Dr Kandiah Somasundara Rajah

Ascot Villa Care Home For Autism & LD

Inspection report

13 Ascot Road
Moseley
Birmingham
West Midlands
B13 9EN

Tel: 01214499845

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 16 August 2017 and was unannounced. Ascot Villa provides accommodation for people who require personal care for up to six people who have learning disabilities and / or autistic spectrum disorders. At the time of our inspection there were four people living there.

We last inspected this service on 08 March 2017. At our inspection we found the provider was requiring improvement in all of the five key questions. We also found that the provider was in breach of the law in Regulations 12 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection we asked the provider to send us an action plan detailing what actions they would take to improve the service, which was returned to us in a timely manner. We also issued a warning notice for breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This notice tells the provider what actions they must comply with and by when. The date we told the provider they had to be compliant with this regulation was 26 May 2017.

This inspection was a comprehensive inspection which looked at all five key questions. At this inspection we found some small improvements had been made in some areas but the provider had failed to secure adequate improvements to improve the safety and quality of service provided to people. The provider was now failing to meet the requirements of the law in other areas and the governance system operated by the provider had not improved sufficiently which meant the terms of the warning notice had not been met. Breaches in regulation found at the last inspection had also failed to be complied with and a further breach of Regulation 9, in relation to person centred care was also identified.

The previous registered manager had left the home in December 2016 and at the time of our inspection a replacement had not been found. As a temporary measure an acting manager was in post and the provider told us they visited the home weekly. A registered manager is a person who has registered with the Care Quality Commission 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.

Staff did not always understand the risks to people's health and safety and these were not always recorded in their care records. There was sufficient staff to meet people's needs, but there was a large turnover of staff which put people at risk of inconsistent or unsafe care. The provider did not operate a safe recruitment system which meant people were at risk of receiving care from staff who were not suitable to provide care to them. Staff understood their responsibility to raise concerns regarding potential abuse.

People were supported by staff who had some training. Staff we spoke to told us they had received some training but staff did not have all the skills and knowledge they required to meet people's specific care needs. Staff understood the need to ask for consent and we saw they sought consent before providing any care. The manager had applied the principles on the Mental Capacity Act 2005 (MCA) in relation to applying for deprivation of liberty safeguards, but had not ensured decisions about people's care were always made

in their best interests. People's nutritional needs were being met. People had access to other health professionals when their health needs changed.

People had choices about their care and staff listened to them and respected their choice on a daily basis, but decisions and choices about their future care and support needs were not discussed with people. People were treated with dignity and respect by staff. Staff encouraged people's independence where possible.

People received care which was not fully responsive to their individual needs but people had some choices about the care they received. Some improvements were required to ensure people's care records contained up to date and accurate information about the care they received. People and their relatives told us they felt comfortable raising complaints with the manager, although none had been received.

The governance system in place was not effective as it did not highlight the areas where we found concerns during our inspection. Although people told us they were happy with the care they received, we could not be assured this was sustainable as there was no oversight of the service by the provider and there was no registered manager at the service. The provider had not taken effective action to improve the quality of the service since our last visit. Staff did not feel fully supported in their role.

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.

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.

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.

People's risks were not always assessed and recorded in their care plan.

Improvements were required in the management of people's medicines as people could not be assured they would receive their medicines as prescribed.

The recruitment system did not ensure people were supported by staff who were safe to work with vulnerable adults.

People and their relatives told us they felt safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff who had not received training in all the skills needed to meet their needs.

Staff obtained verbal consent from people before providing care, but people were not involved in larger decisions that might affect them.

The principles of Mental Capacity Act 2005 were not being fully adhered to in relation to the use of best interest decisions.

People received support from other healthcare professionals when appropriate.

Is the service caring?

Requires Improvement

The service was not always caring.

People may not have felt cared for as the environment worn and unclean.

People told us they received support from staff who were kind, but relatives said that not all staff were caring.

