Trafford Council

# Ascot House

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on the 15 and 20 November 2017 and was unannounced. Our last inspection of the service was on the 14 and 23 January 2016 we rated the service 'Good'. We found the service to be good in safe, effective, caring and well led domain. We rated the responsive domain requires improvement.

Ascot House is an intermediate care service provided by Trafford Council and Pennine Care, it provides therapy led rehabilitation for adults. Intermediate care is a service which helps people to recover from illness or an accident, to regain independence and to remain in their own homes. Ascot House is registered to provide accommodation for persons who require nursing or personal care for up to 45 people. There are 45 single rooms across five individual units. Nine of the rooms are used as step down beds for people waiting for residential care or additional care and support packages at home. There are lounge and kitchen facilities within each unit and areas for rehabilitation and exercise to be undertaken. The service aims to provide a 21 day turnaround for rehabilitation to enable people to return to their own home. At the time of inspection, the service was full.

A registered manager was in post. 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.

People did receive their prescribed medicines on time and medication was stored safely. However, medicines quantities were not always correctly managed.

Quality assurance systems were in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people. However, these systems had failed to ensure medicines were safely managed.

Staff were aware of the signs and symptoms of abuse, how to report concerns and who they would report to. There was a whistle blowing policy in place and staff were aware of the policy and were also aware of the safeguarding policy.

There were robust policies, procedures and risk assessments in place in relation to health and safety and fire safety.

Staff were kind and caring to people living at the service. They were knowledgeable about the person and their needs and followed agreed plans of care and exercise plans.

Staff received training appropriate to the service and staff were given the opportunity to continue their own personal development. However, some staff felt the service needed to improve on the number of supervisions they received.
People and their representatives were very complimentary of the service and what it achieves to enable

people to return to their own home.

Recruitment processes were robust and safeguarded against unsuitable people obtaining employment at the service.

Care plans, risk assessments and exercise plans were detailed and gave staff the information they needed to support people.

At this inspection we found one breach of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the management of medicines. You can see what action we have told the provider to take at the back of the full version of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Medicines were not always safely managed. Procedures were not fully developed in relation to "when required" medication and audits were unable to be completed due to stocks of medication not being recorded.

All health and safety checks of the service were found to be completed within the appropriate time scales.

There were detailed care plans and risk assessment in place to care and support people to remain independent and where appropriate, return to their own home.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff did not always receive regular supervision in line with organisational policy and have the opportunity to participate in staff meetings

The rehabilitation was a positive experience for all the people we spoke to and led to people being able to return to their own home. The continuity of care meant that people were less likely to be re-admitted to hospital.

Peoples nutrition risk was closely monitored and appropriate plans and referrals put into place to prevent weight loss

### Is the service caring?

**Good**

The service was caring.

We saw people were treated with dignity and respect.

We saw positive interactions with people using the service and staff knew the needs of the people they supported.

People were very complimentary about the service and felt well cared for.

## Is the service responsive?

Good

The service was responsive.

Care files contained information to support each person. Detailed moving and handling plans were in place to support the person and their rehabilitation.

Discharge arrangements were thorough and involved the person. Arrangements were made to minimise the risk of hospital re-admission.

Further work around activities for people on the step down unit would be beneficial.

## Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager lacked oversight of the safe management of medicines

People using the service were very complimentary of the registered manager and the service they provide.

The registered manager ensured there was enough staff to support people safely

# 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 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 15 and 20 November 2017 and was unannounced. The inspection team consisted of two inspectors on the first day of inspection. One inspector returned for the second day of inspection.

The provider had completed a Provider Information Return (PIR) prior to our inspection. The PIR 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 reviewed other information that we held about the service including notifications. A notification is information about important events which the service is required to send us by law.

We contacted the local authority commissioning and safeguarding teams as well as the local healthwatch board and infection control. They did not raise any concerns about Ascot House prior to the inspection. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. All of the comments and feedback received was reviewed and used to assist and inform our inspection.

