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Ascot Villa 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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 8 March 2017 and was unannounced. At our last focussed inspection in October 2016 we found that the home required improvement in the areas of Well Led and Responsive. At this inspection we found that the service had not improved.

Ascot Villa is a care home without nursing for up to six people who have learning disabilities. At the time of the visit five people were using the service. Prior to our visit we had received notification that the registered manager had left the home some months earlier and that the provider was in the process of appointing a new registered manager. There was an acting manager in post at the time of the inspection. 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found breaches in some of the regulations. There were no processes in place to effectively monitor and assess risks within the service and to drive improvements. We identified that the notifications of events and occurrences had not been made as required. People were not consistently supported by staff who had been robustly recruited. Individual risks to people in the event of an emergency had not been assessed to enable staff to know how to safely support people. You can see what action we told the provider to take at the back of the full version of the report.

People were comfortable and relaxed within the home. Staff understood safeguarding but had not had training to support their understanding. Not all staff knew how to keep people safe when their conditions changed. Not all incidents had been recorded or actions taken to keep people safe from them recurring. We could not be sure that people would be kept safe in the event of a fire within the home. People were supported by sufficient numbers of staff but they had not always been recruited safely.

Staff had received supervision and induction but there was no method of staff receiving the training they needed to deliver care well. People had their consent sought and some people were protected by the deprivation of liberty safeguards. The manager had not considered the needs of some people who may have needed to have their liberty safeguarded.

People had adequate amounts to eat and drink but the nutritional value of the food that was eaten had not always been considered. People were not always supported to maintain their health and well-being by the regular attendance to health appointments.

Staff at the home were kind and caring. They helped people maintain their privacy but we saw some examples of where staff did not always treat people with dignity. The ability of the home to promote people's independence was not robust. People's information was kept confidentially.

Staff knew what people liked and disliked, but people's choices were not always respected. People had access to activities in the community and staff supported them to take part in activities of their choice.

The provider had not always notified us of certain events they were required to, such as safeguarding. Accidents and incidents were not well recorded or looked at for trends or patterns to assist in identification if changes needed to be made or if additional support for people was necessary.

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

People were not always kept safe

People were not kept safe as risk assessments had not been updated when people's medical condition changed.

People could not be sure that they would be safely supported in the event of a fire.

Recruitment checks of staff were not robust.

People were supported by sufficient numbers of staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received the training they required to effectively meet the needs of people.

The provider had not ensured that the principles of the Mental Capacity Act (2205) were being adhered to.

Staff received supervision and induction.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not have support to promote their independence.

People's dignity was not always maintained.

People had access to a range of activities of their choice.

Records were kept confidential.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and, where appropriate, their relatives had not always been involved in planning and reviewing their care.

People's choices were not always respected.

The provider had a complaints process.

Is the service well-led?

Requires Improvement

The service was not always well led.

No audits or monitoring of the service had been undertaken.

The provider had not notified us of events in line with regulation.

The manager did not have up to date knowledge in relation to some areas of service provision.

Ratings were appropriately displayed.

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 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 inspection took place on 8 March 2017 and was unannounced.

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

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

During our inspection visit we spoke with the manager, the provider, and three members of the staff team and the relative of one person. We spoke briefly to two people who lived at the home and other people declined to talk with us on the day of our inspection. We sampled the records, including people's care plans, staffing records, complaints, medication and quality monitoring.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in March 2016 this area had been rated good. At this inspection we found that it had returned to its rating prior to March 2016 of requires improvement. People were supported by staff who knew some detail about people's individual risks and actions they would take to keep people safe. However we found that not all staff knew how to support all the people who lived at the home safely. For example one person had a risk assessment that stated their medication should be locked away in a cupboard in their bedroom. This was to prevent the person taking the medication incorrectly. On the day of our visit the medication was not locked away in a safe place. When we raised this with the manager they were not aware that the medicines had been left outside of the locked cupboard.

Each person had support plans and a range of risk assessments in place to help staff understand how to best support the people they cared for. Some risk assessments had been recently reviewed. However we noted that the risk assessment for one person had not been changed following a significant health issue occurring that had required the immediate support of health professionals. Staff we spoke with gave inconsistent answers about what support was needed to keep the person safe. When the same person had experienced a repeated health episode a member of staff had called the duty 'on call' manager for advice before calling a required ambulance. The person had experienced a delay in receiving the support they needed to keep them safe.

