W Scott

Ascot House - Nottingham

Inspection report

30-40 Percival Road
Sherwood
Nottingham
Nottinghamshire
NG5 2EY

Tel: 01159606506

Date of inspection visit:
18 May 2023
24 May 2023

Date of publication:
24 May 2024

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Ascot House is a residential care home. It provides support to a maximum of 20 people. At the time of the inspection, the service specialised in supporting people with mental health and/or substance miss-use difficulties. At the time of our inspection there were 19 people using the service.

People's experience of using this service and what we found

People did not always have good outcomes. Staff did not have the training, competency or supervision to carry out their roles safely.

The environment was unclean and not safe. Medicines were not given hygienically or safely. Lessons were not learnt when thing went wrong.
Health professionals visited the service; however their recommendations were not always clearly followed.

The governance of the service did not ensure that high quality care was provided. Reviews and audits were not effective at identifying and driving improvements. Staff were not always safely recruited.

There were enough staff to support people safely. Staff knew how to report concerns of abuse.

The provider had notified CQC of events that occurred at the service. People's complaints had been responded to.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 9 November 2019).

At the last inspection, the provider was in breach of 3 regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of these regulations.

Why we inspected
The inspection was prompted in part due to concerns received about neglectful care and environmental safety. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ascot House on our website at www.cqc.org.uk

Enforcement
We have identified breaches in relation to safe care and treatment, staff skills, and governance.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Ascot House - Nottingham

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by 3 inspectors Two inspectors visited Ascot House. A third inspector remained off-site and reviewed documents that were emailed across by the staff team.

Service and service type
Ascot House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ascot House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We also spoke to the local authority stakeholders to review information

they held about the service. We reviewed information and concerns we had received about the service. We used all this information to plan our inspection.

During the inspection
We were unable to speak to people at the service. This is because they were either unable to communicate with us or did not want to talk to us. Instead, we observed the care provided, to help us understand peoples experiences of their care. We spoke with 5 staff members and the registered manager.

We reviewed a range of records. This included the relevant parts of 5 people's care records and multiple medication records. We looked at 3 staff files in relation to the safety of recruitment. A variety of records relating to the management of the service, including policies, training records and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider continued to be in breach of regulation 12.

Assessing risk, safety monitoring and management

- People were at high risk of scalding from hot water temperatures from shower water. Health and safety guidance is for shower temperature in a care home to be below 43 degrees Celsius. The staff team had not tested the water temperatures of the showers to ensure they were safe to use. When the inspector tested the temperatures, they were all above the recommended guidance. For example, one shower measured at 55 degrees Celsius which could cause a serious injury from scalding.
- People were at risk of burns from hot radiators. Not all radiators were suitably covered and left exposed hot surfaces that people could touch .
- The environment was not suitably adapted to support people with mobility needs. There were exposed ledges and steps around the property that put people at risk of falls. We observed one person was at high risk of falls when using an unsuitable ramp. We raised our concerns with the management team, but when we returned 6 days later the person remained at risk of falling when using this ramp. Limited action had been taken to protect the person from falls using the ramp.
- Some people who lived with conditions which caused them to be confused ,were at high risk of falls. They slept upstairs but there was limited risk management to prevent people falling down the stairs. In response to our concerns the registered manager arranged for a stair gate to be fitted, but individual risk assessments remained poor quality as they did not provide guidance to staff on how to mitigate this risk.
- One person was at risk of choking or aspiration caused by difficulties in swallowing. They had been prescribed a modified textured diet and thickened drinks by health professionals. We observed they were given the wrong textured food for their lunch, placing them at risk of choking. This concern was raised with care staff; however, the person was again given the incorrect textured food for their desert. We raised our concerns with the management team. Although the person was served the correct textured meal when we visited 6 days later, they were left alone with access to a drink that had not been thickened. The person continued to be at risk of harm.
- Care plans did not always provide enough detail for staff to provide safe care. For example, one person had a medical device that required routine care. Staff did not have enough guidance on how to support this person's medical device. This placed the person at risk of infections, skin damage and failure of the medical device.

