St Martin Of Tours Housing Association Limited

Wilton Villas

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Wilton Villas provides residential care for men who may have mental health issues, a substance misuse issue or a learning disability. The service can accommodate up to 28 people with mental health problems and/or substance misuse issues, each person having their own bedroom. The service recognised that some people may have an additional learning disability so a specific five bed flat within the building was created for people with a mental health, substance misuse history and who also have a learning disability.
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People's experience of using this service and what we found
We saw that risk assessments concerning people's day to day mental health and other support needs were clear and regularly reviewed. There were descriptions of potential risks and information for staff about action to be taken to reduce risks and how to respond if new risks emerged. The service liaised with community based health and social care professionals, but could be clearer about their expectations about time frames for responses to requests for mental health assessments.

We found that the quality assurance system was not effective because it had not fully identified and reduced risks to people using the service from a long standing anti-social behaviour matter. Lessons from previous incidents had not been learnt.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service support this practice.

The provider usually reported concerns to CQC via statutory notifications as required by legislation, with the exception of a recent involvement of the police that was not reported to CQC.

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 (Inspection report published on 9 August 2018). At this inspection the rating had deteriorated to requires improvement.

Why we inspected
We received concerns in relation to the potential safety of people and management of the service. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-Led only. We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

We found no evidence during this inspection that people were currently at unnecessary risk of harm at

Wilton Villas. However, kitchen cleaning was not suitable to minimise the risk of contamination of food and food storage areas on each floor except the first floor. Please see the Safe and Well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wilton Villas on our website at www.cqc.org.uk.

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Wilton Villas

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
This focused inspection was carried out by one inspector.

Service and service type
Wilton Villas is a 'care home'. People in care homes receive accommodation and nursing or 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We looked at information we had received about the service, including notifications and other information shared with us by the local authority.

We used this information to plan our inspection.

During the inspection
We spoke with two people that used the service although they did not want to share their views with us at the time of our visit. We spoke with eleven members of staff including the deputy manager, operations manager, nominated individual, two care workers and the substance misuse specialist worker.

We reviewed a range of records. This included three people's care records and multiple medicines records. We looked at risk assessments and incident reports.

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

Requires Improvement

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 deteriorated to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.
Systems and processes to safeguard people from the risk of abuse
● People using the service were not always protected from abuse. There had been ongoing issues in the local community relating to drug use and anti-social behaviour. The provider had been addressing these matters through actions such as employing a drugs worker and taking part in community safety meetings. This had not been fully effective at making sure that the anti-social behaviour did not adversely affect people using this service. There were improvements after the inspection with the provider giving CQC details about incidents and action they were taking to address this in the best interest of people using the service. The provider had policies and procedures in place to safeguard people from abuse.
● Staff told us that they had training about safeguarding adults from abuse. They were able to tell us about their responsibilities to protect people from abuse and neglect, including behaviours exhibited by people that may cause them harm. They knew that they needed to report any concerns or suspicions to the manager, and if necessary, the local authority safeguarding team, police and CQC. However, in one instance this had not happened.
Learning lessons when things go wrong
● Accidents and incidents were recorded along with subsequent actions taken to reduce the likelihood of them happening again. Where people had shown signs of deteriorating mental health the service liaised with community mental health teams.
Although the provider had responded to concerns that people may be using drugs in the local community by increasing walk arounds in the, local area to check any anti-social behaviour, we did not judge that the provider had fully learnt lessons from previous incidents. The issue of anti-social behaviour had been present within the environment of the home for a long period of time and the provider had not been able to successfully respond, reduce the incidence of anti-social behaviour and work with local partners to keep people safe.

Assessing risk, safety monitoring and management
● Most people living at the home had long histories of drug and alcohol dependency. We looked at the risk assessments and support plans for three people who, from other notifications we had received, had been identified as possibly at higher risk due to this or other behaviours. The risk assessments for each person described people's current risks, including behaviours or potential substance misuse and what should be done to address these issues if they arose.
● Actions were in place to reduce the likelihood of drug use in the home and in the local area. Staff undertook regular hourly 'walk rounds' of the nearby areas where drug use or drug dealing may be taking place. Spot checks of people's rooms had taken place if concern about suspected drug use arose. We asked

the deputy manager why a spot check had not taken place for two days after a person was recently thought to have used drugs. They replied that it should have happened sooner and thought it was due to miss communication. We were told by the operations manager that the service provider was increasing random spot checks.

