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Ascot Villa Care Home For Autism & LD

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

Summary of findings

Overall summary

We undertook this unannounced inspection of Ascot Villa Care Home on 12 and 15 March 2018. At our previous inspection undertaken on 9 and 10 November 2017 the provider was found to be in breach of Regulations 9, 12, 17. At the inspection on 9 and 10 November 2017 the provider had not met the conditions of a Warning Notice in relation to Good Governance that we had served on them previously. Following the inspection on 9 and 10 November we asked the provider to complete an action plan to show us what they would do, and by when, to improve the quality and safety of service people received to at least good. This action plan was received by us within the requested time frame. At this inspection, we found that the actions in the plan had not been completed and the provider had failed to make sufficient and timely improvements to the quality and safety of the service. This meant people continued to receive and inadequate service

During this inspection, we found that the provider remained in breach of Regulations, 9, 12 and 17 and further breaches in Regulations 11, 16 and 18 have been identified. The Warning Notice remains unmet.

Ascot Villa 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. Ascot Villa accommodates up to six people in one building. At the time of our inspection there were four people living at Ascot Villa.

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. At the time of our inspection there was no Registered manager in post at Ascot Villa.

Systems to safeguard people were not adequate to keep people safe. Risk assessments had not been completed well or reviewed when needed. Staff had a limited understanding of the risks to people's health and safety. Risks that were specific to individuals were not always known about by staff. Not all staff understood their responsibility to raise concerns regarding potential abuse. Medicines were mostly managed well but when people needed 'as required' or homely medication, we could not be sure these were given to people safely.

There were sufficient staff to meet people's needs. The provider operated a safe recruitment system, which meant people were supported by suitable staff.

Staff did not all have the training they needed to undertake their roles safely or well. The processes of gaining meaningful consent to care were not robust as there was no effective process of ensuring decisions were made in the best interests of people. People's communication needs were not being met. People had a choice of food given to them on the day but were not meaningfully involved in planning their menus. Ascot Villa did not work well with other organisations to ensure continuity of care. People had some access to health professionals when their health needs changed, however we were not confident that all healthcare

needs were well met.

People's communication needs were not met at Ascot Villa. People were not communicated with well, and their opinions and views were not sought in the most appropriate way to enable them to join in and make decisions as much as possible. People did not have their independence promoted and staff and management did not have an understanding of how to do this in line with guidance such as Registering the Right Support. This CQC policy states that care services should have been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. People's privacy and dignity were upheld and we saw that staff were caring and kind when they were with people. We saw staff respond to people in a timely way, responding kindly if they were in discomfort or distress.

The care at Ascot Villa was not personalised and staff focused on completing tasks with people. People were not actively involved in making decisions about their home and lives on a regular basis, and their preferences and were therefore not properly respected. There was no method of making sure that people contributed to their care plans or reviews. Communication with people was not in line with Accessible Information Standards and therefore Ascot Villa did not include them as much as possible in decisions about them. Some people may have experienced unnecessary isolation, as people's opportunities to participate in activities were limited. Care records included some information that was personal to people, but important information was omitted and in some cases incorrect. Records were not always available for staff to refer to when needed.

There was no clear process for people or their relatives to use to make complaints. The home had a policy but it was not known about or used. Relatives told us they had spoken to staff in the past when there was a problem but they were not always listened to. There was evidence of how complaints had been dealt with in the past.

Governance and oversight of Ascot Villa had not improved since our last inspection. The governance system that had been outlined in the action plan had not been implemented at the time of our inspection. There had been no improvement of quality or actions taken by the provider to mitigate risks. There were very few audits of the service and those that did take place were not effective.

People were treated with dignity and respect, but they were not actively involved in making decisions about their day-to-day care. People had little choice or control in their lives and their care was not individual to them. They had limited involvement with the planning and review of their support, and people's opportunities to participate in activities were limited. Care records included some information that was personal to people, but important information was omitted. Records were not always available for staff to refer to when needed.

The provider did not manage the service to ensure that people received high quality care. The audits that were in place were ineffective and the overall culture was not empowering to the people who lived there. People and staff were not encouraged to contribute to the development of the service. A positive open culture was not seen to be promoted and we were not assured that the provider understood their responsibilities as a registered person. The provider was not up to date with current practices or national guidance and they told us that they employed staff to meet the regulation and operate the service.

