Nash Care Homes Ltd

Ashleigh House

Inspection report

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Date of inspection visit:
03 March 2020
08 March 2020

Date of publication:
11 May 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Ashleigh House is registered to provide accommodation and personal care for up to nine people with physical and learning disabilities including Autism. Eight people were using the service at the time of our inspection. The service is larger than current best practice guidance and no steps had been taken to create a domestic and homely feel. Bedrooms had not been personalised and communal areas were sparsely decorated.

People's experience of using this service and what we found
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. The outcomes for people did not fully reflect the principles and values of Registering the Right Support. People were not always treated fully engaged with or treated as partners in their own care.

A lack of understanding by both management and staff in relation to safeguarding people placed them at risk of abuse. Concerns raised during the inspection have led to ongoing safeguarding investigations. People did not always receive support that promoted their privacy and dignity.

The service lacked a positive culture and people were not at the heart of the service they received. Support was task focused and emphasis was placed on managing people as a collective rather than enabling them to lead individual and meaningful lives. People had limited access to activities that developed their skills and independence.

There was an absence of strong leadership to effectively coach and constructively challenge staff practices. This coupled with a lack of staff training meant that staff did not have the necessary skills and experience to deliver support in line with best practice.

Staffing levels were insufficient to meet people's individual and holistic needs. There was a lack of clarity in respect of people's one-to-one hours. Recruitment practices failed to adequately assess whether new staff were suitable for their role.

Medicines were not always administered as prescribed. Whilst people were supported to access their doctor when needed, staff did not work appropriately in partnership with other healthcare professionals to meet people's holistic needs.

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

Rating at last inspection (and update)
The last rating for this service was Inadequate (published 17 January 2020).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and the way people were being treated at the service. A decision was made for us to inspect and examine those risks.

Enforcement

We have identified breaches in relation to the provision of person-centred care, treating people with dignity and respect, restrictions on freedom, safe care, safeguarding from abuse, good governance, staff recruitment and training.

We are mindful of the impact of COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor the service closely and work with our partner agencies to ensure people are safeguarded. The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of Inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as Inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Ashleigh House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Ashleigh House 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
Both inspection visits were unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us 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 inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We met with all of the eight people who used the service and observed the care that was provided to them. We had individual conversations with two people and three relatives about their experience of the care provided. We spoke with ten members of staff including the registered manager, deputy manager and eight care workers.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with ten health and social care professionals who have recently had involvement with the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now remained the same and is still rated as Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to protect people from the risk of abuse. This was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of Regulation 13.

● The relatives spoken with expressed that they were happy their loved ones were safe and well looked after at Ashleigh House. Despite this we found that people were not adequately protected from the risk of abuse.
● During the inspection one person made an allegation about the way a staff member had treated them. This allegation was immediately reported to the Local Authority and is still under investigation.
● The registered manager did not fully understand their role in safeguarding people and required significant direction in taking the steps needed to keep people safe. Subsequent notifications to the relevant agencies were made using incorrect forms and inaccurate information.
● Staff were unable to accurately define the meaning of safeguarding nor demonstrate that they knew what to do if they suspected abuse. For example, when one staff member was asked what they understood by the term 'safeguarding' they said they thought it was "Safe Guiding" and meant to "Guide someone away from an incident." Similarly, another staff member told us that "Safeguarding is about separating people. Like [person's name] and [person's name]; we keep them separate from each other."
● Incidents of potential abuse were not recognised by staff, nor were they recorded or reported to the relevant authorities. During the inspection we observed interactions in which staff spoke inappropriately to people. Despite other staff being in the room, none of them challenged the way people were treated or raised these incidents with the registered manager who was available within the service.

The failure to ensure that people were protected from the risk of abuse is a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure risks to safety were managed without being restricted. The provider had further failed to ensure incidents and accidents were appropriately recorded

and analysed to prevent re-occurrence. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of Regulation 12.

