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Ascot Lodge Care Home For Autism & LD

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 11 March 2015 and was unannounced. We last inspected this service in May 2014 and at that time the registered provider was failing to meet two of the regulations of the Health and Social Care Act 2008 which we looked at. We found that people were not adequately protected as new staff were not subject to robust recruitment procedures and the systems in place to monitor the safety and quality of the service were inadequate. Following that inspection we met with the registered provider, and they submitted an action plan detailing how they would develop and improve the service to meet these shortfalls. We returned to the service in March 2015 and found that the registered provider had made improvements to the service but the breaches of regulation had not been fully met.

Ascot Lodge is registered to provide care and accommodation for up to three people who have a learning disability, who are living with autism, and who may experience mental ill health. At the time of our

Summary of findings

inspection there were two people residing at the home. The accommodation comprised of three single ground floor bedrooms. The home had a bathroom, communal living space and facilities for people to cook.

The home did not have a registered manager. 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. Although a manager was in post they had not applied for registration with the Commission. There had not been a registered manager for over six months which put the registered provider in breach of their conditions of registration. There was a manager in place who had been working in the home for several months.

People living at Ascot Lodge were not consistently safe. We found that the registered provider was not using the information they had gathered about people to help plan their care, assess risks or protect people from avoidable harm. There were inadequate numbers of staff on duty to provide people with the support they required and to help people stay safe. You can see what action we told the provider to take at the back of the full version of the report.

Medicines were being well managed and we found people were receiving their prescribed medicines at the correct time, in the correct dose.

The registered provider was not complying with the requirements of the Mental Capacity Act 2005. Staff we met told us that they did not have the knowledge required to enable them to work confidently or competently within the act however staff had changed some of their practices in an attempt to comply with the act. This had resulted in people being placed at increased risk of harm.

People had been supported to attend healthcare appointments and some people had made significant improvements to their health. However the systems in place to monitor and evaluate people's health were not good enough to identify if people were receiving care which met their needs.

People were being supported to eat and drink a varied diet that was to their liking and met their cultural preferences.

People told us they valued the relationships they had built up with staff over time. We observed and heard caring and compassionate interactions between people and staff.

People had a variety of different activities they could do each day. These included attending day centres operated by the local authority and undertaking activities related to running a home. Although people were supported to pursue an interest or hobby that was of interest to them people did not have the opportunity to undertake some of the activities regularly.

The leadership of the service had not ensured people always got a safe and good quality service that met their needs. The registered provider had not ensured that the service met the specific needs of the people living at Ascot Lodge. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

People were not protected from avoidable harm because the provider had not identified or responded to known risks.

Risks that people took were not underpinned by robust assessments to keep them safe. Staff did not all have the knowledge or skills to make judgements about the suitability or safety of risks people were wishing to take.

There were insufficient staff on duty to meet people's needs.

Medicines were well managed, and we saw evidence that people had the medicines they required when they needed them.

Is the service effective?

Requires Improvement

The service was not effective.

Staff had not been supported to obtain the knowledge and skills required to support people's specific needs.

The registered provider was not complying with the requirements of the Mental Capacity Act 2005.

People were offered a varied diet that reflected their tastes and cultural diversity.

People had been supported to attend healthcare appointments and some people had made significant improvements to their health.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they liked the staff that supported them. We observed and heard kind and friendly interactions during our inspection.

The provider had not provided staff with the resources and support they required to deliver a caring service that met people's needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received personalised care, as the service was small and staff had got to know people's needs and wishes.

People had only limited opportunities to undertake activities both in and outside the home that they were interested in.

Summary of findings

People's experiences when raising concerns were variable. Although some people had found this positive other people reported that the provider did not ensure that changes were made in response to their concerns.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider had not ensured that appropriately skilled staff and the necessary resources were available to meet people's specific support needs.

The registered provider was not providing good quality care to people using the service. Assurance and quality checking systems in place were ineffective and failed to address the requirements of the law.

Ascot Lodge 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 was planned to check 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 unannounced inspection took place on 11 March 2015. The inspection was undertaken by two inspectors. Before our inspection we looked at the information we held about the service. This included the actions the provider told us they would take in response to concerns raised at our last visit. The provider had recently commenced sending notifications about accidents/incidents and safeguarding alerts which they are required to send us by law.

During the inspection we met and spoke with the two people who were living at the home. People's care needs meant that the information they were able to share with us about their experience of the home was limited. We spoke with three of the staff who were on duty, the home manager, the registered provider and a person working on behalf of the registered provider. After the inspection we spoke with one relative and with two health and social care professionals who support people living at Ascot Lodge.