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, it 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.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Risks to people were not effectively assessed, managed or reviewed leaving people at risk of inappropriate or unsafe care
.
Medicines that were given 'as required' or PRN and homely medicines were not all administered safely.

Staff were recruited and inducted safely.

Is the service effective?

Inadequate

The service was not effective.

People's healthcare needs were not responded to in a consistent or timely manner.

Staff did not have suitable or sufficient training or learning to do their roles well.

People did not have decisions made with them that were in their best interests.

People had adequate food but were not involved in planning for or buying it.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not actively involved in making decisions about their care, or to have meaningful choice or control in their lives.

People's independence was not encouraged or developed.

People's privacy and confidentiality was respected, and they were supported to stay in contact with family members who were important to them.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive care that was individual to them.

People were able to take part in activities they enjoyed, but these opportunities were limited.

Care records included some information that was personal to people, but important information was omitted.

People who used the service did not have opportunities to share their views and they were not aware how to raise concerns.

Is the service well-led?

Inadequate

The service was not well led.

Audits of the service were not in place and no system was being used to identify and bring about improvements.

People were not empowered by the culture of the service or the skills of the staff.

Adequate and contemporaneous records were not kept.

The provider was not up to date with current practices, or national guidance.

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 12 and 15 March 2018 and was unannounced. The inspection team comprised of two inspectors and one specialist advisor. The specialist advisor had specialist skills relating to learning disability and autism.

On this occasion, we had not asked the provider to send us a provider information return (PIR). A PIR is a form that asks the provider to give some key information about the service. This includes what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt was relevant.

We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information we had received from the public. We also received feedback from the local authority who commission the care. We used this information to formulate our inspection plan.

We observed staff interacting with people within the home but people did not want to talk with us. We spoke with two relatives and one health professional. We spoke with five members of staff, the acting manager, the manager who was applying to be the registered manager and the provider.
We looked at the care records of four people and pathway tracked three people. Pathway tracking is a way of seeing if services and care are delivered well. We looked at the recruitment records of four staff, and asked to see other information such as complaints records, and information relating to accidents and food. We also asked to look at records that related to the management of the service.

After the inspection, the provider sent us some of the information we had requested during the inspection. We received details of staff training. However, we did not receive information we had requested in relation to audits.

Inadequate

Is the service safe?

Our findings

At our previous two inspections of this service in August 2017 and November 2017, we found the key area of 'Safe' to be Inadequate. We also identified a breach of Regulation 12 because people's safety at the service had not been ensured or promoted by the staff team. At this inspection, we found people were still not receiving safe care and the service remained in breach of Regulation 12. We found the key area of 'safe' to remain Inadequate because the provider had failed to make improvements to ensure people's safety, despite ongoing and significant concerns about the safety of the service.

Relatives we spoke with were not sure if people at Ascot Villa were safe. One relative said, "I don't know what's going on…I just don't have the information [about how they keep my relative safe]." During this inspection, we found the provider had failed to robustly assess risks to people so staff did not have all the information they needed to keep people safe. We found people's risks and changing needs were not monitored or updated in a way that promoted and ensured their safety. For example one person had three separate risk assessments in relation to how they were to be supported in the event of a fire. They contained significantly different instructions to staff and were kept in different parts of the home. Staff we spoke to could not tell us how they would support the person to leave the home in the event of a fire. The provider had failed to ensure that actions to take were clear and co-ordinated, despite it being known this person needed specific support to ensure they evacuated the building in the event of a fire. Planned fire drills had not occurred which meant this person had not had the opportunity to practice evacuating and staff had not had the opportunity to review how they would support the person in the event of fire.

For another person, we asked staff how they supported one person in the community as they had a history of becoming distressed, and behaving in socially unacceptable ways when in the community. The staff member said that there was no risk assessment they knew of, and told us that staff did not have the training or knowledge to keep the person safe while outside. The provider had failed to have accurate information available for staff to follow. The inspector and staff member then reviewed the person's paperwork together and found undated behaviour management information, which the staff member told us, was no longer applicable as the person's behaviour was very different now to how it was described in the information. This meant that staff may have supported the person in a way that did not protect them from known risks.

We found that despite two people having mobility issues neither of them had a falls risk assessment. Staff were not aware that people were prone to falling. On a hospital discharge letter of one of the people dated June 2017, it advised that they should have a falls risk assessment completed. This had not been completed and so staff did not have the knowledge and skills to keep people safe and avoid falls where possible.