● Relatives told us that they believed their loved ones were safe at Ashleigh House and drew comparisons to their experience of people living at other services where they had not felt they had been cared for safely.
● Whilst immediate risks to people's safety were mitigated, this was due to restricting their movement and freedoms rather than an enabling approach to risk management.
● We observed that staff sat close to people and required that they remain in communal areas where staff were based at all times. Staff told us they did this because people needed to be, "Watched closely" at all times.
● Staff did not understand how to safely support people with behaviours when their mood became heightened. For example, we saw a person start hitting the floor with their trainers. The person's care records reflected this as a known indicator of behaviour that might challenge. Instead of following the guidance by distracting the person or engaging them in an alternative activity, a staff member shouted across the communal room, "Bye bye shoes." The staff member then looked at us and said, "That will make him stop because he doesn't want to lose his shoes."
● Another staff member described how one person jumped up and down as their behaviour escalated. When asked what they would do to de-escalate this behaviour they told us, "I would get to his close face and ask what he was doing. Then he'd calm down." The behaviour support plan for managing this person's 'excitable' behaviours stated that staff should, 'Keep out of [person's name] personal space.'
● Accidents and incidents at the service were not routinely recorded in a way which enabled them to be analysed and reviewed for trends. The registered manager told us, "Incidents and accidents here are very rare." This statement contradicted their description of people's behaviour as being, "Very challenging." We viewed the log of incidents and found that the only ones that had been included were where events had been reported by external professionals.
● Some people had a tendency to exhibit sexualised behaviour and remove items of clothing in communal areas. The registered manager told us that such incidents would be reported and recorded. During the inspection we observed two people repeatedly removing items of clothing and walking around communal areas in a semi-naked state. None of these incidents were reported or recorded by the staff who witnessed them. Staff either ignored the incident or chastised people for the behaviour.

The failure to ensure risks to safety were managed without people being restricted and failure to analyse incidents to prevent a reoccurrence was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection the provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of Regulation 18.

● Prior to the inspection we asked the registered manager to confirm what constituted safe staffing levels at the service. They told us that a minimum of five staff were required during the day and supplied us with

copies of their rotas which showed this to be the case. Feedback from other professionals highlighted that these minimum staffing levels may not have been maintained in the evenings and at weekends.
● When we arrived at 6pm on the first inspection day, there were only four staff on duty. The registered manager was detailed on the rota as being on duty until 8pm, but staff informed us that he had left for the day at 5:15pm. Staff also told us that there were usually four staff on duty during the evenings.
● Our second inspection day was a Sunday and we arrived at 10am. On arrival we found three staff in the service who were supporting four people. The staff member in charge of the shift told us that another staff member was out on the minibus with the other four people. Each of the people on the minibus had been assessed as requiring minimum one-to-one support outside the service.
● The registered manager and deputy manager were recorded on the rota as being on duty. Neither were present at the time of our arrival and the staff on duty confirmed that they had not seen them that morning.
● The registered manager had sent us information in respect of the one to one staff support hours that people required each day. On both inspection days people did not receive this support because there were not enough staff available to do this.
● Staff were not deployed in a way that met people's individual needs. Staff were observed taking active steps to keep people in one communal area of the service so they could be supervised as a group. During the evening of our first inspection day, people were observed to be kept in the dining room. For example, one person left the area and a staff member called after them, "Come here, come here, come here, come here." Similarly, staff told another person, "[Person's name], go and sit in your place." The staff member repeatedly stared at the person and pointed their finger at them until they had returned to their seat.

The failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Previous improvements to the operation of safe recruitment practices had not been sustained. People were once again placed at risk because the registered manager had failed to ensure new staff were appropriately vetted prior to starting work.
● The application form and interview notes for one new member of staff indicated that they had previous experience of working in care. This was not reflected in the person's documented employment history. The staff member confirmed they had worked in domiciliary care services prior to starting at Ashleigh House but was unable to explain why they had not included this information on their employment history. The registered manager also failed to offer an explanation as to why they had not questioned the employment gap or sought references in respect of this person's relevant previous work, despite taking copies of certificates of training relating to care work during this period.
● Another recently recruited member of staff told us that they also worked part-time at another care home. Their application form reflected this, although no reference from this employer had been sought. The references on file for this person related to a previous non-care based position and a care provider the staff member had worked for in 2015. When the registered manager was asked about why they had not requested a reference from the person's most current care experience they replied, "There's no reason why we can't get one now."

The failure to operate safe and effective recruitment procedures was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Relatives told us that people received their medicines as prescribed. One relative informed us, "[Person's name] gets the right medicine here. [Person] was on a cocktail of medication before coming here – most of

which was unnecessary and that's stopped here."

● Despite the positive feedback from relatives, the medicines practice we observed, and information shared by other professionals was that the management of medicines was not safe.