People were not kept consistently safe by systems that reduced the likelihood of accidents or incidents happening again. Systems were in place to record incidents and accidents. We found however that not all accidents or incidents had been recorded. For example one person had experienced incidents of aggression outside of the home and while the manager assured us these had been looked into and responded to appropriately they were not recorded. We did not find evidence of the persons care plan or risk assessment being updated in response to the incidents. We also found that management did not review the accident or incident records to check for trends or patterns. There were no systems in place to ensure management maintained an overview of incidents in order to possibly reduce their recurrence in the future.

People could not be confident that staff knew how to assist them to evacuate safely in the event of a fire. We noted that there was a weekly smoke alarm test but the manager told us that no fire alarms or fire drills had taken place for over one year, and personal emergency evacuation plans had not been completed for people. Staff were not aware of how people using the service would respond in the event of a fire emergency. We asked the manager if the home had a fire risk assessment which they assured us they did have, but this could not be located on the day of the inspection visit. After the visit the manager sent us a fire extinguisher certificate, but a fire risk assessment was not made available to us. We could not be sure that the home had appropriate risk assessments and safety measures in place to protect people in the event of a fire.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were not always supported by staff that had been robustly recruited to ensure they were suitable for the work undertaken. Before our inspection we had been informed that some staff had behaved in a way that had resulted in some serious safeguarding concerns. We looked at how the provider recruited staff and found that people may not have been safe from harm as the provider had not ensured safe recruitment practices. From staff files we were not able to confirm that there were satisfactory recruitment and selection procedures in place which met the requirements of the current regulations. In all of the files we found that there were application forms, proof of identity including photographs and interview notes. However three of the four files did not have appropriate references. Of those three staff, one was person was on induction and two staff members had been working unsupervised within the home for some time. When we spoke with the manager they were aware that the references had not been received and told us they were trying to obtain them.

We found that staff had Disclosure and Barring Service or police checks on their recruitment files. We saw that one check had revealed an issue. Although the manager advised that they had discussed and considered the issues there was no record of the discussion or indication of a risk assessment having been conducted.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were relaxed and moved about the home as they chose. We met most of the people who lived at the home during the inspection visit, and they appeared relaxed and comfortable in their surroundings. We saw that two people were happy to come into the main office area while we were there. People appeared comfortable and at ease chatting to the staff and manager in the office. One member of staff told us, "People are really safe here."

People were protected from the risk of abuse because staff we spoke with knew what constituted abuse and what to do if they suspected someone was being abused. They knew how to report their concerns to the manager and or external agencies such as the Care Quality Commission or the Local Authority. Staff we spoke with could describe the different signs and symptoms that a person might present which would indicate they were being abused. Staff were not able to confirm that they had received training in safeguarding to support their understanding. The homes policy and procedure had been developed by the provider to offer guidance for staff on safeguarding and whistleblowing. A copy of the local authority's safeguarding adult's procedure was also in place for reference.

People were supported by sufficient numbers of staff. We found that there were sufficient numbers of staff on duty to meet people's care and support needs. We noted that the service endeavoured to ensure that a consistent team of staff supported people due to their complex support needs. The manager and staff told us there was always one waking and one sleeping night staff, and an on-call service was also in operation to provide additional support for staff when needed. We checked staff rotas which confirmed that the manager had a system for ensuring staff were always available as required. During our visit we saw that one member of staff had to leave suddenly due to a family emergency and the manager then found another staff member to replace them within the hour. This showed that the manager had sufficient numbers of staff to rely on in an emergency.

We found that that the provider had a policy for the administration of medication, but it was not being adhered to. The policy was accessible to staff and they had signed to say they had read it. We noted that the homes policy required that two staff who were trained in administering medication were to administer it at all times. However, when we spoke with staff, some were not all aware that this was required, and one

member of staff told us that this was not always done. When we spoke with the manager they were not aware that the policy had not been adhered to.

We looked at the medicine administration record (MAR) for some people who lived at the home and found that they had been had been correctly completed. We checked the balances for some people's medicines and they were accurate with the record of what medicines had been administered. This indicated that people had received their required medication. We noted that staff who were responsible for administering medicines had received training to do this from a local pharmacy. Staff told us, and the manager confirmed that staff had not had checks on their competency to continue to administer medication safely.