One person was not wearing their prescribed shoes to enable them to walk safely and another person had fallen the day before our inspection with no action taken to assess this. People were not kept safe as their risk assessments were poor or missing. The provider had failed to ensure staff had the knowledge they needed to ensure people's safety and wellbeing.

During our previous two inspections we identified that another person did not have an appropriate risk

assessment in place to enable staff to support them with their on-going health concerns. Staff did not have the knowledge to keep the person safe when they became ill. Staff we spoke with had some knowledge of the person's health support needs but this was not consistent and did not ensure the person's safety. At this inspection we found that risks to the person from their health condition still had not been assessed or actions taken by the provider to keep them safe. Staff did not have sufficient guidance to keep people safe, mitigate risk and ensure their health needs were met. The provider had failed to update or implement robust care plans and risk assessments to provide adequate information to staff, despite previous inspection reports identifying these issues. The provider had continuously failed ensure and promote people's safety, placing people at ongoing risk of receiving inappropriate or unsafe care and support.

The provider had introduced a new system of administering medication that was easier for staff for follow. We found that staff had administered most medication safely due to the introduction of a 'bio dose' system, which makes sure that tablets are in individual pots to enable safe administration. We saw medicines were clearly labelled and dated from the pharmacy. We looked at the medicines administration record (MAR) charts for two people and saw that routinely prescribed medicines were recorded well.

Some people needed medication on an 'as required' or PRN basis, and we saw that these were being regularly given and recorded. However, guidelines for when to give these medicines were not available to staff. For example, it was not clear when people should receive medicines that helped them remain calm. Staff gave us inconsistent accounts as to when they would give these medicines, which placed people at risk of unsafe medicine administration for 'as required' medicines. A health care professional told us, "I've repeatedly asked for PRN protocols and guidance, but they are not available." Despite this issue being raised at previous inspections the provider had failed to ensure this guidance was available for staff to ensure they administered these medicines safely.

People were put at risk by the inappropriate use of homely medicines. We discussed the use of 'homely medicines' with staff. These are over the counter medicines such as mild painkillers. At our last inspection we saw that one person had been using a homely medicine and this had not been checked with a healthcare professional to see if there were any potential side effects or contra indications with the person's existing health or their other medicines. At this inspection we saw that the same homely medicine was still in the persons cupboard, and the person was therefore still at risk of being medicated incorrectly. Homely medications were not recorded and staff did not know if the person had been given this medication. We raised this with the manager and they told us there was still no process for auditing any homely medicines. The provider had failed to keep people safe from the inappropriate use of homely medicines even though this issue had been raised in the last inspection report.

The provider had failed to ensure that one person attended important health appointments and their treatment had therefore been delayed. There was no system to ensure people attended important health appointments, placing people's health and well-being at risk.

We looked at how the provider learnt from mistakes and how they planned to improve their service as a result of that learning. We found that there were no systems or processes in place to do this. For example, at our previous two inspections we found that processes to reduce the likelihood of accidents and incidents happening again were not in place. At this inspection we saw that the provider now used an accident book as a record of when accidents occurred. We noted however that this was used only as a list of accidents and that no analysis or learning had taken place as a result. For example, one person had recently fallen and only a handwritten note was made on their file, no actions had been taken or trends looked for to reduce the likelihood of recurrence. This meant people were not protected from future harm due to an inadequate oversight and response to incidents which had occurred.

The care and support people received was not safe and processes and checks were not in place to ensure safe care. This was a continued breach of Regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People at Ascot Villa chose not to speak with us on the days of the inspection, but we observed that they appeared well. All the staff we spoke with felt that people were kept safe from actual harm or the risk of abuse. However, we could not be sure that staff understood their responsibilities in relation to reporting safeguarding concerns as only five of nine staff had the opportunity of attending safeguarding training within the last three years. Staff we spoke with were not consistently clear on what safeguarding people meant, or how to whistle blow if that was needed. One member of staff said, "I've never heard of whistle blowing, I didn't know I could do that." A relative we spoke with said, "I think [my relative] is safe with [two named members of staff] but I don't know about the other staff, I just don't know them." We saw there was a safeguarding policy at Ascot Villa but were unable to locate any information at the inspection in relation to the safeguarding incidents we had been made aware of. The provider and manager were not clear about what action had been taken to protect people from the risk of abuse or avoidable harm. This meant that the provider did not have oversight of safeguarding concerns and had not followed processes that ensured safeguarding concerns were responded to in a timely and appropriate manner.