During the inspection we observed interactions between staff and people who used the service within the communal lounges and dining areas. We also looked at four bedrooms. We spoke with four staff members, the registered manager, the therapy lead, an occupational therapist, a physiotherapist, a district nurse and a GP. We spoke with six people who used the service and two relatives. We looked at records relating to the service. This included three care records, four staff personnel files, daily record notes, 10 medication administration records (MAR), staffing rotas, training and supervision records, minutes from staff meetings, maintenance records, quality assurance systems, incidents and accidents records, policies and procedures and compliments and complaints records.

Requires Improvement

# Is the service safe?

## Our findings

All the people we spoke with said they felt safe staying at Ascot House, one person said, "I've felt very safe here", "The environment helps you get on your feet; the physio's are good; they are determined to make you safe."

Staff had received training in safeguarding vulnerable adults and knew what action they would take if they witnessed or suspected abuse had taken place. One staff member told us "I look out for any emotional issues or if they tell me anything or I see any bruises." They could describe signs and symptoms of abuse and were confident that the registered manager would act on any concerns they had. Staff told us that they were aware of the whistle bowing policy and knew how to follow the policy should they need to report a concern. All the staff we spoke with said they would feel confident to report any concerns they had to the registered manager or therapy lead.

People we spoke with said they would be confident to report any concerns that they had. One person said "I would tell my daughter." Another person said "I would speak to the manager or the staff but I have no complaints."

People said they received their medicines as prescribed. One person said, "I take my tablets at home, but I prefer the staff to give them to me when I am here, it feels safer." We found that people's medicines were stored in named individual drawers in a medicines trolley, which was stored in a locked room. This kept the medicines safe and reduced the risk of mistakes being made.

We saw that when people came to Ascot House for a period of rehabilitation, a hospital discharge summary always accompanied them. We saw that any medicines coming into the service were checked against the discharge summary. This ensured that people received their medicines as prescribed. We saw that a photo of the person was attached to the blister pack of the persons medicines and an additional photograph attached to the medication administration record (MAR). This enabled the staff to clearly identify whom they were administering medicines to.

Medicines were administered by deputy managers who had been trained in the safe handling of medicines and medication awareness.

We checked quantities of boxed medicines for 10 people and observed that there wasn't always a clear audit trail of the amount of "when required" medicines that had been administered. Stock levels did not always balance correctly according to the number given on the MAR. Medication wasn't always being booked in, carried forward or showing as returned on the MAR which meant boxed medication could not be audited. This meant we could not be assured the medicines in stock were all accounted for, nor could we confirm that people had received their medicines as prescribed.

We saw "when required" protocols in place for the types of medicine being administered and what it was for, but guidance was not in place to clearly inform staff why the person may require this medication. Staff told

us that people were able to tell them if they required a medicine for pain relief other than on the step down unit where people's capacity fluctuated. People staying on the step down unit were awaiting a residential care placement of further package of care at home. We did see people being offered pain relief during the medicine administration round.

We saw that the MAR had not always been fully completed which meant that people may not have received their medicines as prescribed. We saw that on three MAR records; the number of medicines being brought into the service had not been clearly documented. This meant that stocks of medication could not be audited. Furthermore, on five MAR records we viewed, the stocks of medicines recorded did not match up to what was available. MAR records for the administration of topical creams were kept in people's rooms and accompanied by cream charts, however, we found some MAR and cream charts did not have directions for use. Staff confirmed that they did apply topical creams or observed people apply their own creams but the lack of directions for use was insufficient.

We saw that some medicines were being recorded in the controlled drugs register. The controlled drugs register is used on premises where controlled drugs are stored under the Misuse of Drugs Act (2001). Medicines recorded on the register were also being recorded on a "when required" medicines form. We saw that the balance on these records did not always match which made auditing the medication difficult. This is because staff were signing two records inconsistently.