We looked at records about people's needs and the care and support they had been offered and received, the recruitment records of three members of staff, the systems in place to manage and administer peoples medicines and the systems in place to ensure the service was safe and providing a good quality service.

Requires Improvement

Is the service safe?

Our findings

We last inspected this service in May 2014. At that inspection we found that the registered provider was not meeting all the safety needs of the people living at Ascot Lodge or the requirements of the Health and Social Care Act 2008. The recruitment checks undertaken before people started work were inadequate. Failing to provide an effective recruitment procedure placed people at risk from staff that might be unsuitable to work in adult social care. Following our inspection we met with the registered provider. They submitted an action plan detailing the work that would be undertaken. In March 2015 we found that the provider had improved the recruitment procedures but there was no evidence that full recruitment checks had been undertaken for all of the staff employed at the home. Our visit also identified new risks to people's safety.

We looked at the recruitment records of three members of staff. We did not find that full or robust checks had been undertaken for all staff prior to them being offered a position within the home. This did not ensure that people were protected from the risks associated with staff that were unsuitable to work in adult social care. We found that the registered person had not protected people against the risk of unsafe recruitment. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There were inadequate numbers of staff on duty to meet people's needs. We spoke with staff who told us they felt more staff were required. Staff and members of the management team inconsistently described the levels of support and supervision that people had. Some people had assessment documents written by the local authority that was purchasing their care. These included information about how many staff people needed to meet their needs. The rotas and the number of staff on duty at the time of inspection were not consistent with these requirements.

We found there were significant periods of time when staff worked alone. We looked at the arrangements in place for lone staff to seek assistance in the event of an emergency arising. There were no robust systems to enable staff to be able to seek help. One person living at Ascot Lodge was observed to be left in the home without staff support. There was no written risk assessment or skills assessments to show this was safe. Staff we spoke with were unsure of how long the person could be left alone for or what the person would do in the event of them needing the support of staff. There were occasions during the day when the home was unstaffed, and staff support would not have been available for this person should they have required it. We found that the registered person had not protected people against the risk of inadequate numbers of staff. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We asked people if they felt safe living at Ascot Lodge. People's comments included, "I like everything." A relative told us, "[Name of person] is happy. That is the main thing." Staff we met told us that people living at Ascot Lodge were safe. Their comments included, "I think people are really safe here," and "The residents are really safe here and the managers sort things out quickly." Staff we met were able to describe different types of abuse and tell us the action they would take in the event of abuse being reported or suspected. Training records we looked at showed that staff had been provided with recent training in this area.

We were informed by the manager that risks people were taking or exposed to had been assessed and we were shown individual documents for each person. As we spent time with people and talked with staff we identified that in many cases the person's needs had changed from the individual records we had been shown, and neither the risk assessment nor staff practice had been developed or reviewed to reflect this. The provider had not ensured that people would receive care or support which would protect them from the risk of harm.

All of the people who used the service needed staff to manage and administer their medicines. We observed staff giving people their medicines in a way and at a pace that was suitable to them. People chose not to talk with us about their medicine management. We spoke with staff at the pharmacy who supplies medicines to the home. They told us there were no concerns with medicines management at the home, and the findings of their recent audit had been positive. Staff we spoke with told us they had been provided with the training and support they needed to administer medicines safely. One member of staff told us, "I had medicines training with the local chemist-it was good. All staff are trained to administer

Requires Improvement

Is the service safe?

medication. If there is a problem it is dealt with really quickly." Our observations, records and audits within the home all provided evidence that medicines were being well managed.

We observed that the maintenance of the home was good. We found that all equipment and appliances including the gas, electric and hot water were in good working order. The manager was able to demonstrate that shortfalls within the environment were picked up either by staff or in a specific environmental audit. We saw records showing that the maintenance team responded promptly to these requests for repairs. A member of staff told us," The maintenance comes quickly if we call them. Nothing here is broken, although it does all need decorating."

Requires Improvement

Is the service effective?

Our findings

We last inspected this service in May 2014. At that time we found the registered provider was not meeting all the care and welfare needs of the people living at Ascot Lodge or the requirements of the Health and Social Care Act 2008. Following our inspection we met with the registered provider. They submitted an action plan detailing the work that would be undertaken. In March 2015 we found that the breach we had previously identified had not been met. We also identified numerous new concerns regarding people's care, treatment and support.

The registered provider, manager and staff we spoke with were unable to clearly describe their responsibilities or the requirements under the Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty.

