provided to people.

Working in partnership with others
•The provider did not work with the local authority to ensure people were safeguarded from abuse.
•The provider did not request additional funding from the local authority to increase staffing levels to ensure people's needs were met.
•The provider did not consider accessing an independent advocate for people who used the service, so their voice would be heard.
•The provider did not work with employment agencies to support people to gain employment.
•The provider did not work with the relevant agencies to support people to access further education.

This is a breach of regulation 17, Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•The provider is required by law to inform us of incidents that have occurred in the home.
•We found where an accident had occurred, and the person required medical intervention, the Commission was not notified of this.

This is a breach of regulation 18, Notice of incident, Care Quality Commission (Registration) Regulations 2009.

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 14 Registration Regulations 2009 Notifications – notices of absence The provider was unable to evidence that there was a registered manager in post for the day to day carrying on of the regulated activity.

The enforcement action we took:

NOP to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider did not inform the Commission of an accident that had occurred in the home where the person required medical intervention.

The enforcement action we took:

NOP to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not involved in meetings relating to their care assessment so were at risk of not receiving a service specific to their needs.

The enforcement action we took:

NOP to remove location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not given the opportunity to make decisions about the care and support they received. The provider was unable to demonstrate that people who made decisions on people's behalf had power of attorney.

The enforcement action we took:

NOP to remove the location.

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 not taken any action to assess or mitigate the risk to people. People did not always receive their medicines as prescribed which placed their health at risk.

The enforcement action we took:

NOP to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse because staff did not have the skills to recognise abuse or to safeguard them from this.

The enforcement action we took:

NOP to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems in place to assess, monitor or improve the quality and safety of the service provided to people.

The enforcement action we took:

NOP to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were at risk of their needs not being met because there were insufficient staff provided and at times staff were not present in the home. Staff did not always have the relevant skills to meet people's care needs safely. New staff were not supported in their role which, placed people at risk of inadequate care and support.

The enforcement action we took:

NOP to remove the location.