Trafford Metropolitan Borough Council

Ascot House

Inspection report

Ascot Ave
Sale
Manchester
Cheshire
M33 4GT

Tel: 01619620996

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Ascot House was last inspected in June 2014 when it was found to be meeting the regulatory requirements which applied to a home of this kind.

The current inspection took place on 14 January 2016 and was unannounced. The inspector returned to complete the inspection on 21 January 2016.

Ascot House is a residential home for older people provided by Trafford Metropolitan Borough Council. The home accommodates up to 35 people in single rooms. It is situated on a residential estate and has a small car park to the front of the premises. The home provides assessment and rehabilitation services and is provided by the Council in partnership with the Pennine Care NHS Foundation Trust which provides the therapy services which people receive whilst staying at the home. In addition a small number of respite places are available.

There is a registered manager at the home. 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.

We found that the home was safe and that the people who lived there felt safe. Relatives also felt that people who lived in the home were safe. Medicines were properly managed and the home was clean with steps taken to prevent the spread of infections. Most people thought the food was good and that there were sufficient staff to provide the personal care they required.

The staff team working at Ascot House were considered to be kind and treated the people who lived there with dignity. People were encouraged to develop their independence whilst staying in the home so that after a period of reablement and rehabilitation they would be able to move on with success. The home had a stable staff team and supervisory and management staff worked together to cover all the tasks required.

There were few social activities available in the home so sometimes people complained that they were bored. Visiting times for relatives were advertised as limited because of the therapy activities arranged in the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The home was safe. People told us that they felt safe and staff said they would report anything untoward to the registered manager, Medicines were stored and managed safely and there were arrangements in place for people to safely do so for themselves where they wished this.

The registered manager took steps to make sure that people who were employed in the home were suitable. The home was clean and staff took appropriate measures to avoid cross-infection.

Is the service effective?

Good

The home was effective. The registered manager had a good understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards for occasions when these would be required. There were sufficient staff who were trained appropriately so that they could provide personal care for the people who lived in the home.

Most people said that the food in the home was good and people with special dietary requirements were catered for properly. People were offered drinks when they wanted them.

Is the service caring?

Good

The home was caring. Most people said the staff were caring and kind and treated them with respect. Care documentation was comprehensive and there were arrangements to make sure that people's weights were monitored and other personal care was provided where people wished this. People received a range of therapies whilst in the home all aimed to help them to live more independently when they moved on. There were arrangements for advocacy where people required this.

Is the service responsive?

Requires Improvement

The home was not always responsive. There were few social activities organised within the home and little for people to do when they were not engaged in therapy. Visiting times were advertised as restricted although in practice there was more

flexibility. People did not always feel that they had been involved in the care that was being arranged for them.

Most people spoke positively about their stay, and said that they were given choices whilst in the home. Transition into and out of the home was managed carefully. The home helped professionals to make assessments of people's needs when they moved on from Ascot House.

Is the service well-led?

Good

The home was well-led. The registered manager took steps to find out people's views about the service they received. The supervisory and management staff worked as a team in order to make sure that the work of the home was completed.

The home had most of the policies and procedures required in a home like this in place although some needed to be updated and made more accessible. The home notified the Care Quality Commission appropriately about incidents and responded to complaints promptly.

Ascot House

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 was 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.

The home was last inspected in June 2014 when it was found to be meeting the regulatory requirements which applied to a home of this kind.

This inspection took place on 14 January 2016 and was unannounced. It was undertaken by an adult social care inspector together with an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service in this instance services for older people. The inspector returned to complete the inspection on 21 January 2016. During the inspection information was requested from the local authority which commissions services and is responsible for safeguarding adults in the area in which the home is located. We reviewed this along with information already held by the Care Quality Commission (CQC) such as previous inspection reports, registration information and notifications made by the provider to the CQC.

During the inspection we talked with eleven people who used the service as well as three relatives and other visitors to people who lived in the home. We spoke with three professionals visiting the home.

We spoke with ten members of staff as well as the registered manager of the home and the registered manager's line manager. We looked around different areas of the home at various times and in the bedrooms of people who lived there. We looked at five care plans and five staff files as well as other records used by staff in connection with the care of people in the home. We also looked at audits and other quality assurance documents as well as the home's policies and procedures.

Good

Is the service safe?

Our findings

All the people we spoke with and their visitors told us that they thought the home was safe. One person told us "I'm safe here" and another said "There's lots of young men on duty but that's fine with me" whilst a third person replied "Safe? Oh yes." Another person said "Safe? Yes and my belongings are safe" and a fifth person said "I've no concerns about my belongings, they're safe".

People told us that they were happy with the way their medicines were managed ""I get it (the medicine) at the right time". People told us that they thought the home was clean saying ""The staff clean every day", "It's beautifully clean". A visitor commented "Everywhere looks clean".