Staff respected people's choices and treated people with dignity and respect.

Is the service responsive?

Requires Improvement 

The service was not consistently responsive.

People did not have a range of activities and interests or structure to their days that met their needs or wishes.

People were not involved in ensuring their care plans reflected their interests.

People told us they felt comfortable in raising concerns, but none had done so. The manager had systems to respond appropriately.

Is the service well-led?

Inadequate 

The service was not well led.

The provider had failed to ensure that people and staff were supported by consistent leadership and staff.

Staff did not express confidence in the leadership of the service or feel supported in their role.

The provider had failed to meet the requirements of a warning notice and breaches of regulation.

Ascot Villa Care Home For Autism & LD

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 checked 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.

This inspection took place on 16 August 2017 and was unannounced. The inspection team consisted of two inspectors.

As part of planning the inspection we checked if the provider had sent us any notifications. These contain details of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We also looked at any information that had been sent to us by the commissioners of the service and Healthwatch. We used this information to plan what areas we were going to focus on during our inspection visit.

Before the inspection the provider was asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report.

During our inspection visit we spoke to three people who lived at the home. We spoke with the manager, the provider and three members of the staff team. After the inspection we spoke on the phone with the relatives of three people and one health care professional. We sampled the records, including people's care records, staffing records, complaints, medication and quality monitoring. After the inspection visit the manager sent us information that we had requested which we reviewed in order to help us reach our judgements.

Inadequate

Is the service safe?

Our findings

At our previous inspection of this service we found the key area of 'Safe' to require improvement. We found there was a breach of Regulations 12 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; because risks to people were not being consistently assessed or managed and the provider did not consistently complete safe recruitment checks. At this inspection we found sufficient improvements had not been made and the provider remained in breach of these regulations.

At our previous inspection we found that while each person had a care plan and a risk assessment, not all the risk assessments had been kept up to date with peoples changing support or health needs. At this inspection we found that this had not improved. We found that a person's risk assessment had not been updated when they experienced a decline in their health condition. It did not provide guidance for staff of how to support the person to remain safe if they became unwell again. Staff we spoke with could not clearly tell us what they would do if the person became unwell. At this inspection we also found that another person had specific risk assessment instructions to keep them safe while out in the community and two members of staff we spoke with did not know about these instructions or the protocol to keep the person safe. One member of staff said, "I'm not sure staff would know what to do." The lack of staff knowledge and recorded information may have caused considerable harm to people as they are at risk of not receiving timely medical intervention or may abscond in the community putting themselves at risk of harm.

During our previous inspection we found that systems to reduce the likelihood of accidents or incidents happening again were not robust. We found that this had not improved. The provider did not have a method of recording accidents within the home, and we saw that all incidents were written in people's daily notes. The provider had not developed a method or system to ensure they maintained an overview of incidents or accidents in order to reduce their possible recurrence in the future.

Medicines were not managed safely. We could not be sure medication was always given to people. One person's relative we spoke with said that they were not always confident that they had been given certain prescribed medication as the person's behaviour was different and unsettled which indicated to the relative that the person had missed their medicines. We could not be sure people received their medicines as prescribed because there were gaps and errors in recording. Staff could not tell us if people had received their medication on those dates. When people needed some 'as required' medication, staff did not always follow the agreed guidelines to do this safely.

The manager and staff told us they had received training to administer medicines safely by the local pharmacy. However there were no records available of when the training had been given or when refresher training would be required so staff remained knowledgeable about how to administer medication safely. The manager told us that they did not conduct observations of competency checks to ensure that staff administered medicines safely and results of medication audits were not recorded. Although the provider had not recorded if people had consented to have their medication administered by staff, we saw staff seek people's permission before they supported them to take their medicines.