We saw that the home was generally clean, and staff said that most cleaning was undertaken by night staff. Two members of the inspection team noted a strong and unpleasant smell of urine in one person's bedroom. A member of staff said, "We haven't done a deep clean in that room, it does smell bad in there." There were no audits undertaken to check if areas of the home had been cleaned to a suitable standard. We found that there was an 'ad hoc' approach to cleaning within the home and that Infection control practice and prevention within the home remained an area of concern.

Since our last inspection, we saw that some improvements had been made to the environment of the home. We saw that areas had been redecorated and concerns with the maintenance of the building had been rectified. Staff told us that they always had a supply of protective gloves and aprons to use when they supported people with personal care.

We saw that there were sufficient staff to support people in line with their care needs. During our inspection people were supported in a timely manner. Relatives we spoke with told us that they had no concerns about the staffing levels within the home and we saw the rotas of the staff that showed the service made sure sufficient staff were available.

We reviewed staff recruitment files and saw that the provider's recruitment process contained the relevant checks before staff worked with people. Staff told us that the provider had taken up references about them and they had been interviewed as part of the recruitment and selection process. The manager showed us the current DBS or police checks that they held for all of the staff who worked at Ascot Villa. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care.

Inadequate

Is the service effective?

Our findings

At our previous inspection of this service in August 2017, we found the key area of 'Effective' to require improvement. These concerns related to staff having not had adequate training and learning opportunities in relation to learning disabilities and autism. In addition, the service was not operating within the principles of the Mental capacity Act. At this inspection, we found that the service continued to have serious concerns in these areas and it is now rated as Inadequate in this key area.

People received care and support that was not based on current standards or good practice. For example people were routinely deskilled by staff who did not understand the need to promote independence. For example, staff did things for people such as cooking and laundry rather than having a system of supporting and promoting people to develop their independence. We found that staff did not have sufficient skills and knowledge to deliver effective care. We reviewed the training of staff during our conversations and by looking at the staff matrix and saw that only three of the nine employed staff had relevant qualifications or training that related to learning disabilities or autism. Other staff had no training in this area at all, despite providing care and support to people with needs in those areas.

The provider had failed to train staff and ensure they had the skills needed to deliver effective care. The senior manager told us that staff were not undertaking the Care Certificate or an equivalent training programme. The Care Certificate is a nationally recognised induction programme for new staff and new staff had been recruited and did not have this level of basic knowledge. A relative told us, "I'm not sure if the workers are trained or if they can cope with [my relative]." This lack of training and knowledge meant that the majority of staff did not have the skills necessary to meet the needs of people they cared for.

At the last two inspections, we saw that staff did not have sufficient access to core training to enable them to know the specific support needs of the people they cared for, such as epilepsy training, or responding to challenging behaviour. At this inspection, we found that this situation had not improved and the provider had failed to support staff to obtain appropriate training or qualifications in specific areas. A review undertaken by a social work practitioner in January 2018 noted that staff needed training to update their skills and knowledge. We found staff were unaware of what was expected of them, particularly in relation to effectively communicating with people and that guidance for their role and how to meet people's support needs proactively was lacking. A health care professional we spoke with said, "[Staff] don't understand the importance of things, I stress it to them but they just don't get it."

We also found that the provider still did not have an up to date or effective system or process that identified what training staff had undertaken or when it needed to be refreshed. We found that staff did not have adequate training or skills and were therefore not competent in their roles. They were also unable to recognise poor practice such as deskilling people in areas where their independence should be promoted. The provider had failed to make sure staff had the skills and knowledge they needed.

The lack of training, learning and development of individual staff members has meant they are unable to fulfil the requirements of their role. This was a breach of Regulation 18, of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

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, "We have supervisions and there is a three day induction." Two staff told us they had received supervisions but evidence of these processes or how they were monitored were not available to us on the days of the inspection.

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).