None of the staff we spoke with expressed any concerns about the safety of people in the home. We asked the staff to tell us what they understood about safeguarding. They were able to identify the kinds of abuse which might affect people who lived in the home and told us that if they suspected anything untoward they would tell the registered manager. We also asked a visiting professional who confirmed that they had never had any safeguarding concerns about the home.

We looked at the arrangements for administering medicines in the home. We saw that the home had developed a local policy for medicines which reflected the particular circumstances of the people who stayed there. This included the requirement that only staff who had been appropriately trained and shown to be competent in administering medicines could do so. We saw that only these staff administered medicines during our inspection.

We saw that people were usually discharged from hospital with two weeks supply of medicines. The home arranged for information about these medicines to be provided to the local GP's surgery with whom people were registered on a temporary basis. The local pharmacy was alerted to the need to provide medicines once this initial supply had been used.

A medicines file for each person was created which included their photograph so that they could be identified. The photograph was also attached to the blister pack for the current week in which medicines were supplied. Blister packs are used with monitored dosage systems and simplify the administration of most solid medicines to ensure the correct dose. Further initial supplies were stored securely in the secure medicines room. The medicines file included a medicine administration record (MAR) created for each person. We saw that the MAR sheet had been checked and included information about how and when each medicine should be given.

Where medicines could not be supplied through the blister pack (for example boxed medicines) these were kept together with the blister packs and registered on the MAR sheets. We saw that the MAR sheets had been checked against the medicines prescribed by the hospital which had discharged the person. Where there was any shortfall, for example in any medicines required in addition to the blister pack, the registered manager required the discharging hospital to provide these urgently and if necessary by taxi and told us that if they were not forthcoming she would regard this as a safeguarding matter.

We met an NHS pharmacy technician who visited the home on a regular basis. They told us that they undertook reconciliations of each new person's medicines against hospital discharge paperwork and medical history and we saw records on people's care files which confirmed this.

Once initial supplies of medicines had been exhausted further medicines were provided by a prescription from the local surgery filled by a local chemist. New supplies were again reconciled with the person's records on delivery to the home.

We saw that any changes to people's medicines during their stay were noted on the MAR sheet in writing by the visiting general practitioner. When people were discharged from the home they took their medicines with them and an appropriate fax was sent to their own general practitioner notifying them of this. Such changes and the number of people being admitted to and discharged from the home meant that surpluses of unwanted medication could accumulate which were posted into a locked medicines cabinet to which only the registered manager had a key. A record was kept of these medicines against which the registered manager could make a reconciliation before arranging for disposal.

All the medicines were stored appropriately in locked trolleys which were attached to the wall when not in use. The temperatures at which they were stored was monitored to ensure that they were kept in the correct temperature range to ensure the medicines retained their efficacy. There was a medicines refrigerator whose temperature was also monitored and we checked that the temperature was in the correct range. This contained insulin which was administered by the district nursing service which could also access supplies of dressings kept in the home.

All stores of medicines were kept in locked rooms, trolleys or in medicines cabinets secured to the wall. Controlled drugs were also kept in one of these rooms in a dedicated locked cabinet designed for this purpose with a separate record kept of their administration. We saw that the registered manager undertook appropriate audits of these and the other medicines in the home. The chemist which supplied the home had also undertaken its own audit of arrangements and found them to be satisfactory.

The home's focus on reablement meant that wherever possible people were encouraged to administer their own medicines and locked drawers were available in each bedroom to allow these to be stored safely. The home completed a risk assessment on each person on admission to the home which identified any assistance required with medicines and provided a risk assessment in each instance together with details of the assistance required. Where medicines were prescribed PRN (or "as required") we saw that information was provided to staff about the circumstances in which the medicines should be offered particularly where the person might not be able to ask for them themselves. We saw one person being asked by staff administering medicine if they required paracetamol and checking when the last dose had been administered to avoid giving the next dose too soon. These arrangements helped to ensure that medicines were stored and administered safely in the home.

Most of the people we spoke with thought there were sufficient staff working in the home. We looked at staffing rotas for the last four weeks and saw that they matched the level of staffing we saw during our inspection. In each of the four units there was one member of care staff on duty in the mornings and afternoons until 10 pm at night when the three night staff who covered the whole home took over. In addition each pair of units shared a further care worker who was described to us as a "floater" able to move between units as required.

Additional staff working in the home included three domestic staff in the morning with two in the afternoon together with a cook and a laundry/kitchen assistant. The registered manager and two other supervisory

staff were additional to these numbers.

Staff told us that they regularly rotated around the different roles and could also call on other units for staff support if this was required. We saw that some of this staffing was funded by the local NHS trust so as to enable the service to promote independence. During our inspection we saw that this included helping someone to have a bath. We saw that the staffing levels were about to be significantly augmented by funding from the local NHS Clinical Commissioning Group in order to strengthen the home's intermediate care activities.