At our previous inspection we found that two members of staff had not always signed to confirm a person had received their medication as prescribed in line with the provider's policy. We found the provider had not taken effective action to address this error. A member of staff told us that sometimes the medicines were still administered by only one member of staff. We looked at the MAR charts of all the people who lived at the home and saw that there were frequent gaps in the recording of when medicines should have been administered and often only one signature was in place. We also saw that there were considerable inconsistencies in the codes used by staff to record any incidence that had happened when the medicine was being given, such as when a person refused to take their medication. Staff were unable to explain these inconsistencies to us. We could not be sure that people had received their medicines as planned or when needed

Where medicines were prescribed to be administered 'as required', there were instructions for staff providing information about the person's symptoms which would indicate that they should be administered. We found however that these instructions had not been followed. For example staff did not always follow guidance to seek authorisation from a manager before administering a specific medicine. We found that when the medicine had been given without authorisation being granted this had not been identified or addressed by managers. Another medicine that should be given regularly for a person to remain healthy had not been given. We found that on two separate occasions staff had judged that the medicine was not required. They had not sought medical guidance as to the potential consequences and risks of withholding the person's prescribed medication. This deliberate omission of medication had not been identified or addressed by the management.

We found that medicines were stored in locked cupboards in each person's bedrooms and they were stored securely. The recording of temperatures at which the medications were kept was not consistent however. Medicines that are stored outside to the appropriate temperature range may lose their effectiveness.

The provider had not taken effective action since our last inspection to ensure people received their medication safely and remained in the breach of Regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our previous inspection we found that people were not always supported by staff that had been robustly recruited to ensure they were suitable and safe to undertake their roles. We found that this had not improved. The provider had not been able to demonstrate that staff were safe to begin work as references had not been collected for one member of staff who was working unsupervised on the day of our inspection. When we spoke with the manager, they were aware that the member of staff was working without assuring themselves that the person was suitable to work as a carer within the home. We noted that some safe recruitment practices such as appropriate DBS or police checks were in place. However, we also saw that two of the current DBS checks had disclosures listed on them that the manager had not taken into consideration when they employed the staff. We noted that while these concerns were likely to be of low risk to people, the manager told us that they had not been considered as part of the recruitment process. The manager discussed with us that they were aware that these same issues had been of concern during the previous inspection.

At this inspection we found there had been no improvements to ensuring the employment of suitable staff and the provider remained in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we last inspected the service we found that people could not be confident that staff knew how to assist them to evacuate safely in the event of a fire, or that systems were in place to ensure people remained

safe. We asked the West Midland Fire Service to attend the service after our last inspection. At this inspection we saw evidence that the fire service had been and advised various actions to be completed. We saw records that appropriate action had been taken with relation to training staff to be fire marshals, fire detection systems had been tested and fire risk assessments had been put in place. After the inspection we saw a letter from the fire service that said that the home had reached a 'reasonable level of fire safety.' However, during our inspection we saw that a fire extinguisher was used to prop open a fire door contrary to recognised good practice. We brought this to the attention of the manager but the extinguisher continued to keep the door open throughout our inspection.

People told us they felt safe, one person said," [The staff] keep me nice and safe." A relative said "I think [my relative] is safe." We spoke with staff who knew what constituted abuse and what to do if they suspected someone was being abused. They knew how to report their concerns to the registered manager and or external agencies. Staff we spoke with could describe the different signs and symptoms that a person might present which would indicate they were being abused. However, staff told us and records confirmed not all staff had received recent training in adult safeguarding. This put people at risk of being supported by staff who may not know the latest safeguarding practices.

People we spoke with said that they would like more staff so that they could go out more often. During our inspection we saw that there were enough staff available to support people within the home in a timely manner, however there were not enough staff to take people out to enjoy activities within the community as frequently as might be expected. Staff told us that the shifts were not short staffed, but that they worked very long hours. A relative said, "I think they could do with more staff." The service had a clear staffing rota and the manager told us they were in the process of recruiting more staff to cover shifts where needed. Another relative told us, "It's always short staffed, staff leave there all the time." The impact of having a high turnover of staff may have a negative impact on people as they are frequently being supported by new staff who are getting to know them.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection of this service we found the key area of 'Effective' to require improvement. These concerns were that staff had not received adequate training and the service was not operating within the principles of the Mental capacity Act. At this inspection we found that the service continued to require improvement in this key area.