We found that there wasn't a clear record of anti-coagulant medicine for one person as the amounts of medicine being delivered had not been clearly recorded on the MAR. This meant stock levels could not be audited. However, the person had received the medication as prescribed.

We saw for one person who was being prescribed a short term course of medicine, that there was more tablets remaining than there should have been. The registered manager discussed this with the GP at the time of inspection to clarify if this would have had a medical impact on the person. The GP advised the registered manager that the person was at no risk.

On the second day of our inspection, the registered manager told us that they had developed further forms for staff administering medication which gave prompts to record medicines being brought into the service and being returned. The registered manager told us that they had communicated this to the deputy's and they were to be used with immediate effect.

We saw that one person had been assessed to administer their own medication. Medication was then placed in a locked drawer in the person's bedroom. Staff would prompt the person to taken the medication. This assisted in the person remaining independent in taking their medicines.

We saw that medicines were audited monthly, but no concerns had been raised in the audits in relation to balances of medicines. We also saw that regular temperature checks in place for the medicine rooms and fridges.

Medicines were not managed safely. The provider did not ensure that balances of medicines were accounted for. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities 2014)

From the four staff personnel files we viewed, we saw the required checks had been made including a Disclosure and Barring Service Check (DBS) and two references, one being from the most recent employer. The files contained an application form which included a full employment history. The registered manager

told us that they had confirmation of DBS checks and references for the staff who were not directly employed by the organisation and these were seen on file. This meant that all staff employed at the service had undergone the required checks to keep people safe.

Throughout the inspection, we observed that there were enough staff on duty to meet the needs of people. There were two deputy managers, 10 care workers, two patient support workers on the dates of the inspection. There was also additional support from the occupational therapists and physiotherapists, district nurses, the GP, social care assessors and admin staff. This was a common theme throughout the week from eight am until five pm. Therapy staff were not available during the evenings or weekends.

The service uses the Barthel index to monitor and adjust staffing levels. The Barthel index looks at a person's daily functions to assist in the level of staff support required to care for them and keep them safe.

Staff told us that two care workers on each unit was sufficient to meet people's needs and that staffing levels had been increased from one care worker and an additional floating staff member. One person told us "There are generally enough staff." Another said "They [staff] answer the buzzers quickly when I used them." A relative told us "They [staff] seem to have the time for people to answer any questions and provide reassurance."

Each person staying at the service had a white board in their room which contained information on the persons mobility, transfers and assistance required. This helped the staff to know what the person's ability was and what help they needed. We saw that there was a system of coloured tags on peoples walking frames. This was to help staff quickly identify what support the person needed to mobilise. As people's mobility improved, the tag system was updated and one person told us "There is a friendly rivalry of who can improve their mobility the fastest." Another person said "They [staff] watch you all the time to make sure you are okay." This told us that there was lots of encouragement to support people to regain their independence in a safe way.

We saw that care file contained a falls screening assessment and a post fall checklist. This assessed people's risks of falling and documented the outcomes in place to reduce the risks.

Staff were able to tell us what the procedure was to support people in the event of a fall occurring. Staff said they would summon help from the senior person to assess the person and if required, use a hoist or an "Elk" which inflates and gradually raises people up from the floor. We saw that staff had completed incident forms for any accidents and incidents and observations were documented following an incident and outcomes reviewed to help to prevent future occurrences.

We saw that care files contained assessments for physiotherapy, exercise plans and moving and handling assessments. There were regular documentation made in care files and two sets of notes used. One for therapy staff and one for care staff. This meant that detailed information was recorded about the person to assist in their rehabilitation.

We saw detailed moving and handling assessments in care files. This meant that staff supporting each person were aware of how to move and handle people in the most appropriate and safe way.