At the last two inspections, we found that significant decisions in the lives of people were not made in line with MCA. At this inspection, we found that this had not improved. The provider did not have a process that ensured decisions were made in people's best interests when they were deemed to lack capacity. For example, one person who was subject to a DoLS, had decisions made for them by staff in relation to whether or not they could access the kitchen, this decision had not been reached as part of a best interest. On the first day of our inspection we found that the kitchen was locked and two staff told us this was because the person 'lacked capacity.' No consideration had been given by staff or the provider as to risk assessing whether the person could have safe access to the kitchen area.
Another person had become upset on public transport and a decision had been made by the manager to stop them using public transport in the future. This decision had not been made using a best interests process and had not been reviewed. There was no evidence of best interests meetings for any of the people living at Ascot Villa or any consideration being given to how to keep the people safe in the least restrictive manner possible. Staff we spoke with were not aware of how these processes worked and had a poor understanding of the MCA and their responsibilities We found that the provider 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 people's rights.

The provider had failed to obtain meaningful consent to care from people, and staff were unclear about the legal requirements relating to this. For example, we saw that two people, who were deemed not to have capacity to make decisions about their care, had signed their own care records. Staff we spoke to about this thought it was appropriate, and that their signatures represented the person's involvement and contribution. A member of staff told us that was usual practice and did not understand why someone who lacked capacity to consent to their plan of care would not sign their care plan. No efforts had been made to explain the content of people's care plans to them. People were not involved in meaningful ways to participate in their care planning or reviews of it. There was no effective system, such as a key worker system or residents meetings, in place to support people to be involved in decisions about their care and their home. The provider did not monitor how staff sought consent from people or how restrictions were used in practice within the home.

We found that three people had received DoLS authorisations to restrict their liberty and the provider had reapplied for these as required. Staff we spoke with knew which people could go out alone and those who needed to be accompanied by staff. However, one of the authorisations was not available for us to review on the day of the inspection and it was therefore unclear if any conditions contained within it were being applied correctly by the provider.

At the last inspection we found staff had limited knowledge about the requirements of DoLS and MCA. At this inspection, we found that this remained the case even though staff told us they had recently received some in-house training in relation to this legislation.

The provider had not acted within the principles of the MCA and had ensured decisions were made in peoples best interests or were the least restrictive option for them. This was a breach of Regulation 11, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not have consistent access to health care professionals to maintain their health and wellbeing. The provider had not ensured that appointments were kept and that people had the timely health intervention they needed. For example, one person had an important health appointment that they were not supported to attend in both November 2017 and again in December 2017. A health care professional told us that the person would have been discharged from the hospital without their intervention. The lack of support from the provider with these health appointments has delayed treatment, and prolonged the person's ill health. The provider did not meet the health and needs of people to impacting on their wellbeing.

Relatives told us that GPs were called when needed, and they considered that their relatives' health was looked after well. Whilst we found some evidence on people's care records that they had accessed a range of health care support which included, district nurses, doctors, dentist and opticians; the provider had not made sure that people had consistent access to all the healthcare services they needed. For example, one person had not been supported to access community learning disability nurses. We also noted that people did not have Health Action Plans. These are used to promote longer term health improvements and are in line with good practice recommendations for people who have a learning disability. We also saw that only one person had a Hospital Passport, which is used to ensure that people get appropriate and safe care and support from health providers and others when they move or access other services. The provider had failed to make sure that all the people who used the service had consistent support to access health care.

We found that staff did not have adequate knowledge about how they should support people to maintain their health and well-being. For example, staff told us they had regularly weighed people. However, there was no care plan that identified for each person what a healthy weight would be, or why they needed to be weighed at all. Staff spoken with did not know if people needed support to maintain, increase or decrease their weight. A health care professional said that they had asked for one person's weight to be monitored due to ongoing health issues, but this had not been done. In another example, we found one person did not have the most suitable mattress in place for them to use given their health condition and the needs of their skin. The person had a general mattress with waterproof protectors on it, rather than a more appropriate pressure relieving waterproof mattress.

We found that the care and support delivered did not consistently reflect best practice guidance, for providers supporting people with a learning disability and autism. For example, there was no partnership working with other organisations and no methods of keeping up to date with current guidance and practice. We also found that advice given by external professionals was not always acted upon such as how to support people better with their communication needs. People's assessed needs and consequent care plans were not completed well or thoroughly and the records relating to these were in different parts of the home with very little order or consistency. A member of staff said, "With the paperwork I don't understand half of it, it's difficult