We looked at the arrangements the provider made for ensuring that staff recruited to work in the service were suitable to do so. We looked at recruitment records and saw copies of application forms from which the provider could verify employment history and qualifications. The provider used an interviewing schedule to assess applicants and recorded their answers. The provider followed up references provided by the applicants to verify their past employment history and copies of their references were retained on the files. A record was made of the date a Criminal Records Bureau (CRB now Disclosure and Barring Service (DBS)) check had been made together with the reference number for the check. An exercise to renew all DBS checks was currently in progress which had led to some of the paperwork being temporarily disorganised.

We found that in three of the files the information required by regulations was incomplete. The files did not always include photographs of the staff concerned and did not always include proofs of identity. In one instance we were unable to match the references provided with the referees nominated by the employee. Employers should always verify the identity of a person giving a written reference to ensure that it is genuine and follow up on variation between the referees given by an employee and the reference which is actually provided. We raised these omissions with the registered manager.

All staff wore photo identity badges meaning that an additional photograph of them was stored centrally within the provider's records. We were shown scanned records that showed that proofs of identity had been produced whilst applying for new DBS checks. The registered manager told us that she checked all recruitment documentation and had recently refused to appoint an applicant because she was not satisfied by the veracity of the information provided. This showed that the registered manager was alert to the role she played in ensuring that suitable staff were appointed to work in the home.

Because staff recruited by the local NHS trust were deployed to work within the home the registered manager also showed us how she sought similar information from that employer so that in her role as registered manager she could be assured that they were suitable to work in the service.

We looked around the home and saw that it was clean. We checked the bathrooms and toilets and found that they were clean and equipped with supplies of personal protective equipment (PPE) such as disposable gloves and aprons which were dispensed from racks mounted on the wall. Dispensing PPE in this way helps to avoid cross-infection. We saw that staff used PPE whilst providing personal care to the people who lived in the home. Staff told us that they had received infection control training within the last two years. However on one unit when we asked to see schedules of cleaning we were told that these were not completed very regularly although all the tasks appeared to have been undertaken. We saw that the most recent infection control inspection had checked that these were available at that time.

We were provided with a report from the local NHS infection control service which showed that the assessment unit in the home had been inspected within the last twelve months. We checked that items identified as a priority had been addressed. There are no ensuite toilet facilities in the bedrooms at Ascot House and most people use a commode. We were told that this often replicates the most likely practice

when the person goes home.

The infection control report had highlighted the need for better equipment to be made available for the cleaning of bedpans and commode equipment. During our inspection we saw that the registered manager had already arranged for a supplier to call and provide an estimate for this and was making arrangements for its installation. We saw that the registered manager had responded to other recommendations such as installing a wash-handbasin in in the laundry.

Given the number of admissions to Ascot House, cross-infection between those arriving and those already living in the home is an increased risk (there were three discharges and two admissions on the first day of our inspection and six discharges with three admissions on or around the second). People in this situation are often vulnerable to increased susceptibility to infection which is unpleasant for them and could interfere with their reablement programme and subsequent return home.

We were told that the home used specialised equipment (Oxypharm) to ensure that each room was thoroughly cleansed after use and in preparation for the next person. We talked with staff who operated this equipment and found that they were knowledgeable about how to use it. The registered manager told us that there had not been an outbreak of this kind of infection since 2012. We saw that the home had a contract for the safe collection and disposal of waste to help ensure that this did not present a hazard.

Good

Is the service effective?

Our findings

One person told us "The staffing here is OK – same ones each day" and a visitor commented "There's always plenty of care staff when I come".

People's comments about the food varied. One person told us "The food is OK" and another said ""Food excellent, choice of main meals. We have enough drinks. If I want one I ask the staff and there are plenty of biscuits." Other comments included "Food is OK. – plenty of it, sometimes too much. Plenty of tea and biscuits too" and ""Food acceptable, plenty of cups of tea" and "Food's been wonderful, plenty of variety."

Other comments were more mixed and sometimes less positive. "Food OK – enough of it yes. There's choice. Staff come round and ask what we want. Lunch today is omelette and beans or sausage egg and beans, but I don't want beans". Another person told us "Choice but not brilliant. A bit monotonous, and bland" and "Lots of beans - too many - and sometimes the tea's cold". Another person said ""Ham, chips and peas were all cold. Chips had been redone. But we have plenty of drinks" although a visitor commented "I noticed plenty of drinks were provided but I've not been offered one. If I was I'd be prepared to pay for it".

We looked at the arrangements for food and drink in the home. Throughout the day we heard people being offered drinks and saw staff preparing these. Supplies of milk and juice were kept on each unit. Breakfast was prepared locally on each unit and we saw people eating toast and cereals with porridge and fruit juice available.

We saw that most food was prepared in a central kitchen and supplied in heated trolleys to each of the four units in the home. On the first day of our inspection the menu showed that lunch was as had been described to us - sausage or egg or choice of omelette with beans. The evening meal was steak and mushroom pie or macaroni cheese served with mashed potato and vegetables. On the second day there was soup and sandwiches for lunch with either meat and potato pie or fish with vegetables and potatoes. A vegetarian option was available and both meals were followed by a pudding. A full cooked breakfast was available on a Saturday and we were told that the Sunday roast lunch was very enjoyable.