We saw that for people who wished to manage their own medicines, assessments had been carried out to ensure that they were able to do this safely. Where medicines were prescribed to be administered 'as required' (PRN), there were instructions for staff which provided information about the person's symptoms and conditions which would mean that they should be administered. This meant that people received their self-administered and PRN medication safely.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in March 2016, the home was rated as requiring improvement in this area. At this inspection we found that the necessary improvements had not been made. Communication between management and staff was not completely effective. Staff told us they participated and contributed to handovers between shifts to enable staff to facilitate continuity for people. Staff we spoke with told us that communication was inconsistent within the team. One member of staff said, "Handover causes some stress because night staff don't listen." There had been recent staff meetings and the minutes revealed that managers had shared information about the home. We did not see evidence in the team meeting minutes that staff discussed people's care or staff responsibilities.

Staff told us that they received an induction which included getting to know people's needs and shadow more established staff. One member of staff told us, "I did shadow shifts for two weeks." There was documentary evidence that inductions had taken take place that introduced new staff to the people who lived at the home, however the induction training provided did not comply with national expectations. The manager told us that the care certificate [a nationally recognised induction programme for new staff] was not being used as staff were currently enrolled on level health and social care training at level three. After the inspection visit, we saw evidence that only three staff had started that qualification. Therefore at the time of our visit other staff had been employed and were working at the home without the manager assuring themselves that that they had the appropriate level of training. After the inspection the manager assured us that all staff had been registered to begin appropriate training.

Staff we spoke with told us that they received regular supervision to reflect on their care practices and to enable them to care and support people effectively. One member of staff told us, "I've had supervision." and we saw records that confirmed this. Staff and the manager told us that they did not undertake observations of staff's care practices to monitor and assess how the knowledge and skills gained by the staff were being put into practice. Staff told us they felt supported by the manager but not well led.

The manager and staff told us that they had not received any up to date training in core areas such as autism, epilepsy or how to support people whose behaviours might be of concern. One member of staff said, "I've not had good training here." This meant that staff had not received the guidance and support they required in key areas to keep people safe and well. We noted that while three staff had commenced basic training in the form of level three national qualification health and social care, specific training they might need had not been made available to them. The manager advised that they had plans to organise for this training to begin but no plans, dates or specific details of training to be undertaken were made were available to us.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We 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 were being met. The manager and the staff demonstrated that they had some awareness of the requirements in relation to the MCA, and DoLS, but these were not consistently followed.

We saw that the manager had sought and taken appropriate advice in relation to some people in the home. Some people had received authorisations to restrict their liberty and the manager had reapplied for these as required. However, the manager had not given due consideration to other people living in the home, who may have needed the protection of a Deprivation of Liberty Safeguard. Staff had some knowledge about the requirements of DoLS and the Mental Capacity Act but had not received training to support them in understanding their responsibilities.

We saw that people were involved in the routine daily decisions of the home and were asked for their consent whenever appropriate. We noted that most staff were knowledgeable in how to do this to ensure good outcomes for the people they were supporting. For larger decisions however the home did not have a process of ensuring decisions were made in people's best interests. For example we discussed how one person was supported when they became distressed and presented behaviour that was difficult to manage. Records in the home indicated that restrictions could be imposed to help manage behaviour that challenged although staff and management had contradictory views about if this practice would be undertaken. We found that how to support the person when they were unhappy was not clearly understood or documented. We discussed with the manager that the use of negative reinforcement as a way of controlling behaviour was not considered good practice. The manager had not considered the use of best interest decisions within the Mental Capacity Act as a way of protecting the person's rights.

At this inspection we found people were not always being supported to eat a nutritious and varied diet. Three staff told us that the food people ate was not very good. Comments included, "The food needs improving." and "I have told [the manager] that the food needs improving, it's not varied and we need more fruit and veg." People were given choices of what food they ate from a menu that had been prepared by the staff. Staff told us they had used the preferences of people to draw up the menu and that it changed regularly. We saw that peoples choices of food based on their religion and culture had been taken into consideration in menu planning.