Staff told us that they received an induction which included getting to know people's needs and shadow more established staff. One member of staff told us, "I know about the people here." There was documentary evidence that inductions had taken take place that introduced new staff to the people who lived at the home. The manager told us that the care certificate [a nationally recognised induction programme for new staff] was not being used as staff were currently enrolled on health and social care training at a higher level. Staff we spoke with confirmed this.

At the last inspection we noted that staff did not have access to core training to enable them to know the specific support needs of the people they cared for, such as epilepsy or responding to challenging behaviour. Staff told us that training had begun to improve and recently and they had undertaken online fire training and first aid training. At the inspection, the manager still did not have a system or process to identify the training staff had undertaken or when they would require further training. After the inspection the manager sent us a list of areas of core training had been undertaken by staff. This showed that of 11 staff only two had undertaken challenging behaviour training, three staff had received mental capacity awareness, and no staff had received training in relation to epilepsy. We found that while some improvements had been made they were neither timely nor sufficient to ensure people were supported by staff who had the skills and knowledge to meet their specific needs. For example people who experienced epilepsy were not supported by staff who understood that condition or had the knowledge or skills to support people safely and well.

Staff we spoke with did not consistently tell us that they received supervision to reflect on their care practices and to enable them to care and support people effectively. One member of staff told us, "I've had supervision." Another staff member said they had not had supervision. The manager told us that no supervisions had been undertaken but we saw a list of supervisions that appeared to have taken place. The list had many gaps in it, and we were told it was out of date. Staff remained unsupported in their role and did not have the guidance to reflect and improve their practice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw that the manager had sought and taken appropriate advice in relation to people in the home. Some people had received authorisations to restrict their liberty and the manager had reapplied for these as required. We found staff had some knowledge about the requirements of DoLS and MCA but had not received training to support them in fully understanding their responsibilities. Since our last inspection the manager had considered all the people in the home in relation to the MCA and we found that where one person was considered to have capacity to make their own decisions, staff were aware of this and supported the person appropriately.

We saw that people were involved in their routine daily decisions such as what to wear and where to be in the home, and noted people were asked for their consent whenever appropriate. At the last inspection we found that for larger decisions however the provider did not have a process of ensuring decisions were made in people's best interests when they lacked capacity. At this inspection we found that this had not improved, for example one person who had been deemed not to have capacity had decisions made for them by their relative who did not have the legal authority to do so. The manager had not considered the use of best interest decisions within the Mental Capacity Act, and had therefore failed to ensure the principles of MCA had been upheld to protect this person's rights

At our last inspection we found that the nutritional needs of people were not being met. At this inspection we found that there had been some improvements. People told us they enjoyed the food and had choices about what they ate. One person said, "The food is alright, I eat it. I'm trying new things now." A relative said, "[The food] all seems pretty basic and plain really." We saw staff were available when people required support to eat their meals and choices were offered to people verbally. Staff told us they cooked the meals for people and that all staff did this. We saw that the service had a planned menu which changed weekly. Food shopping was often done by staff and sometimes they included people in the shopping trips but this was not always the case. We found that people were not as involved in choosing their food as they could be

People had access to health professionals to maintain their health and wellbeing. Relatives told us that GPs were called when needed, and appointments were kept to keep people safe and well. During discussions with staff and the manager they confirmed that people's health appointments were kept and recorded in the daily notes which we saw. Evidence on peoples care records showed that they accessed a range of health care support which included, district nurses, doctors, dentist and opticians. We noted however that people did not have Health Action Plans. These are used to ensure that people get appropriate and safe care and support from health providers and others when they move or access other services.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection of this service we found the key area of 'Caring' to require improvement as staff did not always promote peoples independence or ensure they received dignified care. At this inspection we found that the service had not responded sufficiently well in this area, and that the service continued to require improvement.