We visited the kitchen and talked with each of the cooks on duty on either day of the inspection. The kitchen was clean and suitably equipped for a home of this size. We were asked to wear suitable personal protective equipment (PPE) before entering the kitchen. We saw that the menu for the home followed a three-weekly cycle so as to ensure variety and appeared balanced across the five food types required for good nutrition. We saw that fruit was included in the menu and the cook told us that this could also be made available on request.

The cook had a good understanding of the preparation of meals for people who had specific requirements such as because they had diabetes or needed their food to be specially prepared, for example by being pureed where people had swallowing difficulties. Appropriate sugar substitutes were used in the first instance and in the second once food was of a suitable consistency the components of the meal were kept separate rather than their being mixed together. This helps to preserve the distinctive aroma, taste and

appearance of the different components of these meals. We checked on the specific meal being prepared and served to one person who required a special diet to confirm that this was the case.

The only menu we saw on public display was outside the central kitchen but we saw staff talking to residents about their choice for lunch the following day. Because people had mentioned them to us we looked for beans but they did not appear frequently on the menus we looked at. When we raised people's comments with the registered manager she suggested that they might relate to alternatives provided when the main menu choice was not preferred. Since we had heard staff offering either cheese or beans on toast as an alternative this appeared to be a plausible explanation. The registered manager agreed to look into these comments.

We saw that there were refrigerators kept in each unit. Each of these had a chart attached with space to record daily temperature readings each day to ensure that they were operated within the correct range. However these charts had not always been completed and where they had been then on two occasions in different units the temperature had been recorded as higher than the safe range for storing foodstuffs (0°C to 4°C). The registered manager told us that the refrigerators were only used for storing milk, juice and eye drops (the latter to be available as part of people's rehabilitation work) but in one instance the temperature was recorded as higher than the maximum recommended for eye drops (8°C). When we returned for the second day of our inspection the logs were being completed daily and showing the correct temperatures for the items stored in the refrigerators.

When we spoke with staff they told us they had received training in areas such as safeguarding, moving and handling, dementia care, the Mental Capacity Act 2005 and infection control practice and that this had taken place within the last eighteen months.

We checked staff files and saw that these included copies of relevant training certificates and a log of mandatory training. This included a wide range of training but on the records that we saw staff appeared to have completed only some of these components such as first aid, dementia awareness, fire safety, coping with challenging behaviour, infection control and recording skills. There were no records of induction although we were told that this was undertaken with the support of the sector skills council (Skills for Care) workbook.

We raised this with the registered manager who explained that quite recently the provider had transferred training records to a central computer system. The registered manager had not been provided with the necessary authorisations to access and use the information contained in these systems and so was initially unable to provide us with the information we required. At our request she contacted the appropriate department who provided us with samples of the training records from which we could see that staff had undertaken a range of training during the last two years. We were able to confirm from this sample that staff had completed elements of mandatory training including safeguarding of adults.

The current system of recording did not fully support the registered manager's responsibility to ensure that her staff were trained and that this training was kept up to date. We saw that as a result of the registered manager's enquiry this matter had been raised with the provider for consideration and her line manager undertook to follow this up.

Ascot House is a residential home and does not provide nursing services (although the registered manager told us that they were currently applying to have their registration extended to include this). The "Information for service users and families" leaflet states that the home will not accept people with needs relating to elderly mental infirmity. However we saw that in practice this did not exclude people who no

longer had mental capacity or were living with some form of dementia.

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).

The registered manager told us that there were no people subject to DoLS in the home at the time of our inspection. Our records showed that in the last year there had been six applications made to the local authority under the DoLS arrangements. We looked at the records relating to one of these applications and found that it had been correctly submitted by the registered manager although the supervising (local) authority had not responded before the person had left the home.

The Ascot House "Information for service users and families" document we were shown stated that where a person may not have mental capacity they will be assessed for this by a community or hospital professional prior to admission. A best interest meeting would then be convened to determine whether the person should be admitted to the home. A best interest meeting allows everyone who might have knowledge of a person's preferences to make a decision where they are unable to do so on their own. We did not see records of any best interest meetings relating to people's admission to the home but we did see evidence of best interest meetings in relation to other decisions relating to people living in the home.

We spoke with staff who showed a good understanding of issues of consent and mental capacity and so we concluded that that the provider has properly trained and prepared relevant staff as appropriate in understanding the requirements of the MCA 2005 in general, and the specific requirements of the DoLS. We were told that a social worker is to be recruited for attachment to the home and that this would improve the ability of the service to undertake tasks related to the MCA 2005.