Staff we spoke knew some of the key objectives associated with the MCA but were unclear about how, when or why the MCA should be used. Staff we spoke with told us, "I don't really know about mental capacity" and "I have had some training but not about capacity assessments." None of the people we met had been subject to an assessment under the MCA although some people's needs suggested this would have been appropriate. We found that staff had made a range of decisions for people, believing them to be in their best interest, but these decisions and actions had not been fully risk assessed or considered in line with the MCA guidance. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We observed meals being provided regularly across the day, and we observed people helping themselves to or being offered snacks and drinks. People told us that they had opportunity to make decisions about what they would like to eat and drink in both discussions at the home, and when they were out shopping at local supermarkets. The records of food eaten and the stocks of the food in the home did not provide evidence that people would have opportunity to eat five portions of fruit and vegetables if they wished to. We were informed by staff that people had no specific needs regards their food and drinks (although we found food monitoring records) and people were happy with the selection of foods and meals available which represented their preferences and a wide variety of cultures and tastes.

Staff we met told us they had received an induction, and had a chance to get to know people before providing their care. Staff we met told us they had been provided with training, and some staff had brought transferable skills and experiences they had gained in previous employment. Staff we spoke with had a strong value base, but did not demonstrate a detailed knowledge of the needs of people with a learning disability, people living with autism, or the needs of people with mental ill health. Training records we looked at showed staff had not been provided with training in these subject areas. We found only two of the ten members of staff had received training in supporting people when they were distressed and only five of the ten staff had training about autism. Staff we spoke with told us they had received training, their comments included, "When I started I shadowed for two days… I did lots of training on DVD. The induction was very good." Staff told us they felt supported by their manager, and were able to access informal support at any time. Formal supervisions had been held monthly and staff meetings were also held regularly. Staff told us, "I have supervisions every month and monthly staff meetings. If we miss a staff meeting we get a one to one [individual meeting with the manager]." We found that staff were well supported but that the team lacked the specialist knowledge required to meet the needs of the people living at Ascot Lodge.

People told us they had been supported to see the Doctor when they were unwell, and were able to tell us about some of the community health staff they had got to know over many years that had supported them to stay healthy. Staff we spoke with were able to describe the actions they took each day to help people stay healthy. Staff described ways they reminded or prompted people, which was consistent with promoting people's independence.

People and staff told us, and we saw records that showed people were supported to attend appointments at local hospitals. The manager was able to explain how they had pursued appointments for one person, and the positive

Requires Improvement

Is the service effective?

benefit this had resulted in for the person. There was evidence that people had seen a range of health care professionals over time, but the records and discussions with people and staff did not provide evidence these had all been with the frequency recommended to stay healthy.

Requires Improvement

Is the service caring?

Our findings

Staff we spoke with were able to tell us a lot about each person, including their likes, preferences regards their culture and faith and important people in their life. The manager described how she had spent time with each person's family when she started work at the home to ensure she got to know about the person in as much detail as possible. We observed staff adapting the way they worked to meet the needs and preferences of each person. One member of staff we spoke with commented about other staff and told us, "All the staff are kind I've never seen anything bad.".

Whilst we observed that people appeared comfortable and relaxed with the staff that were supporting them, we observed that one person had been left on their own in the home. Records showed this occurred on a regular basis. The person was not unhappy with this arrangement but there was no evidence that the person was safe, comfortable or had means of obtaining support.

People had been supported to undertake their personal care and to dress in a style that reflected their taste, gender and the weather.

We were informed that no one used an advocate and that some people's family were involved and consulted in people's care when this was necessary. Throughout the inspection we observed staff explaining and reassuring people about the plans for the day.

We observed that staff knocked the door and waited for people to tell them to come inside their bedrooms. One member of staff we spoke with told us, "If we give care, the privacy is there. The doors are always shut and we always knock."

While we observed individual interactions that were kind and compassionate we found that the provider had not resourced or established the home in such a way to ensure that people could be assured their needs would always be well met.

Requires Improvement

Is the service responsive?

Our findings

The small size of the service had enabled staff to get to know people well, and to spend time getting to know what people liked and how they liked to be supported. We observed the support that each person was offered in respect of everyday activities of daily living was suited to their individual needs.

We observed some good examples of people being encouraged to have choice and control over their life. On the day of inspection this included making choices about where they would like to go and what they would like to do. Staff had supported one person who had expressed a desire to stop smoking and they were pleased with this achievement.