People told us that they were confident with staff and liked them. During our visit we spent time in the communal areas and saw that staff interacted with people in a kind way. We saw staff respond to people's communication in a timely manner. However, there were mixed views about how caring staff were. One member of staff told us, "The care staff do their job but don't really care about the people here." One relative said, "Some staff care OK, but others don't really care." We found that due to the lack of staff's knowledge and skills in some areas of people's particular support needs, staff had not been supported by the provider to deliver care in the most appropriate and caring manner.

On one occasion we saw that a member of staff had returned after a holiday and one person was very happy to see them again and to chat with them. At our last inspection we found that some staff had communicated with people in a condescending and inappropriate way. At this inspection we found that conversations were appropriate and respectful.

At our last inspection there was very limited evidence to support that people's independence skills had been developed or that there were a range of suitable daily activities available to them. People told us they did household chores and that there were limited opportunities to promote their independence. However, we saw that opportunities were very limited and often missed to assist people with developing their daily living skills and to involve people with day to day tasks. We found that actively promoting people's independence had not improved since the last inspection.

We saw that care had not been taken to ensure that all people lived in a safe and comfortable environment. Where adjustments where needed to the environment in response to a high level of wear and tear and ensure facilities were fit for purpose these had not been made. A relative told us, "It's out of date, people should have nice things in their home, it's tatty and not good enough really." We saw that the home was in need of redecoration and some basic maintenance work to ensure that people lived comfortably and in pleasant surroundings. For example the kitchen needed to be updated and cleaned; there was also a five inch hole in the wall in a corridor. When we brought this to the attention of the provider we noted that a contractor was on site immediately and staff cleaned the kitchen. Staff told us however that they had been requesting the hole to be fixed for several weeks. This did not demonstrate that the people who used the service were considered worthy and deserving of a pleasant environment in which to live.

Following our inspection we asked the local environmental health officer to attend the service to assess the safety of the food preparation areas and they told us that significant improvements were required.

People could not be confident that their views would always be listened to and acted on. We saw that

residents meetings had not taken place as planned. The provider was not consistently working in partnership with all people to support them to make informed decisions about their care and environment.

People told us and we saw that people had their privacy and dignity respected. One person said, "The staff are nice to me." Throughout our inspection we saw several examples of staff interacting with people in a respectful and dignified manner. All the staff we spoke with had a good understanding of confidentiality and how to protect people's rights in relation to it. We saw that while some personal documents were left within the home in public areas, that staff understood their role with regards to confidentiality, and were aware of the need to lock documents away when they had been completed.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection of this service we found the key area of 'Responsive' to require improvement. At this inspection we found that the service had not responded sufficiently well in this area, and was now in breach of regulations.

People did not receive care which consistently responded to their individual needs. For example, some people did not express their needs and wishes verbally, but there was no use of communication aids to support people with expressing their wishes or choices. People were not given real choices and options because the way in which the service communicated with them did not respond to their needs. There were no signs within the home that people could easily understand such as which room was the bathroom or which room was each person's bedroom. For new people moving into the home this could be confusing. We saw that the lounge area was functional, with limited activities for people to engage with, or to prompt conversation. There was no evidence that people were supported to engage in their interests apart from one person who told us they enjoyed knitting and listening to music. We saw that the only information displayed in the lounge was staff notices and staff information.

Care records we saw contained information about people's personal preferences, daily routine and some life history. The care plans and risk assessments we saw did not effectively recognise peoples individual support needs and preferences, and were not kept up to date. For example, one person's risk assessment had not been updated after they had experienced a significant increase in episodes of illness. This meant that staff would not have current and accurate knowledge to support this person as needed to keep them safe and well.