We spoke with a professional who was visiting a person who lived in the home. On the first day of our inspection we were told by staff in the home that this professional was attending a "best interest" meeting and saw that the person's relative had also been invited to the meeting although they told us they were unsure about whether the meeting was a "best interest" meeting or not. The professional confirmed to us that they had undertaken a mental capacity assessment on this person prior to their admission but we found that the home had no record of this and was not aware of whether this was the case. No best interest meeting had been recorded by the second day of our inspection. The registered manager agreed to look further into this.

Good

Is the service caring?

Our findings

Most people responded positively when asked about staff and said they were friendly. They told us "Staff are kind, I've no complaints. I'm going home soon and I'll miss the support here" and "Staff very good - they have a joke with you". Other people told us that the "Staff are all nice and kind to me", "They're very much kind and caring", and (The staff) couldn't be kinder, considerate and professional." Visitors supported this view saying "Staff seem OK." and"(The staff) are kind, caring and supportive."

The views of some other people who lived in the home were more mixed. One person told us "Staff are acceptable, sometimes one or two are a bit sharp if they're having a bad day" and another commented "Some (staff) are caring some not, but can't expect them all to be (caring)".

People also told us that most staff usually treated them with respect and considered their privacy. They told us ""They treat me with respect and always knock before they come in (to my room.)" and "I'm always treated with respect". One person felt that practice was variable "Some staff knock, (on the door), some don't." In respect of personal care one person said "I need help to have a bath - staff are sensitive and respect my privacy" whilst another person told us "Staff help me wash myself in the sink in my room".

We saw that staff related to people who lived in the home in a friendly way, sometimes sharing a joke with them. They were respectful and treated people with dignity. We saw staff knocking before entering people's rooms. When staff accompanied people such as to assist them to their bedroom or to the bathroom they did so patiently and in way that supported the person whilst maintaining their independence as far as possible.

Ascot House provides three services across the four units in the home. 15 assessment beds are provided in the two North units together with a further three places for people who are receiving short-term or respite care. People can refer themselves for respite care as we were told that the local authority will not fund new placements.

The remaining 17 beds in the West and South units are designated for people who qualify for intermediate care which is care provided either as a "step down" from a hospital stay to a return to the community (including residential or nursing care) or as a "step up" from the community where some short-term therapy may assist them to manage better in the future. Intermediate care is funded by the local NHS clinical commissioning group (CCG) and therefore people who use the service must be registered with a general practitioner in the CCG area. Assessment and intermediate care services are provided free of charge to people who use the service for a period usually of up to six weeks within which time it is expected that arrangements for discharge will have been made.

We looked at the care files in both the assessment and intermediate care services to see how the documentation supported staff in providing care to the people who lived in the home. Because most people lived in the home for a short period before moving to another location the files reflected this.

Each file had a front sheet which included a photograph of the person who used the service. Personal

preferences were noted such as how people liked to be addressed and any preference as to the gender of their care worker.

The file had a support plan profile which gave an overview of the care people needed. This included mobility/walking, falls, standing/transferring, in/out of bed, up/down stairs, washing and bathing, podiatry, oral hygiene, dressing/undressing, continence, pressure areas/sores, eating/drinking, special diets, communication, sensory, mental health, memory, cooperation, behaviour, orientation, restlessness/wandering, needs at night, religion, cultural activities/hobbies/interests, key holding, handling finances, medication and any existing medical conditions.

We were told that the initial support plan profile was drawn up by staff on admission. We saw on the files that revisions were added as each stay progressed. Although the form was intended to record the person's preferences and we were assured that it was completed with the person wherever possible, there was no space on the form to indicate that the person or their representative had been consulted about the contents or that there was agreement to the care being proposed. This might be particularly important where a person did not have mental capacity and could not agree to their care.

Any allergies were clearly marked. There were risk assessments relating to moving and handling and the files contained appropriate sections relating to other aspects of each person's care such as moving and handling, nutritional screening and medicines.

Daily sheets were completed providing information about what had happened to each person during the day with similar records being completed in respect of the nights when two hourly checks were made on people. We saw that where these checks had caused alarm they had been adjusted by agreement with the person affected so as to alleviate this. All the care records reinforced the reablement approach being taken by the service for example recording how people felt each day and their achievements in respect of areas such as personal care and hygiene, mobility and daily living skills. Notes were added by the night staff. Taken together these notes provided a useful record of a person's stay in the home and a means of communication between staff.

We were told that the home had a keyworker system which allocated each room to a dedicated named member of staff. This member of staff was responsible for making sure that the person staying in that room at that time was offered bathing and was weighed at regular intervals. We looked at records and saw charts recording people's weights taken at weekly intervals, with the method used to record the weight along with a record of the person's weight on admission so that any gain or loss could be easily spotted. The home used recognised tools to assist with these assessments including the Malnutrition Universal Screening Tool (MUST). We saw bathing charts that confirmed that people had been offered and received regular baths generally at weekly intervals. The records confirmed help with other areas of hygiene such as changing people's bedding, offering assistance with nails and cleaning people's spectacles.