● People did not always receive their medicines as prescribed. For example, on the first inspection day two people did not receive their time-critical medicines at the right time. We queried this with the staff member in charge and they told us, "Oh yes, I will do it in a minute. I got distracted." It was a further 30 minutes before one person received their medicine because the staff member administered the medicines in the order the Medication Administration Records (MAR) were filed rather than the times prescribed.

● Feedback from a health care professional involved in the care of one person raised concerns that the registered manager had failed to ensure that a person's medicines had been reduced in line with their advice. As such a person had continued to receive a medicine against the prescriber's instructions. This has been referred as a safeguarding matter.

● Medicines were not always stored securely. On the first inspection day, a staff member left the medicines cupboard open and unattended to six people whilst they left the room to administer medicines to a person who was in another part of the home. A second member of staff who had previously been in the room also left at this time and as such they too failed to recognise the importance of ensuring medicines were stored safely.

● Staff failed to understand the importance of the MAR as a contemporaneous record of medicines that had been administered. On the first inspection day, a staff member was observed inserting signatures on the MAR ahead of administering any medicines. When we questioned what they were doing, they told us they were filling in the gaps. They had not checked these 'gaps' with the medicines in the cupboard to ensure they had actually been given.

● The above concerns were shared with the registered manager who told us that staff had completed medicines training. There was however, no system in place for the regular competency checking of staff in this area.

The failure to ensure the proper and safe management of medicines is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Relatives told us that the home was always clean and tidy when they visited.

● The environment was visibly clean, and staff told us they had access to the necessary equipment to maintain appropriate standards of hygiene.

● Bathrooms and the kitchen were observed to contain the necessary hand washing facilities.

● The registered manager had instructed an external company to support the auditing of infection control procedures.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last inspection the provider had failed to ensure the requirements of the MCA were appropriately applied. This was a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People continued to be supported in a way that restricted their freedom of movement. During the first inspection day we observed that staff required people to remain in the communal dining room where they could supervise them as a group. When people made attempts to leave this area, staff took steps to ensure they returned.
- The locking of other rooms in the house was used as a way of controlling which areas of the service that people had access to. For example, when we arrived on the first inspection day, we asked to speak with a staff member privately in the lounge. The staff member asked staff leading the shift for the key to the lounge. Similarly, when we needed to use the bathroom, we had to ask for the room to be unlocked.
- Care was not always provided in the least restrictive way and ongoing restrictions were not kept under review to ensure they remained necessary and in people's best interests. For example, staff told us that

some people required their personal belongings to be kept locked away because they would damage them. They told us another person needed to have their room kept free of items because they might defecate on them. No staff member spoken with had witnessed any of these behaviours and care records indicated these were historic rather than current behaviours. The registered manager was unable to describe any steps that had been taken to demonstrate these restrictions had been reviewed and were still necessary.
● Staff lacked understanding about the principles of the MCA and were not able to tell us which people had DoLS in place and the conditions attached to them.

The restriction of people's rights and the failure to support people in line with the principles of the MCA was a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure that staff were appropriately trained and supervised in their role. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives spoke positively about the staff who supported their loved ones. One family member told us, "Staff are very good."
● Despite the positive feedback from relatives, other professionals who had recently visited the services expressed their concerns about the competency of staff. For example, one healthcare professional told us, "Staff have poor inclination to interact with people. We have observed staff falling asleep during activities, playing on their phones and not supporting people to make choices or meeting their needs."
● Some staff told us they had completed online training, but this learning was not reflected in the practices we observed. As such, where staff had completed training in safeguarding or mental capacity, they were unable to explain what these subjects were or how they had applied the training to their work.
● The statement of purpose prepared by the registered manager stated Ashleigh House; 'Offers a range of services focused on specialist care for adults with physical or learning disabilities including people with Autism and challenging behaviour." Despite this, staff demonstrated limited or no understanding about best practice requirements in supporting people with these specialist needs. Staff also lacked the skills to communicate effectively with people who used non-verbal ways to express their needs.
● The statement of purpose also described that, 'All support staff undertake the Skills for Care Induction when they join Ashleigh House." There was no evidence that staff had completed an induction in line with the Care Certificate. The registered manager confirmed that staff had not completed this nationally recognised set of standards which health and social care workers are expected to demonstrate in their daily working lives.
● Records in respect of the training and support provided to staff were not accurate. For example, the supervision for one staff member stated, "All mandatory training completed." This staff member was unable to describe any training they had undertaken since being employed at the service. This was raised with the registered manager who confirmed this staff member had not undertaken any learning since being employed at the service and that previous training certificates had not been verified. The registered manager agreed that the statement that the staff member had completed 'All mandatory training' was therefore not true.