Using medicines safely

● People did not receive their medicines hygienically or safely. We observed staff gave people their medicine in disposable medicine pots which had not been cleaned thoroughly as the pots still had left over liquid medicine in the pot. The poor washing of these disposable pots, risks people ingesting other people's medicine. It is also a hygiene concern.

● The provider failed to have adequate safe disposal of medicines procedures. Controlled medicines are subject to increased regulation as they are particularly harmful and/or addictive. We found a controlled medicine had not been disposed of safely. Staff did not have access to a suitable disposal site for this controlled medicine. Staff explained they had thrown it away in a box with other medicines. However, when we looked in this box, the controlled medicine could not be found. There was a risk the controlled medicine could be retrieved and misused.

● Some people had been prescribed highly flammable body creams. They were at high risk of burning themselves when smoking cigarettes. There was no risk assessment or systems in place to reduce this risk of burning when smoking. The management team took action in response to this concern.

Preventing and controlling infection

● People were at risk of ill-health from consuming food that had not been stored safely. For example, ham sandwiches were stored overnight on the kitchen counter.

● Staff and people did not always have access to soap to clean their hands. For example, staff did not have access to soap to wash their hands in the sluice room which is designed to be an area for disposal of human toilet waste. A lack of soap in this room is a high risk of infection transmission. We raised the lack of soap for staff and people on the first inspection day, when we returned 6 days later the management had failed to ensure people had access to washing facilities as there was still no hand soap in a communal bathroom.

● People were at risk of infections from communal areas as the home was unclean. For example, the communal bathroom pull light cords were visibly dirty. These were in use by many people. Together with the lack of soap this increased the risk of cross infection.

● At the time of the inspection, government guidance stated that care staff do not need to routinely wear face masks. We observed that some staff chose to wear face masks. However, these face masks were repeatedly worn incorrectly and below the staff member's chin. We were therefore, not assured that staff used PPE effectively and safely.

● Due to the cleanliness of the environment, we were not assured that people and visitors would be safe from infection.

Learning lessons when things go wrong.

● Care plans and actions to mitigate risks were not always improved after incidents occurred. For example, one person had a sensor to alert staff if they got out of bed. This alert prompted staff attend quickly to help prevent the risk of falls. Staff had recorded that the person often pushed the sensor out of the way, so it didn't work. On one occasion, this moved sensor had resulted in the person falling and not being found promptly by staff. The person's care plan had not been updated after this incident and no checks had been implemented to ensure the sensor was in place. Staff did not have guidance on how to manage this person's fall risk safely in future.

● The management team was not responsive to known concerns. They failed to take actions following our feedback on the first day of inspection in relation to the safe management of the medical device, risk assessments for using the staircase, provision of hand soap or medicines management. We were therefore not assured the management team had learnt from these or knew how to implement the changes to make people safe.

The provider failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks, to control the spread of infections and ensure the proper and safe management of medicines. People were not always kept safe from the risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
The provider was following government guidance in relation to visitors attending the care home

Staffing and recruitment

At our last inspection the provider had failed to ensure staff were suitably skilled. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider continued to be in breach of regulation 18.

● Staff were not always sufficiently trained to meet people's needs. For example, not all staff had received training on how to support a person's medical device, placing this person at risk of harm from not having their device supported safely.
● People living with substance misuse were at risk of not having their needs met. Staff did not have the training, skills or knowledge to care for people with substance misuse needs. A staff member explained they had not received this training to understand how to support people with this need.
● People were at risk of not having their nutritional needs met. Care staff had not received training on people's swallowing needs. The kitchen staff member who had received this training served the wrong texture diet for their swallowing needs. Their competencies had not been checked which meant people continued to be at risk of choking.
● People received care from staff who had not received regular supervision and competency assessments to ensure they were able to carry out their role. This is an ongoing concern from the last inspection.