People had a range of food and drinks available to them, and chose what they wanted to eat on the day from what was available. Staff told us they cooked the meals for people and that people were not supported

to do this themselves, we found that only one person was assisted to make their own snacks. We saw staff were available when people required support to eat their meals, and that this was done with care and at a pace appropriate to each person. Records showed that people's preferences relating to food had been noted, and staff we spoke with knew what people liked to eat and drink. The provider had a planned menu, which some people had been involved in writing. However, we found that one person had planned the menu that would be eaten by other people in the home rather than ensuring the involvement of the people who would be eating those meals. When we brought this to the attention of a manager, they had not recognised the importance in ensuring people were involved in decisions that affected their own choices. Not all the people were directly involved in planning their own meals and those people who were supported by staff on a one to one staffing basis did not have that individualised food preparation. Food shopping was completed by staff, with people going to the shops to buy their own private purchases and not their food. No consideration had been given to how people could be meaningfully involved in this aspect of their lives. We found that people were not as involved in choosing their food as they could be, and the provider was not supporting people to develop their independent living skills in this area.

Requires Improvement

Is the service caring?

Our findings

At the past two inspections of this service, we found the key area of 'Caring' to require improvement as staff did not always promote peoples independence. At this inspection, we found that the service had not improved and that the service remained as Requiring Improvement in this area.

At our last inspection, there was very limited evidence that people's independence skills had been developed or that there were a range of suitable daily activities available to them. Staff told us people did household chores if they wanted to, but there were limited opportunities to promote their independence. We saw that opportunities were missed to assist people with developing their daily living skills and to involve people with day-to-day tasks. For example, we saw that a person had sandwiches made for them even though they were capable with support to do so themselves, staff advised us that this is what always happened. Another person had a glass of water brought to them, which they could easily have done themselves. People were not enabled to be active members of the household. A member of staff said, "We don't do anything around independence, if people do things it's just because they fancy it, there's no programme." For example, no one living at the home was supported to learn to cook simple meals, travel more independently, or develop new friendships or relationships. We found that actively promoting people's independence, and working in line with current good practice guidance around independent living skills had not improved since the last inspection.

Staff had not been supported by the provider to deliver care in the most appropriate and therefore caring way. People were also not given the opportunity to take part in residents meetings or have the support of a key worker system, or access to advocates. We found that people were not involved in directing their care. A health care professional said, "I think the staff care, but they don't understand their role, they are pleasant and kind."

People did not have a range of meaningful activities available to them. A relative said that one person chose to go to bed early in the evening because they are 'lonely'. The provider told us that a part time activities co-ordinator had been in post for three weeks, although they had worked as a carer at the home for over two years. We asked them about their new role. They told us that there were no activity plans in place for people, but they did write down what had been done. We saw that people took part in regular and repetitive activities. There was no information available for people in a format they might understand such as pictures to help them choose an activity and there was no resource folder of information to help plan activities. We looked at the activities people did and we found that they were repetitive and limited. A health care professional said, "[One person] does not have meaningful activities on a regular basis." One person activities were limited to a day centre five days a week, shops on Saturday and a relative's visit every two or three weeks on a Sunday. Other than that, staff told us the person sat and watched TV on their own. A member of staff told us, "There isn't a plan of doing stuff or activities." Where people had stated they wished to do something this had not been consistently facilitated. For example, one person had clearly expressed a wish to go on holiday for over a year and no plans or steps to consider this had been taken.

We recognised that while some people had certain activities on certain days as it helped control their

anxieties, there was no offer of developing activities that had previously been enjoyed and no understanding of how to do this. We found that peoples' independence was not promoted and that they were not offered a sufficient range of meaningful activities.

People we observed seemed comfortable with the staff that supported them. During our visit we spent time in the communal areas when invited we observed how staff supported people in their rooms. We saw that staff interacted with people in a kind way. We saw staff respond to people in a timely manner, and that conversations were appropriate and respectful. Throughout our inspection, we saw several examples of staff interacting with people in a pleasant and relaxed manner. All the staff we spoke with had an appropriate 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.

People and staff told us that they had been supported to choose some furniture for their rooms and some progress had been made to make the home environment more pleasant and comfortable. We saw that the home had received some redecoration and some basic maintenance work. The kitchen had also been refitted with new cupboards. We found that the general environment since our last inspection had improved.

Inadequate

Is the service responsive?

Our findings

At our last two previous inspections of this service on August 2017 and November 2017, we found the key area of 'Responsive' to require improvement. These concerns were identified as a breach of Regulation 9 whereby the provider had not done everything reasonably practicable to make sure people received care that was person centred and reflected their needs and preferences. At this inspection, we found sufficient improvements had not been made and the service remained in breach of Regulation 9. We found the key area of 'responsive' to be Inadequate.