The care files showed that people were encouraged to develop their independence during their stay in the home. As well as the care staff people also had access to a team of therapists which was based in the home. We saw entries on care files from occupational therapists and physiotherapists and their assistants which detailed people's progress. We also saw that people received visits from district nurses, the general practitioner and social workers whilst staying in the home.

We asked a therapist about their view of the service provided by the home and they told us about a person whom we had met and whose records we had looked at with that person's agreement. The therapist told us that at the end of their hospital stay the person had recovered from their medical difficulties and thus were

fit for discharge. However their ability to manage aspects of daily living such as cooking and moving around were impaired. Admission to the home with a period of rehabilitation and reablement with therapist support had enabled the person to regain what the therapist described as their "normal baseline" of functioning.

We saw records relating to another person whose housing had become unsuitable prior to admission to the home. The person had been successful in obtaining new accommodation but this had not been ready for them to occupy. They had used the period of their stay at Ascot House to prepare for their new home with the help of the staff and the registered manager in particular.

We saw that there was a service user guide kept in a folder in each bedroom. This provided people with information about the services available in the home and was produced in a format suitable for people with visual difficulties. The guide emphasised that people were encouraged to be independent, for example, by making drinks for themselves. As well as other information such as about fire precautions, the guide provided details of paid advocacy services from three local services but we were told that no-one in the home was currently using them. We saw references to consideration of whether to involve Independent Mental Capacity Advocates in some of the records and were told that one person currently living in the home had an advocate though outside of these arrangements.

Requires Improvement

Is the service responsive?

Our findings

People were complimentary about their stay at Ascot House. One person told us "Staff are absolutely wonderful. I'm helped with absolutely everything here physically and emotionally" and another said "We have a really good laugh and enjoy one another's company". A third person told us "There's no one nasty, I like it here, can't grumble".

None of the people we spoke with were aware of a formal complaints policy but most said if there was a problem they would sort it out. They said "I don't know who to speak to but if someone upset me I'd tell someone" and "No complaints I'm perfectly satisfied with everything" and "I've no complaints at the moment but would speak to someone if I had". We saw that the complaints policy or arrangements were not included in the service user guide we were provided with during the inspection. However the registered manager has since assured us that these are both included in the latest service user guide and displayed in each of the lounges in the home.

People said they valued the sensor system and the call alarm in the home which alerted staff to their movements and could detect or prevent a fall, for example. "Can't praise them enough - even the night staff. I got out of bed (detected by sensors) and they came to check I was OK". This person was aware that they had sensors in their room.

Other people told us ""There's a bell in my room. I was on the floor once, and they came quickly" and "The buzzer's near my bed, it wouldn't reach when I was watching telly in my chair, but they adapted it and made it (cord) longer. I've not had to wait long (for response)" and "Staff just there if I need them". Another person said "I fell about three weeks ago and cut my head. They called an ambulance and I was taken to hospital."

Staff demonstrated how the sensors worked with the sensor triggering an alarm whenever a person using one moved. Staff carried a portable alarm unit and a code identified which person had triggered the alarm and whether it was their bed or other location such as the chair they were sitting in. From the speed of reaction it was clear that this enabled staff to respond promptly to people and would alert them to any unexpected movement which might be associated with a fall.

The use of sensors was recorded by staff in the support plan profile. The registered manager told us that people were initially assessed as to whether they required a sensor after which it might be removed if appropriate. Consent was taken to be implicit since people could see the sensor equipment however it was not mentioned either in the advance information provided for people or in the service user guide which only identified floor sensors where these were fitted. Where people did not have the mental capacity to make this decision a best interest meeting would have to be held to determine whether or not the sensors would be used.

We saw that the home kept records of the time taken to respond to the electronic call system. We reviewed records for a selection of days and found that calls were usually responded to within one or two minutes. On both days of our inspection we heard the call system operating but did not see any delay in responding to

these calls.

When we last inspected the home we asked the provider to consider making more activities available to people in the home. On this occasion we asked people how they spent their time in the home. One person told us "No communication with the outside, it would be nice to have someone doing some activities e.g. chair exercises" whilst another said "No activities, I just sit and watch the birds". A third person who had been recently admitted told us "No activities so far, but you're looked after" whilst a fourth said "We had a game of skittles in the lounge yesterday". A relative told us "There's no stimulation, the television's on but no one's watching. It seems there's a lot of staff and ladies (people living in the home) sitting around doing nothing".

We did not see a programme of social activities in the home. During our inspection we saw staff playing armchair football with some people on one occasion but beyond this we saw no other social activities apart from relatives visiting. There was a noticeboard advertising the availability of a hairdresser together with prices with a telephone number for people to contact them for appointments. We were told that church services were organised every fortnight.

We saw a sign in the entrance to the home which stated that visiting times to the home were restricted to 11:00 am until 12:30 pm and 6:30 pm until 8:00 pm. We saw that this was reinforced by a notice at the entrance to the home, in the introductory material supplied to people before admission and in the service user guide. The reason given was "to assist by completing the rehabilitation with the service users".