The provider failed to deploy suitably qualified, competent, skilled and experienced staff to meet people's needs. This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff allocated to provide care for people. We saw people received care in a timely way if they needed support.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal

authorisations were in place to deprive a person of their liberty.

Systems and processes to safeguard people from the risk of abuse.

- The safe section of this report describes multiple concerns with the safety of care provided. This means people were not always safe from neglectful care.
- Staff were able to describe how they would report concerns of abuse to the management team. They had received safeguarding training. We had received some whistleblowing concerns about poor quality care prior to our inspection. This suggests that the staff team were confident in alerting external authorities about their concerns.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

At our last inspection the provider had failed to ensure good governance processes were in place. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider continued to be in breach of regulation 17.

- The provider failed to have systems in place to monitor and improve the safety of the environment. The last inspection identified concerns with the cleanliness and safety of the environment, which had not been resolved at this inspection. This placed people at risk of harm from hot water, unsafe food storage and falls risks.
- The provider failed to have systems to monitor the content and quality of people's care plans. Care plans did not always provide clear information to staff. Where these care plans had been reviewed, the reviews had not resulted in improvements being made.
- Audits were not always effective. The registered manager had completed audits of the service; a lot of these audits scored 100%. These audits failed to identify the areas of the service that were unsafe or poor quality. For example, one audit identified that flammable substances were kept in a fire-resistant storage area. We observed these substances were stored in a wooden shed near to the designated smoking area. This is not a fire-resistant storage area.
- The provider failed to have systems to monitor the training staff received. The provider did not keep clear records on the training staff had received. The training matrix designed to easily oversee the training completed and next due was not up to date. We found training certificates that were not listed in this table.
- Poor record keeping and staff skills, meant people may not always have good outcomes. For example, one person's care plan described that they were prescribed insulin. However, they were not actually prescribed this medicine. The incorrect recording of this medicine could impact a person's wellbeing if read by staff or visiting professionals (for example, paramedics).
- The provider failed to have suitable systems for safe recruitment. The provider had received concerns about some staff members' character and history. However, after receiving these concerns the provider had not taken enough action to assess the suitability of these staff before they began working at Ascot House.
- The last inspection identified concerns with: environmental safety, staff training, staff supervisions and

poor risk assessments. These concerns were ongoing at this inspection. There had been poor leadership, to ensure the required improvements were made.

Continuous learning and improving care

● During the inspection, we explained concerns with choking, the environment safety, flammable creams, and scalding from showers. Although the management team took some steps to improve the risks they failed to take suitable action to provide safe care.

● The provider failed to ensure records of the care provided included all the detail required to improve care and learn from incidents. For example, staff had recorded a period of agitation for a person. They had written 'tried to calm them down'. However, there was no further detail on what methods were used and whether it was effective. This meant there was no record of what the trigger for the agitation was, how staff and the person responded and how these actions could be used to manage the person's care effectively in the future.

The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● Records showed that people had received care from external professionals. This professional guidance was recorded in people's care plans for staff to follow. However, this did not always result in high quality care. For example, a professional had recommended an altered diet but we saw this was not provided.

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

● The provider had notified the CQC of events that had occurred at the service. The provider is legally required to do this.

● The provider kept a log of all compliments and complaints that had been made. There was evidence that they had responded to concerns in line with their policies.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The service sent out a regular newsletter, to describe current updates at the service.

● People were engaged with meetings about their care. We saw staff engaged people with decision making, like where they would like to sit for their meal.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not safe from harm.

The enforcement action we took:

We have imposed the conditions on the provider's registration. This includes any new admissions needing permission from the CQC

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was poor oversight and leadership at the service

The enforcement action we took:

We have taken action to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not suitably trained and skilled to complete safe care

The enforcement action we took:

We have taken action to cancel the provider's registration