We looked at people's daily records to see what meal choices they had been provided with and saw there was reliance on prepared foods such as pies and fish fingers. We did note that a small number of meals were prepared with fresh vegetables. We saw that the kitchen cupboards and fridge contained adequate amounts of food including small amounts of vegetables. Staff had not had any training or support in understanding nutritional requirements. For example we saw that one person required their nutrition to be supplemented by prescription drink, these were being given to the person as prescribed. However staff did not aid the person's nutritional intake in any other way with high calorie food or drinks and they told us this had not been considered. We noted that the person had their weight monitored and this was being maintained. This indicated that the person was supported to maintain a healthy weight, but the use of extra food other than supplements had not been made available to the person.

People were supported to access health care appointments. Evidence on some peoples care records showed that they accessed a range of health care support which included, district nurses, doctors, dentist

and opticians. Care plans had not been updated in light of any health care provided and did not reflect the support people needed. . Although people were supported to attend medical appointments we saw that where one person had declined to attend an appointment, staff advised that the consequences of not attending the appointment had not been explained to the person in a way they understood.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in March 2016 this area had been rated good. At this inspection we found that it had returned to its rating prior to March 2016 of requires improvement.

There was very limited evidence to support that people's independence skills had been considered or planned for. One member of staff told us that other staff did not understand how to promote people's independence and that a person's ability to remain continent had reduced because of this lack of understanding. We spoke with the manager about the involvement of advocates for people and were told that currently no one living at the home had access to an advocate.

People's dignity was not always maintained. For example we heard staff refer to people in a kind but condescending manner by saying 'good boy'. We also heard a member of staff ask a person in a loud voice if they wanted to use the toilet. This happened in the person's living room with other people being able to hear the question.

Relatives told us they could visit at any time and that staff made them feel welcome. One relative we spoke with told us, "I'm made welcome and I can visit anytime." We saw relatives visited throughout the day, were made welcome by staff and could meet with their family member in private.

During our visit we spent time in the communal areas and saw that staff interacted with people in a warm and kind way. We saw staff respond to people's communication in a timely and supportive manner. There was a relaxed atmosphere within the home. We saw staff sitting, talking and listening to people and provided comfort and support to people.

We observed staff checked with people before providing physical care and respected their choices in day to day matters. We saw staff checking and asking people what they wanted them to do or where they wanted to be in the home. We saw that there were clear records of how people wanted to be addressed by staff and what they liked to do. We observed staff addressing people by their preferred names and supporting people in line with their wishes. Staff were keen to encourage people to take part in activities they knew people would enjoy and offered reassurance when people became upset.

Staff we spoke with had a good knowledge of people they cared for and spoke fondly about people they supported. They could describe individual preferences of people and knew about things that mattered to them. Staff told us and we saw that they gave people choices and involved them in making decisions about their care and daily lives. We saw communication boards in people's bedrooms that helped them to understand what was planned and to indicate if they wanted changes to their day. There was also evidence of information in pictorial form for people to use if they wanted that. Rooms that we had been invited to see had been personalised with people's photographs and ornaments which all assisted people to feel relaxed and at home.

The provider had a system for ensuring that information was kept confidential and that records and

information about people was only accessed by those who needed it. We saw that private information was securely locked away. Staff demonstrated that they understood the need for confidentiality and to keep records safe. This helped to ensure that information was kept confidential.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in March 2016 this area had been rated good. At this inspection we found that it had returned to its rating prior to March 2016 of requires improvement.
People's choices and wishes were not always respected. Care records we saw contained information about people's personal preferences, daily routines and some life history. They recorded people's likes and dislikes, and what was important to them. For example being left alone when they wanted private time and being supported with their money whilst out in the community. However we found that for one person who preferred to go to bed early the support provided failed to acknowledge that this was the persons preferred choice. Staff told us that they had sometimes dissuaded the person from doing this as it meant the person got up very early the next morning. As a result of this the person had often exhibited behaviours that expressed the person's unhappiness about not being allowed to go to bed. While there was some monitoring of any behaviour that resulted from this action, we saw nothing in the persons care records that showed that this had been a decision reached in the person's best interests. Staff and management were not able to tell us why the person was being stopped from going to bed when they wanted to. We found that the person's choice in this matter had not been respected. People were not consistently offered person centred care that was focussed on meeting their individual needs.