When we raised this with the registered manager and her line manager they told us that the provision of activities did not fall within the function of home because the focus was on reablement and the provision of therapeutic activities according to a "clinically-led model". They added that restrictions on visiting were also made to allow staff to focus on administering medicines uninterrupted. We saw that people received assessment and other therapy during the day which would need to take priority over social activities and activities. However we also saw periods where there was no therapeutic or other activity of this kind when social activities or visiting could have been offered to people.

Two visitors we spoke with both mentioned limited visiting times and thought the home could be more flexible although one assured us that when they had asked the registered manager if they could visit outside these times they had readily agreed. However another thought they "might get into trouble" for outstaying the visiting time to talk to us. We saw that the registered manager was flexible in applying the visiting rule for example, when an appointment was made for a hairdresser to visit. However the current restrictions on visiting times as stated would have presented limitations on visitors living some distance away and elderly visitors who might prefer not to go out after dark but who were unable to visit in the mornings.

Another relative told us that they had been proactive in providing information and photographs about a person's life history because they had noticed this had helped to stimulate their interest and start a conversation. However this relative also told us that they had shown the materials to staff but they did not appear to have the time to look at them. This seemed to them to have been an opportunity lost to help and engage this person.

We saw that staff spent time with people during the process of discharge and gathered round to exchange affectionate kisses and hugs with them and to wish them well. One person who was about to go home told us told us "Staff are very nice. When they went off duty they came to say goodbye as they said they wouldn't be here when I went home".

Ascot House provides care for most people only for a number of weeks after which they move to another destination. This means that it is important that arrangements for transition to and from the home are arranged carefully and in such a way as to minimise the disruption to the people using the service.

We saw that on admission the home received detailed information from the appropriate hospital where a person was being discharged from. We saw that the home received assessment information as well as notification of any infection, skin integrity or other clinical risks. We were told that if this was not available then admission would not proceed. We also saw a checklist used by the home to make sure that all the required steps had been taken prior to admission.

We saw that in the period leading to their discharge appropriate arrangements were made for the person particularly if they required equipment or other services at home. During their stay therapists might make visits to people's homes to assess what was required. We saw one of two social care assessors employed by the home going out on visits and were told that they would be involved in making any necessary discharge arrangements.

Where appropriate a discharge care plan was developed by the home and we saw how this was constructed using a computer system which identified people's requirements and the outcomes required to meet these. The registered manager had the authority to authorise these care packages on the local authority community care system which would result in the authority commissioning community services such as telecare, home care and meals at home. District and other community nursing and other services were arranged and discharge information was sent to the person's general practitioner.

This ensured a smooth transition from the home to the community. We saw copies of a support plan provided to a person when they returned to the community which provided clear information about the services agreed, when they would call and what they would do. We also saw records which showed the same sorts of discussions which related to people moving on to nursing or care homes.

However people did not always feel involved in the care that was being arranged for them. One person told us "I want to go home but (was) told the care (package) was being sorted but I've not a clue what's happening." Another person told us that they were definitely not involved or consulted about their care saying "When I came here I sat on a chair outside the room whilst the staff and my daughter talked about me". One relative told us that whilst they were very satisfied with the care provided they would have liked the home to have been more proactive in providing information and communicating about progress with their relative's care during their stay.

We asked professionals about the value of the service provided by Ascot House. One told us that without this service they were unable to form a clearer picture of a person's needs and could not do so whilst the person was living at home. For example, a clearer assessment of the person's night time needs had been made available on the basis of their stay and this would help the professional to make a clearer assessment of risk in order to support the person when they returned home. However we were told that no written assessment had been provided to the professional by the home in relation to this person's stay.

A relative told us that following a stay in the home they were now much clearer about their relative's needs. In each case we were told that each person's next step either in returning home or moving to a care home could be planned with greater certainty and with a reduced chance of breakdown compared with what might have otherwise been the case.

People told us they had choices such as about the times they got up and went to bed. They told us "Going to

bed and getting up I choose the time" and "I choose when to get up and go to bed, I'm comfortable here." We saw that the home did not have any standalone showers or wet rooms which meant that people had no option other than to have a bath or use an over the bath shower. People confirmed this when they told us "I have a bath, the only shower is over the bath" and another told us "They help me in the bath, they're very good".

We saw staff helping people to make choices about what they were going to eat at mealtimes. We asked staff about how they managed issues of choice particularly where a person might no longer have the capacity to make a decision themselves. They were clear that they could not coerce a person in doing anything that they did not wish to. If someone refused personal care such as bathing, for example, they might attempt to persuade or coax them but otherwise would respect the person's decision. We saw records that showed that people had declined personal care on occasions and that this choice had been respected.

We recommend that the complaints policy and related arrangements are provided to people being admitted to and living in the home, as well as their relatives.