● People met regularly with a designated member of staff [a key worker] and were offered the opportunity to also meet with drugs worker and other rehabilitation services in the community. Where people with drug misuse issues did not wish to meet with anyone to obtain support this was carried forward as a part of the risk assessment and care planning process.

Staffing and recruitment

● We did not review staff recruitment records on this occasion, as our previous examination of these showed that proper and safe recruitment procedures were used. The operations manager in conversation with us said the process remained unchanged and full background checks were obtained.

● Staffing levels remained suitable and the option to increase staffing in specific circumstances was available, including the use of agency staff in additional internal resources were unavailable at any given time.

Using medicines safely

● Staff at the service were able too refer to the provider's policy covering the recording and safe administration of medicines. Staff had training in medicines administration and their competency to do this safely was assessed.

● Medicines were securely stored in a locked medicines cabinet in a room adjacent to the main staff office. Records of medicines administration were recorded properly.

● During our inspection we observed two people coming to the medicines storage room to ask staff for their medicine, which was given to them.

● People had up to date risk assessments in relation to their medicines, including if they took these themselves without staff support. Staff were provided with guidance about what to do, and who to inform, if anyone began refusing to take medicines, not least medicines designed to help people maintain good mental health.

Preventing and controlling infection

● During our inspection we saw that the communal areas of the home were being cleaned by a domestic worker, however, the fabric of the building needed attention in some areas.

● Where people bought and cooked their own food as part of their plans to achieve independence, they were provided with lockable fridges and cupboards in which to store personal food items. When we looked at some of these, we found that there were some failings to store food safely. For example, many cupboards we looked into were unclean and had food or other residue within them.

● We spoke with the operations manager and deputy manager about this. They told us told us they would review the monitoring of the cleanliness of kitchens and speak with domestic staff and people using the service about this. Although people using the service were supposed to be involved in cleaning it is evident that this was not being checked thoroughly enough.

We recommend that advice is sought from a reputable source about maintaining a safe and hygienic environment in relation to food safety.

Requires Improvement

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 the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The deputy manager and staff we spoke with were clear about their roles and responsibilities and the lines of reporting within the home and provider organisation.
- There were quality systems in place which monitored care planning, risk assessments, medicines and other day to day areas of operation of the home. However, the quality monitoring checks had not fully assessed and mitigated the risks presented to people using the service and others of the continued anti-social behaviour issue that was affecting this service, the local area and another care home run by this provider. We did not consider that the provider's quality monitoring systems were effectively assessing, monitoring and mitigating these risks

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

- Joint communal meetings with people using the service took place, although attendance varied as some were less keen to engage than others. A support worker told us that these opportunities were regular although encouraging more people to attend was an ongoing task.
- Staff we spoke with were able to describe the objectives of the service and understood what this meant in their day to day work. The values of the service promoted personalised support, dignity, privacy and anti-discriminatory practice.

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

- During our inspection visit we observed people freely able to approach staff and engage with them without hesitation. The provider had clear expectations,, shared with people using the service and staff, about all people having the right to be treated with dignity and respect and be free from discrimination.
- We attended the afternoon handover between the morning and afternoon staff shifts. The meeting was informative, and information was shared about events that had happened earlier in the day and plans for supporting people during the rest of the afternoon and evening.
- People's equality and diversity needs were understood by the service and supported. Details of these were reflected in people's support plans with guidance provided for staff to follow to meet those needs.

Continuous learning and improving care

● The deputy manager told us about the challenges the service encountered with supporting people. These challenges revolved around supported people with often long term histories of drug and alcohol misuse. On occasion the service experienced delays in response to request for mental health assessments from placing authorities. .

● Increased monitoring of people's activities in the local community had been implemented in light of complaints made alleging anti-social behaviour by people using this and another adjacent service operated by the same provider.

Working in partnership with others

● Staff and management had usually reported concerns in a timely manner, including local authority safeguarding teams and CQC. However, we found one instance in July 2019 where the police were called and we had not been notified about this. We will look into this further.

● Care records showed that the service liaised with community health and social care professionals regularly. The service acknowledged that there could be delays with receiving a response from community mental health teams. The service followed up these requests although accepted that there could be clearer expectations about the timeframe they expect for responses to this by placing authorities.