The failure to ensure staff were appropriately trained and supervised to carry out their roles was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● Meal portions were observed to be large and people were seen to receive sufficient quantities of food and drink.

● Whilst there were no concerns about the people receiving adequate nutrition and hydration, there was a lack of choice in respect of the meals that were served. On both inspection days, people were seen to be given the same meal with no opportunity for people to make individual choices about the food and drinks handed to them.

● Meals were prepared according to the needs of running the service and planned menus were not always followed. For example, on the second inspection day the menu indicated a lunchtime meal of roast beef, but instead people were given chicken curry, rice, boiled potatoes, broccoli and carrots. A staff member told us, "The manager makes the menu, but he rang us this morning and said cook chicken curry because there are only four staff and it will be quicker."

● People's food preferences were known by staff, but meals reflected the needs of the group rather than individual choices. As such, staff told us how one person loved fish, but that seafood is never served at the service because another person is allergic.

● People's support needs at mealtimes were not always respected. For example, the care records for one person stated, "I like to eat on my own' and 'I do not like noisy environments.' On the second inspection day we observed that staff failed to recognise that this person had stopped eating their lunch when they were disturbed by the return of other people to the service. Rather than supporting the person to continue eating, staff assumed the person had finished their meal and the remainder of food was thrown away.

The failure to support people in line with their needs and preferences was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

At our last inspection we recommended that the provider consider how to make the service more homely for people using the service. Changes to the environment had not occurred since we last visited the service.

● The design and layout of the service once again did not reflect the principles and values of Registering the Right Support. No steps had been taken to create a domestic and homely feel and communal areas were sparsely decorated with an institutional feel.

● People had not been adequately supported to personalise their bedrooms and historic behaviours were cited as reasons why these areas lacked personal belongings. No attempts had been made to explore alternative ways of supporting people to create personal spaces that were meaningful to them.

The ongoing lack of personalised care was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Relatives told us they were confident that people's health care needs were understood and met. One family member informed us, "Staff are strict on appointments and [Person's name] goes to the dentist regularly."
● Feedback from a range of other healthcare professionals however highlighted concerns about the effectiveness of the care and treatment people received. For example, one professional told us that staff were not receptive to following their advice and making changes to improve the support that people received. Similarly, another professional informed us they had previously raised a safeguarding alert because they felt staff had failed to recognise the change in, "Presentation around [Person's name] physical health needs and did not support them in a timely way to get medical intervention."
● Care records provided information about people's assessed needs prior to moving to the service. Despite these assessments stating they had been reviewed, it was not clear what steps had been taken to ensure an ongoing assessment of people's needs in line with best practice. The registered manager repeatedly told us that people's abilities and behaviours had improved since moving to Ashleigh House but were unable to demonstrate how their care had been adapted as a result.

The failure to appropriately assess and meet people's needs was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

At our last inspection we recommended that the provider review how staff interacted with people to ensure their dignity was maintained. At this inspection we found that the provider had not taken this advice and staff practices had further deteriorated.

- Relatives told us that staff treated their loved ones well. For example, one parent said, "I see a family atmosphere here." Likewise, another family member commented, "We've had peace of mind since she's been here, the staff are very good."
- Despite the consistently positive feedback from families, our observations and feedback from people did not always reflect this. During the first inspection day, one person made an allegation about the way they had been treated by a member of staff. This matter was immediately referred to the safeguarding team and is currently being investigated. We also noticed that some people appeared nervous around certain members of staff and again this information has been shared with our colleagues at the Local Authority.
- Staff did not always support people in a way that upheld people's human rights. The language used by staff when talking to people did not suggest they were viewed as equals. For example, one person was displaying a heightened state of arousal and a staff member said to them loudly, "You embarrass me, why?" Similarly, in our discussions with staff, they were not always respectful in the way they described people's needs. As such, when talking about a person with a diagnosis of Autism, one staff member told us, "[Person's name] is a fussy lady with her own rules."
- Support was not always provided in a way that promoted people's privacy and dignity. Staff were observed to discuss people's personal needs openly in communal areas. For example, during the first inspection day, one person left the dining area and returned wearing different clothes. Three staff members were heard talking about the personal support that this person had received, with one two staff members saying to a third, "She was wet yeah?" across the communal area.
- Engagement between staff and people was predominantly task orientated. With the exception of staff greeting people when they arrived for their shifts, the only conversations that we observed them having with people were in respect of their care needs. This observation was also reflected in feedback from a health care professional who told us, "All of the interaction I have observed was of a functional nature regarding her care with no opportunities for a social conversation, having a joke or enjoying each other's company."
- Staff did not support people in a way that reflected them as equal partners in their care. For example,