Each person had a care plan to tell staff about their needs and how any risks should be managed. We saw that care plans had been reviewed but these did not always show that people or their relatives had been involved or consulted with, to ascertain if there were changes needed. We saw that where people had capacity to discuss their care they were encouraged to do so and had signed their care records. However where people did not have capacity to understand some more complex areas of their support, efforts had not been made to include them in the process as much as possible.

Each person had a range of activities that they could engage in and go out to if they chose. The activities were focussed on the interests of each person and mainly took place in the community. They included going to the shops, local park and the cinema. People had choices about the gender of their carers and had their culture and religion recognised in the food they chose to eat.

Care records showed that people had the opportunity to visit the home prior to making a decision and moving in. The manager told us and records showed that initial assessments had taken place to identify people's individual support needs. This made sure that the home knew about people's support needs before they moved into the home.

Relatives told us that the manager and staff were approachable and they said that they would tell them if they were not happy or had a complaint. Relatives were confident that the manager would make any necessary changes. We saw that the manager had a system in place for managing complaints and made sure that they were responded to in a timely manner. At the time of our inspection no formal complaints had been received by the manager. Staff told us they knew about the complaints process, and would help people use it if they wanted to. There was not an accessible form of the complaints process that had been made available to people, and the manager was not clear at what point people may have been told about it.

Requires Improvement

Is the service well-led?

Our findings

During our previous comprehensive inspection in March 2016, we identified that improvements were required as the home did not have an effective quality assurance process in place. When we went back in October 2016 to check if there had been any improvements we found that one audit had been undertaken.

Since the last inspection in October 2016 no further audits had taken place. We found that the provider did not have sufficient and robust systems and processes in place to monitor the quality of the service provided to people living at the home. For example, significant changes to people's health had not been recorded in care plans and risk assessments. The absence of an effective audit had meant that this omission had not been identified and addressed.

The provider did not have a system in place to check if staff remained competent to administer medication. Although some audits had been introduced, we found that they were not robust in determining if people received their medicines safely and as prescribed. For example the details about one person's prescribed medication regime that they self-administered had been recorded but this had stopped in December 2016, and the manager was unaware this had happened. There was no system in place to check if training that staff received was up to date or if there was a need to undertake refresher training. There was no effective system in place to identify if staff recruitment processes had been followed.

There were no systems used in the home to check that routine health and safety checks were conducted or that required action was up to date. We found that the homes policy stated that water temperatures should be monitored to ensure that people were protected from the risk of scalding from hot water and the policy also stated that the water should be tested for legionella's disease. These safety checks had not happened, and there was no system in place to make sure they did happen. When we spoke with the manager they were aware that these checks had not been carried out. People had not been protected from the risks associated with fire within the home. The manager did not have a system in place to carry out appropriate risk assessments and to keep them up to date. There was no system of checking if people knew how to evacuate the building if required or that staff knew how to support them if they needed that assistance. We found that quality assurance systems were not in operation within the home, and the provider did not have a plan to implement such a system.

There was no analysis of safeguarding, accident or incidents in order for the service to learn from previous concerns. There had been no audit or monitoring of fire procedures and associated risk assessments to ensure they had been conducted and were up to date.

The registered provider did not have an effective system in place to monitor and identify risks and to improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the provider and manager were not aware of some current guidance. For example there was limited awareness of their responsibilities to send CQC notifications of events as required by law. The

provider had not notified the local authority or CQC in a timely manner about concerns that had been identified in relation to people's safety which included any potential abuse or serious injury to people.

The registered manager had left the service in December 2016, and there was a manager in post. Staff we spoke with told us that the manager was a very nice person but did not know the job. One member of staff said, "[The manager] is very approachable but makes lots of mistakes."

In discussion we found that the manager was unaware of the need to report certain events to the disclosure and barring service in order to protect people, and had recently briefed the staff team in relation to the regulations they needed to be compliant with but had briefed them on an out of date piece of legislation.

We saw that the ratings given in the last inspection were displayed as required, which meant that the home was acting within the specific regulation. Supervisions and team meetings were being held with the staff. Staff told us that they had wanted to meet with the provider to get to know him and we saw this had taken place at a recent team meeting.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not being consistently assessed and managed to provide a safe service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not kept safe as the provider did not consistently complete safe recruitment practice to establish the good character of people employed.

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 17 HSCA RA Regulations 2014 Good governance There was no effective system in place to monitor and improve the service.

The enforcement action we took:

We issued a warning notice.