At this inspection, we found sufficient and timely improvements had not been made with how the service enabled people to communicate in a way that met their needs. No progress had been made since the last inspection in relation to obtaining, or starting the process to obtain, practical aids for people to support their communication and enhance their well-being. For example, two people had limited verbal communication. Health professionals had advised the provider to use pictorial aids to support people and enhance their communication and engagement opportunities despite this being raised at our previous inspection, the provider had made no attempt to introduce these aids to assist people to communicate their needs and choices.

We found that staff did not have an understanding of how people communicated and did not know the difference between people's abilities to receive information and their abilities to express opinions and decisions. We found inconsistent information in care plans wherein some plans suggested a person used a form of communication that staff told us they did not. Another person's relative told us that they used body gestures to communicate. We saw that this was not in their care plan or known about by staff. We found that the service had not implemented the Accessible Information Standards, which are a set of nationally recognised standards for meeting the communication needs relating to disability, impairment or sensory loss. The provider had not met the communication needs of people living at Ascot Villa and had made no attempts to maximise people's opportunity to engage, be involved and communicate their choices. This had a significant negative impact on people's well-being and quality of life.

Some people at Ascot Villa could communicate verbally and staff told us that they gave these people choices and involved them in making decisions about their care and daily lives. During our inspection, we saw that staff gave people choices on day-to-day matters, such as where they wanted to be in the house or a choice of drink. However, the provider did not have any system in place to involve people in making choices about their care where they were unable to communicate verbally. The lack of appropriate communication aids further negatively impacted this process. We found that people did not have other methods in place to support them to meaningfully contribute to their care plans, activities or plans for their future.

People's needs and wishes were not known or acted upon in a timely manner. We saw that each person had care records which varied in detail from person to person, and we found that not all staff knew everything they needed about all the people who lived at Ascot Villa. For example, one person disliked brushing their teeth, but this was not noted in the records or any methods of supporting the person were not written down or known about by staff. A health care professional said, ""The care plans are not person centred and people

are not involved." Individual preferences and aspirations were not known by most staff, and where they were known about, they had not been acted upon in a timely manner. For example, we saw there had been a delay in one person starting to swim for many months. Another person did not achieve their wish of going on holiday for over two years. One member of staff spoke about one person's experience of living at Ascot Villa and described their life as very poor. A relative told us, "When the last manager left a lot of activities just stopped, [my relative] is lonely."

The care and support people received was not person centred and did not reflect their needs and preferences. This was an ongoing breach of Regulation 9, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have a clear or accessible complaints process. When we visited the service at our last inspection, there was some information about the provider's complaints process on display in the main reception area but it was not in an accessible format for the people who lived at the home. This had not improved and no action had been taken by the provider to support people to have access to this information. Relatives were not confident that they could complain and told us that they did not have confidence that the manager would respond to them well. A relative said, "I don't know how I would complain to Ascot Villa, I did phone them [about a year ago]…with a complaint…but they never called me back, so I called the police." We saw there was a policy about how complaints would be dealt with. We asked to see any complaints or concerns that had been raised and how these been addressed by the provider. This information was not available to us during the inspection. One member of staff told us, "I would like to know how to complain." We asked the staff member if someone who lived at Ascot Villa could complain, they said, "[A person] would not know how to complain, maybe through their behaviour they could, but that's all."

The provider did not make sure that complaints were received or acted upon appropriately. This was a breach of Regulation 16, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged and helped to maintain contact with friends and family members, wherever possible. Relatives we spoke with said that they had regular contact with people in the home and were encouraged to visit and support people.

Inadequate

Is the service well-led?

Our findings

At our previous two inspections of this service, we found the key area of 'Well Led' to be Inadequate. These concerns were identified as a breach of Regulation 17 and were in relation to an ineffective auditing and monitoring process to mitigate risks, improve quality or to adequately maintain contemporaneous and accurate records. At this inspection, we found that sufficient and timely improvements had not been made, and the service remained in breach of Regulation 17. We found that the service remained Inadequate in this key area.