We looked at the opportunities people had to undertake activities that were of interest to them, including the opportunities people had to maintain their faith. People chose not to speak with us about this. A member of staff told us, "There's a holiday for four days in Devon in the autumn." People we spoke with were looking forward to this. People's care records contained details about activities people enjoyed. We talked with people about these and looked at the daily records of activities undertaken. We found that people had not been provided with regular opportunities to do the things they were known to enjoy and did not have consistent access to interesting things to do.

We found that people were supported to stay in touch with their family and people important to them. Relatives we spoke with told us that they were made to feel welcome at Ascot Lodge, that people living in the home were supported to make visits to their family home if this was required. They also advised that the manager kept them informed of any changes in the person's well-being. This support enabled people to maintain relationships which were important to them.

Staff we spoke with told us they would feel confident to raise a complaint and said, "I'd go to my manager and fill out a complaints form, I know where it is." One relative we spoke with told us their confidence to raise concerns had recently increased. They said, "I did have major concerns about the place. I never felt there was any point in complaining". The person went on to tell us they did now feel able to complain and would have confidence their concerns would be listened to if they spoke with the manager.

Inadequate

Is the service well-led?

Our findings

We last inspected this service in May 2014. At that time we found the registered provider did not have effective systems to regularly assess and monitor the quality of the service people were receiving at Ascot Lodge or to meet the requirements of the Health and Social Care Act 2008. Following our inspection in May 2014 we met with the registered provider. They submitted an action plan detailing the work that would be undertaken. In March 2015 we found that although the provider had undertaken some work it had not been adequate to ensure this service was providing consistent, good quality care and support. The breach we had previously identified had not been met. The provider had not had regard for the report from the Commission. This was breach of Regulation 10. HSCA 2008(Regulated Activities) Regulations 2010. On 01 April 2015 new regulations came into force and the provider is now in breach of Regulation 17 of the Health and Social Care Act 2008. Regulations 2014.

Locations that are registered with the Care Quality Commission are required to have a registered manager in post. This service had been without a registered manager for over 6 months, which is a breach of the condition of registration. This is a breach of the Health and Social Care Act 2008. Registration regulations 2009. Regulation 5.

We met with the provider, manager and the provider's representative during our inspection. We asked them how they audited the service and assured themselves that the service was operating in the way they wished and expected. The provider informed us that the last recorded audit had been more than one year prior to the inspection. We shared the feedback and findings of the inspection with them, and found that while they accepted the findings they had not previously been aware or understood the challenges and concerns we identified prior to them being brought to their attention. We found numerous examples of audit and checking systems that were inadequate and ineffective. These included monitoring what people had eaten and drunk, monitoring people's weight and incidents when people had been unsettled. The provider had not consistently ensured that the manager had the required support and knowledge to enable compliance with the requirements of the law to be met. Failing to have systems that will identify, assess and manage risks relating to people's health is a breach of the Health and Social Care Act 2008. Regulation 10. On 01 April 2015 new regulations came into force and the provider is now in breach of Regulation 17 of the Health and Social Care Act 2008. Regulations 2014.

The provider offered care and support to people living with autism and a learning disability. The registered provider had failed to establish and develop links with relevant professional bodies that would ensure the service being offered was following current best practice guidelines.

Our own observations, staff we spoke with and a representative of the registered provider told us that the current manager was very focussed on the needs of the people living at the home and did her best to develop and promote a healthy culture and atmosphere within the service. We saw that there had been isolated developments that had improved people's quality of life. However we identified numerous issues that identified the home was not providing care or operating in a way that would comply with the requirements of the Health and Social Care Act. We found that neither the manager nor registered provider had effectively and safely support the people living at Ascot Lodge. Records of inspections undertaken by the Commission confirm that the registered provider had not been able to sustain compliance with the regulations. When the findings of our inspection were brought to the attention of the manager, the provider and the provider's representative they all acknowledged the shortfalls and the providers representative accepted the evidence we shared with them.

Staff we spoke with told us they were happy with the management of the home. They told us the manager often worked alongside them and was always available to support them. The provider had taken action to improve the culture within the home, and this had involved challenging poor practices and staff attitudes. People we spoke with told us of the positive benefits this had brought to the staff morale, and in turn that this was impacting in a positive way on the people living at Ascot Villa.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems in place to assess and monitor the quality of the service were ineffective and had not protected people who were using the service, staff or visitors from unsafe care and treatment or harm. The provider did not have regards to reports prepared by the Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to provide sufficient numbers of staff to meet people's needs. People had not been protected by robust checks being made on staff before they were offered a position within the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People who may require help to consent to care and treatment had not been given the support they required to stay safe and maintain their independence.