We saw that some people had been involved and consulted with about the writing of their care plan but we found that this was not consistent across the service. Where people had capacity to discuss how they wanted to be supported they were encouraged to do so. However, robust efforts had not been made to ensure people who required additional support to express their views were included in reviewing their care plans.

Staff's knowledge about people's specific needs was not consistent For example, one staff member was confused about a person's medical condition and the information they told us was contrary to what other staff told us and what we read in their care records. While we found that staff had a good understanding of people's routines, they did not have knowledge of what people might want to develop or try. One member of staff said, "There's no system of getting from people what they want to do, I just chat." We found that there was no effective way in which people were supported to express their aspirations or wishes.

People told us and we saw that people who we spent time with were regularly asked for their views about their day to day activities. We spoke with the manager about how they included people in choices that might affect them in the longer term such as holidays, home decoration and support about moving towards more independent living. We found that there were no structures in place to do this and the provider did not operate a key worker system to support this. A key worker system is one method that is used to help make

sure people are more meaningfully included in decisions about their care. One member of staff told us, "We don't really involve people here; they just have the same pattern of things to do." We found that longer term options which might be available to people had not been reviewed or discussed with them. A health care professional told us that the lack of structured activities had been detrimental to the wellbeing of one person and may have led to an increase in the use of their 'as required' medication. They said, "[The service] does not know how to structure the day, [the person] can get anxious and upset and instead of using activities and structure, they use 'as required' medication." One member of staff said, "It's the lack of activities, people are bored, it could be a trigger." Another relative we spoke with told us that they were unhappy with the limited time staff spent with their relative and also the repetition of activities which they felt meant the person was bored. We found that the service offered limited activities to people, many of which were not meaningful or interesting to them.

We found that there were no proactive systems, or a culture in place to ensure all people using the service were responded to on an individual basis. The service was not designed to meet the needs of the people that are living there. People's care records and staffs knowledge of people's conditions was poor which meant people were at risk of not getting the care and support they needed. We found that care was task based and there was very limited evidence of trying to find out how people might want to spend their time or how they would like their care and support to be delivered. This was compounded by a lack of accessible systems which would have enabled people to communicate their views more readily.

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

The service made sure that people were supported by staff of their choosing. Staff told us and we saw evidence that a diversity of staff were on shift at anyone time to support people appropriately.

We could not be confident that the service listened to peoples' concerns in order to improve the quality of the care provided. The service had information about how to make a complaint however we did not see that this was provided in an accessible format that people living at the service could easily understand. During discussions with people and staff it was not clear when people had been told of their right to complain if they so wished. Staff told us that some people would not be able to make a complaint but would be reliant on them or a family member to raise concerns on the person's behalf. One person told us," [The manager] would help me if I needed to complain". A relative said, "I could complain…but things don't change." A member of staff said, "If we complain about something like the hole in the wall or the state of the decorating, they say they will do it but nothing gets done, it's just left."

The manager told us that there had been no concerns or complaints raised by, or on behalf of, people using the service. We noted that this was the case at the last inspection. We asked the manager what happened with informal complaints or concerns and they told us that they were dealt with. There were no records available to confirm this however. We found that the service did not support people to raise their concerns, and therefore people were not actively listened to.

Inadequate

Is the service well-led?

Our findings

At our previous inspection of this service we found the key area of 'Well-led' to require improvement. This was because there was no effective governance system in place. Following that inspection we issued a warning notice in relation to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.We asked the provider to comply with this regulation by 26 May 2017. At this inspection we found that most of the areas of the warning notice had not been sufficiently addressed. The provider had not ensured the service was improving and meeting the requirements of the warning notice and they remained in breach of this regulation

We found insufficient improvements had been made in the governance system and with monitoring and auditing the service. For example people's risks continued to not be recorded in their care plans. This meant that people were not consistently kept safe from harm and their wellbeing was not promoted in a manner that met their support needs. Staff did not have comprehensive and ongoing training to ensure that they had the skills and knowledge to support people well and this continued to be unmonitored by the provider. There was no drive for continuous improvements and people experienced this by having repetitive activities and inadequate communication. This represented an ongoing failure on the part of the provider to address these issues.