where staff were providing one-to-one support to people this was done in a way which was controlling rather than enabling. As such, we observed that one person spent a large proportion of their evening sat on the floor. Three different staff members provided one-to-one monitoring of this person and each of those staff sat on a chair looking down at the person.

● People were not encouraged to develop their independence or given opportunities to learn new skills. Staff were unable to give any examples about the way they supported people to become more independent. The language used by managers and staff reflected a culture where people were viewed as children who needed "Watching" and "Looking after."

The failure to treat people with dignity and respect and support people in a way which protected their Human Rights was a breach of Regulation 10. (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

At our last inspection the provider had failed to ensure that care and treatment was planned around people's needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Relatives told us that they believed people received appropriate support. One family member described the support their loved one received as, "Very high-quality care."
- The positive feedback received from relatives however, was not reflected by other health and social care professionals who had ongoing and regular contact with the service. For example, one such professional told us, "As a team we have concerns regarding the service being able to meet the basic needs of people."
- People did always receive support that was personalised to their needs and preferences. We observed that support was arranged to manage the needs of the group, rather than individual routines and choices. When we arrived at the service at 6pm on the first inspection day six of the eight people were dressed ready for bed. We observed that people were sat in the communal dining room with no activity and little engagement from staff. At 7:43pm we asked a staff member what people would usually be doing at this time to which they replied, "Most would have gone to bed if you weren't here."
- Care plans were in place, but these were not reflected in care we observed being provided nor were the staff on duty familiar with their contents. For example, the care plan for one person described some of the behaviours we observed during the inspection and stated that triggers for such behaviours included, 'Changes to the environment, being denied a request and boredom.' The person's care plan went on to describe that the person needs, 'To be fully occupied' and outlined preferred ways of doing this. During the inspection, the person's heightened behaviour was either ignored or chastised. No attempts were made by staff to divert the person's attention or engage them in a meaningful activity.
- People's wishes or needs in respect of end of life care were not known or planned.

The ongoing lack of personalised care was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them;

● Relatives told us that they could visit whenever they wanted to, and that staff supported people to do things they enjoyed.

Despite the positive feedback from the relatives spoken with, other professionals described that in their experience, people were "Occupationally deprived." For example, feedback from the local Community Team for People with Learning Disabilities stated, "There is a lack of appropriate meaningful activities" and that their observations of in-house activities was that, "The activities provided are inappropriate and unsafe."

● Our observations also highlighted that there was a lack of opportunity for people to engage in activities that were meaningful and fulfilling. Whilst one person did attend a college during the week, other activities centred around people going out for drives or walks as a group. No attempt was made by staff to engage people in activities within the service.

● Staffing levels were not arranged to enable people to participate in activities that interested or developed them. One person's care manager told us that it was important that they attended church each week. During the inspection this person did not attend the church service as expected. When discussed with staff, they told us, "They didn't go to church because there wasn't a driver on duty to take them."

● Records relating to activities that were either planned or had taken place were inaccurate. For example, trampolining was recorded as an activity that was planned for the second day of the inspection and which people had done in the preceding days before. Staff said this referred to people using the trampoline in the garden. The trampoline however was observed to be broken and pushed up against the side of the fence. A staff member advised that it had been damaged in a storm and had not been used for two to three weeks.

The failure to support people to develop their independence and be involved within their community was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs; Improving care quality in response to complaints or concerns

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Staff did not always have the appropriate skills to communicate with people effectively. Staff told us that most of the people living at Ashleigh House used Makaton as a way of communicating their needs. We also observed that people used these simple signs to express their needs. Despite Makaton being a primary communication system with the service, not all staff had been trained to use it.

● Staff did not always respond to people's non-verbal expression of their needs. We observed that people became frustrated at times during the inspection, but this was either not noticed or ignored by staff. For example, one person was attempting to fold a table cloth and struggling to do so. They were becoming visibly irritated by this and yet staff failed to intervene and offer support.