We recommend that the provider reviews the availability of activities and publicity around visiting times.

Good

Is the service well-led?

Our findings

Comments about the service were generally positive. One person told us "It's been a wonderful experience – sometimes you lose faith in human beings but all the help here has restored my faith". Another person told us "Atmosphere lovely, staff are regular, the same ones and know my likes and dislikes." And a third said "I wanted to give staff (a cleaner) some money but they wouldn't take it. They don't get much." This person told us that they understood the manager would not allow staff to take monetary gifts but said they did not agree with this.

Ascot House has had the same registered manager since September 2011. It was evident from talking with her and from the staff that the staff team had a great deal of experience of working together in residential homes in the area.

The registered manager told us that it was not practical to arrange meetings with people who used the service and their relatives to review or consult about the service because almost nobody stayed in the home for more than six weeks at a time. We saw though that each person who had used the intermediate care service had been offered an opportunity to comment on it on a written form on their discharge. We looked at these and saw that people had recorded overwhelmingly positive comments such as "The care has been very good", "I am extremely satisfied" and "I think it is wonderful the care you receive" and "A lovely place – I wish I could stay longer".

We also saw that the registered manager arranged for regular fortnightly surveys to be available to people who used the service which allowed them to comment on the quality of the food in the home. These also were overwhelmingly positive.

We asked the registered manager to provide us with any other audits they undertook to assure the quality of the service provided. We were shown a number of generic risk assessments which covered key areas such as cleaning, kitchen activities, hazards relating to care tasks and infection control all of which had been recently reviewed. We saw that the registered manager had responded proactively to infection control audits by the local NHS team by providing detailed responses to their findings and actioning their recommendations where this was possible.

We saw the record of a visit by an elected member of the Council which is the provider of the home. This had been completed within the last three months and was comprehensive and detailed. It was clear from the record that the visitor had been thorough during their visit and covered not only aspects of care within the home but other arrangements such as for advocacy, primary care and other therapies and relationships with the community such as local churches. Both the elected member and registered manager had made suggestions for improvements to this form so that it would be more effective.

We saw that there was evidence that staff had been supervised. The staff files included records of staff supervision and personal development reviews (PDR) which allowed staff to raise matters of concern as well and their managers to respond. We saw from records that these sessions had been conducted at intervals of

three to four months.

We saw evidence that key equipment in the home including the lifts had been serviced within the last twelve months and that there had been regular fire drills testing using a different zone each time. Other fire precaution systems had been tested weekly. Medicines procedure audits had been completed at roughly monthly intervals and medical safety alerts were filed and up to date. We saw evidence that an audit and assurance service check had been undertaken by the provider. Although largely finance-focussed this included areas such as governance, regulation, legal compliance and performance but had not been completed since May 2013 and so was unlikely to reflect the current position accurately.

We asked for a number of policies and procedures. The Mental Capacity Act 2005 procedure was dated 2007 and required revision to take account of developments in DoLS which have taken place more recently. However we saw that a practical DoLS process flowchart was displayed in the main office.

The registered manager told us she could not produce a printed version of the home's safeguarding policy because this relied on the provider whose policy in this regard was only available on the internet. The registered manager told us that each member of staff had a personal internet account which allowed them to access these procedures and showed us how this worked. The provider had a confidential reporting code which advised staff on what to do if they encountered poor practices at work however this did not explicitly include the staff right to refer to an external agency approved to receive such concerns such as the Care Quality Commission (CQC). We brought this to the attention of the registered manager and her line manager.

The home had adopted the infection control policy provided by the local NHS provider trust. This was comprehensive and included the requirements of the Department of Health's "Code of Practice on the prevention and control of infections and related guidance" which is relevant to homes of this type. We noted however that the home's copy of the trust's policy had not been reviewed in October 2015 when it was due. We saw that the home had developed a local policy for medicines which reflected the particular circumstances of the people who stayed there.

Registered providers of services such as Ascot House are required to notify the CQC about certain events which may affect people who live in the home and the service provided to them. This helps the CQC to discharge its statutory responsibilities to protect and promote the health, safety and welfare of people who use health and social care services.

We reviewed the notifications which had been made to the CQC by the provider in the last year and found that appropriate action had been taken to inform us in respect of one incident. We were not shown a complaints policy and did not see one displayed in the home but we asked the registered manager to provide us with information about any complaints received in the last year. There had been one complaint and we saw that the registered manager had sought to respond to this promptly and within 10 days of it being received at the home.

The registered manager organised the supervisory tasks of the home by delegating them to four assessment coordinators. We saw that staff supervision was organised through them as well as responsibility for specific areas such as hoist and sling checks, building risks, prescriptions and monitoring bathing and weighing. Each coordinator was designated responsibility for one of the units and in addition had common responsibilities such as for support plans and rotas. We were told that because of the difficulty of organising meetings for the whole staff group which worked different shifts that staff meetings were organised for each shift separately and took place quarterly.