There remained no effective system of collecting feedback from people and their relatives. Efforts had not been made to improve how people were included in their care and support as much as possible. There were no robust systems in place to find out what people thought of the service and how it could be improved.

After our last inspection the provider had failed to introduce systems to effectively monitor and analyse accidents and incidents to reduce the likelihood of their reoccurrence. We noted however that there had been action taken to record all events in people's daily records which we saw were completed and detailed. But the monitoring of them was ineffective. There were no effective systems to ensure people's care plans would be updated when their conditions changed. This put people at risk of receiving inappropriate and unsafe care.

Fire risks had been identified and safety measures were in place although there was no evidence that systems to monitor these measures were effective. We did not find that safe systems were in place to ensure that the checks were maintained. Health and safety checks of some areas of the environment remained inadequate. Although a system had been introduced to check water temperatures at the home were at safe levels, records of these checks were not always completed and discrepancies had not been identified by the provider. We saw a number of occasions when the temperature of the water exceeded the recommended amount and no action had been taken to rectify this issue. This put people and staff at risk of scolding.

The recruitment process for staff remained unsafe and appropriate steps had not been taken to ensure staff had the skills and knowledge to undertake their role. We found that the provider was not aware of the DBS disclosures and the lack of documentation that had been requested. The provider had not conducted an effective audit of these processes.

Medication audits remained ineffective and did not identify when medication had been administered inappropriately or when records were completed incorrectly. Concerns from our last inspection about the safe handling of medicines had still not been adequately addressed to ensure people were safe.

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

The provider had not taken effective action to ensure there was a registered manager in post in line with their statutory duty. When the last registered manager left in December 2016, and the provider told us that various attempts had been made to recruit a new registered manager for the service but this still had not happened. Before the inspection we issued a letter informing the provider that there was a potential breach of Section 33 of the Health and Social Care Act 2008, in relation to not having a registered manager for an extended period of time. The provider explained that they had identified someone who was going to apply to CQC to become the registered manager of the service.

People said that they liked living at the home and we observed that people seemed relaxed and well. One member of staff bought their dog into the home when they were of shift and we saw that people enjoyed the contact with a pet. Although relatives we spoke with said they felt that people were safe at the home they all told us they had concerns about how the home was run. One relative told us, "It's not so good [at Ascot Villa] really." Another relative said, "There are issues with the managers…there's been a lot of miscommunication, there is room for improvement." All the relatives we spoke with told us that communication with them could be better and they gave examples of where poor communication had taken place.

Staff also told us that they felt that the lack of a registered manager had been detrimental for them and the people who lived at the home. All the staff we spoke with said the service could be improved. One staff member said, "It's not very good here." Another staff member told us, "The management is really poor." Staff seemed unclear on their roles and the role of the manager and told us that they felt the amount of money available to buy food and household items was not sufficient. We raised this with the manager and provider who said that they were unaware of this concern. Staff said that they would not be comfortable with a loved one of theirs to live at the home unless it improved.

The manager was aware of their responsibilities. We saw that the ratings given in the last inspection were displayed as required, and team meetings were being held with the staff in order to share information. Where safeguarding incidents had been raised the manager had investigated these and taken appropriate action as required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not done everything reasonably practicable to make sure people received a person centred service which reflected their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive consistently safe care and the provider had not made sure that risks were appropriately mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to have systems or processes in place that monitored and assessed the service and led to improvements in quality and safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to make sure that staff employed by the service were safe and suitable to undertake their job roles.