● Feedback from the Speech and Language Therapist highlighted that concerns about how staff communicated and interacted with people was an ongoing concern to them. As such, they told us, "The environment [at Ashleigh House] is not conducive to people being able to approach staff and be listened to." They went on to state, "Communication aids that the home has are generic and not necessarily meaningful to [individuals]."

● The communication aids shown to us by the registered manager were in pristine condition and were kept in the registered manager's office which meant that they were not always readily available to people and

staff.

Improving care quality in response to complaints or concerns

● Relatives told us they had no complaints about the service. One family member informed us, "I cannot find any fault at all."

● The service had a complaints policy and the registered manager told us there had been no complaints since the last inspection.

● Due to the absence of quality assurance processes in place and staff's lack of meaningful engagement with people, it was not possible to ascertain whether people's views were listened to and acted upon.

The failure to have systems in place that assess service user's experience of the quality of the service was an ongoing breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same and is still rated as Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;

At our last inspection the provider had failed to ensure there was an effective monitoring system in place. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● This is the third consecutive inspection which has identified significant failings at the service and led to an overall rating of Inadequate.
● Previously identified breaches in Regulations had not been met and where earlier progress had been made, this had not been sustained. For example, improvements identified at the last inspection in respect of systems for recruiting new staff had not been maintained and the service was again in breach of Regulation 19.
● Assurances given by the provider that action would be taken to address shortfalls were not reflective of what was actually happening within the service. Following the last inspection, the registered manager submitted an action plan which outlined how the Requirement Actions would be addressed. The measures they told us they would take in respect of safeguarding people from abuse, protecting people's legal rights and supporting people to access meaningful activities had not been taken and there were still breaches of Regulations against each of these areas.
● The registered manager was still not leading the service in accordance with their published Statement of Purpose (SoP). The SoP stated: "To provide the highest standard of physical, emotional, spiritual and social care that recognises the needs of the individuals." The repeated breaches in Regulations and Inadequate outcomes for people as highlighted throughout this report does not support this assertion.
● There was no system in place for monitoring or reviewing the quality of care. Despite ongoing concerns with the running of the service, the registered manager confirmed that to date no audits or quality checks had taken place in respect of the service. As such, the service had not complied with previous breaches and standards across the service had deteriorated further.

The failure to have systems in place that assess service user's experience of the quality of the service was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

- The service was not person-centred, and people were not empowered to lead active and meaningful lives. Support was consistently provided in a task-focused way which did not reflect people's individual needs and preferences. People's freedom of movement around the service was heavily restricted and daily routines were designed to support the collective needs of the group.
- Care was planned and recorded by managers with little involvement or input from people.
- There were no systems in place to obtain feedback from people, their representatives or other stakeholders about the running of the service. The registered manager confirmed no surveys had been sent out since the last inspection and no other means had been used to canvass opinions about what people would like to see changed or improved.

The failure to design care collaboratively with people was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

- The registered manager had failed to take multi-agency concerns seriously and had not been open and transparent about the ongoing breaches in Regulations. Despite not having taken the action they told us they had in their action plan the provider was not honest about this.
- Assurances given in respect of staffing levels was not accurate. The registered manager had submitted rotas to us prior to the inspection that were not an accurate reflection of the numbers operating within the service.
- The culture of the service was not open and honest. For example, the registered manager provided false information about a person living at the service when raising a safeguarding alert to the local authority. Staff had to be reminded to tell the truth when we asked why staff named on the rota were not on duty and differing accounts were provided.
- Feedback from other health and social care professionals highlighted a reluctance for managers and staff at Ashleigh House to work collaboratively with them to improve outcomes for people.

It is therefore recommended that the provider issue a letter to people using their service and other stakeholders, outlining the shortfalls and share how they intend to make the necessary improvements to the quality and safety of the service.

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 registered person had failed to provide people with personalised support that met their individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person had failed to ensure that people received a service that protected their privacy and dignity and promoted their independence.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had failed to ensure that support was provided in accordance with the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to ensure that people risks to people's health and safety were appropriately assessed and mitigated in accordance with their individual needs and legal rights.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person failed to ensure that people were safeguarded from the risk of abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had failed to implement adequate systems to continually assess, monitor and improve the quality and safety of the services provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person had failed to operate safe and effective systems which ensure only fit and proper person were employed to wok at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had failed to ensure sufficient numbers of suitably qualified, skilled and competent staff were deployed so as to meet the needs of service users.