A relative told us, "Most of the trouble has been with managers coming and going, one of them was dreadful." A professional health provider said, "I have constant reassurances but I do not trust them." We found that there were ongoing systematic and widespread failings in the oversight, leadership and monitoring of the home which meant people did not always receive safe care or effective support. Despite previous inspections identifying shortfalls to governance systems and the quality of care provided, we found that insufficient progress had been made to the auditing and governance systems of Ascot Villa. A health care professional said, "[The person] is not in danger, but they could have a much better quality of life."

We reviewed the action plan the provider had been sent to us in response to the concerns, which had been raised at the last inspection in this key area. We found that of the 16 points that had been listed in the action plan, ten had not been started and two had only been partially completed. Actions that had not been completed included a programme of staff training, implementation of communication aids and support for people, auditing of the service and updating of risk assessments. When we spoke to the managers and the provider about these concerns and the lack of progress on the action plan, they were unable to tell us why it had not been progressed within the timescales specified on it. We remained concerned that sufficient oversight of the improvements needed had not been robustly undertaken

The provider did not understand the principles of good quality assurance and there had been no improvement in this area since our last inspection or implementation of a robust improvement plan. We asked the manager to provide us with audits of the medication, which they agreed to send to us after the inspection. We did not receive these audits. Audits or checks staff training, staff supervision and the environment of the home had not been completed. The provider had failed to make any tangible improvements in these areas, which meant people continued to experience an inadequate service.

The provider did not have a culture of learning from events or any tools to reflect on what had worked well at Ascot Villa or what had not. There was no drive to make improvements or clear action plan to implement changes to the safety and quality of service.

The understanding and skills of both staff and management remained insufficient. A health professional told us, "[Staff] don't have adequate skills and knowledge, I have fed that back to [the manager], they know." We found that actions had not been taken to improve staff skills.

People's risks were still not recorded and updated as necessary, which meant people were placed at risk of

unsafe or inappropriate care because staff did not have the information they needed to keep people safe. Governance systems had not ensured care plans had been updated and therefore staff continued to be unaware of how to support all people safely and well. Staff training had not improved since the last inspection, and staff still did not have access to training and learning which would enable them to provide safe, effective care. For example, no training around supporting people with learning disabilities or appropriate communication methods with people had been given to staff. Many of the people using the service required support with communication and the provider had not ensured staff had the skills required to communicate effectively with people which significantly impacted the quality of care people experienced.

Oversight of people's health needs was not sufficient to keep people safe and well. In addition, the oversight of incidents and accidents that had occurred was ineffective, and did not ensure lessons were learnt and future risks mitigated against. Accidents and incidents were recorded in various places such as on people's own records or in an accident book. However, there was no formal trends analysis of the incidents at the home. A health professional said, "There is still unclear guidance, it is very inconsistent, the leadership is very poor."

The assessment and monitoring of the service to mitigate risk and drive improvement was not effective. This was a continued breach of Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had ensured that regulations relating to notifications had been met and the manager was returning notifications to us as required. The manager told us that the provider intended to support Ascot Villa to develop, and had made commitments to that end in the form of future investment in the building and its contents. We saw that some decorating had taken place and new furniture had been ordered. Data was not managed robustly and during our inspection, we found several examples of where information was misplaced or not available. For example, information relating to complaints or accidents and incidents were not available for us to review.

At the time of our inspection, surveys or other methods of collating opinions or views about the service provided had not been undertaken with people or their relatives. At our previous inspection, the manager had advised that feedback was gained informally when relatives telephoned or visited, but there was no evidence that this had been used to improve the service to people This meant that opportunities had not been taken to gather feedback to improve the service for the people living at Ascot Villa.

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 9 HSCA RA Regulations 2014 Person-centred care The care and support people received was not person centred and did not reflect their needs and preferences. This was an ongoing breach of Regulation 9, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Proposed cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not acted within the principles of the MCA and ensured decisions were made in people's best interests or were the least restrictive option for them. This was a breach of Regulation 11, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

Proposed cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care and support people received was not safe and processes and checks were not in place to ensure safe care. This was a continued breach of Regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Proposed cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 16 HSCA RA Regulations 2014 Receiving

personal care	and acting on complaints The provider did not make sure that complaints were received or acted upon appropriately. This was a breach of Regulation 16, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Proposed cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The assessment and monitoring of the service to mitigate risk and drive improvement was not effective. This was a continued breach of Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Proposed cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The lack of training, learning and development of individual staff members has meant they are unable to fulfil the requirements of their role. This was a breach of Regulation 18, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Proposed cancellation of registration