The senior occupational therapist told us that with permission of the person, they visited their home prior to discharge. They assessed the home and looked at safety such as any steps to the property, use of stairs and access to rooms. This allowed the therapist to see if any additional equipment would be needed to assist the person to return home. There were also additional checks made to ensure the person could access and

switch on heating, complete laundry and make drinks and meals for themselves. This was to ensure that the person was safe to return home and to assist in preventing re-admission to hospital.

We observed that the service used pressure relieving mattresses and cushions, this assisted in preventing pressure sores occurring. We saw that people had their skin assessed on admission and district nurse's provided support to manage pressure sores and gave advice on pressure area care. We saw evidence that pressure ulcers were reviewed as part of the weekly Multi-Disciplinary Team (MDT) meeting. This meant that people were receiving suitable care for the treatment and prevention of pressure sores.

We saw that people had been assessed for the use of sensor mats. This made the staff team aware of when people may be mobile in the communal areas or bedrooms and assisted in the prevention of falls. We saw staff attend to people where the sensor had raised the alarm, in a timely manner. People we spoke with told us that they were aware why the mats were being used.

We observed that bedrooms had low profiling beds and crash mats where people had been identified of being are risk of falling from the bed. There were also nurse call points in all rooms, bathroom and communal areas. This assisted in a person summoning help quickly in an emergency.

Personal Emergency Evacuation Plans (PEEPS) were kept for each person to guide staff on the support required to leave the building in an emergency.

We saw all equipment had been serviced according to the manufacturer's instructions. There were internal checks of the fire alarm system, emergency lighting, nurse call alarm and water and room temperatures. We viewed servicing certificates which were in date for gas, fire alarms, emergency lighting, carbon monoxide monitoring, hoists, passenger lift and an assisted bath. Fire drills and full evacuations of the service were held at three monthly intervals. There was a fire risk assessment in place completed by an external provider and all actions had been completed. We saw that monthly fire drills were completed for all staff.

The provider had completed a legionella risk assessment and the registered manager told us that any rooms not in use were flushed in line with the provider's legionella risk assessment. Samples of water had been tested for legionella. We also saw an asbestos management plan in place.

We saw that there was a monthly infection control audit in place and we observed that Personal Protective Equipment (PPE) was readily available throughout the service. This monitored the cleanliness of the home and helped to prevent and manage any outbreaks of infection or illness. The registered manager told us that she had requested a further sluice facility which had been a recommendation of the local authority infection control report. A sluice facility is where disposables such as incontinence pads and bedpans are dealt with.

We found the service clean throughout

Requires Improvement

# Is the service effective?

## Our findings

All the people we spoke to said staying at Ascot House had helped them with their recovery. One person said "The staff are great here, they help me get back on my feet." Another person said [Staff name] is great, the best at helping me to shave and look my best."

Staff we spoke with said that they were kept up to date with training and did most of their training online. We saw that staff were receiving regular training which included moving and handling, safeguarding, equality and diversity, fire safety and basic first aid. One staff member told us that they had been able to complete a level 3 diploma while working at the service.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

We saw that the staff had received training in DoLS and the MCA. The service had not made any referrals for DoLS assessments as the registered manager told us that people are assessed for capacity as part of the initial assessment and if people cannot consent to the assessment, then they are unsuitable to receive rehabilitation at Ascot House. This is because Ascot House provides intensive rehabilitation therapy to enable people to return to their own home and people need to be able to follow the exercise plans and continue with exercises without staff support where appropriate.

The service uses 'The Six Item Cognitive Impairment Test' (6CIT) to assess people's cognition. This asks six questions to assess if people are aware of the time, month and year, remember an address and other questions. This gives an indication that people may have cognition issues and may require a different type of support.

On the step down unit, we observed that some people that were staying for a longer period of time while long term care packages were being arranged. Some people within the unit did have a diagnosis of dementia but there were no capacity assessments available. Staff told us that social workers did visit to complete assessments of people's needs and this information was available in people's care files. The service should consider once capacity assessments have been completed, if a referral for a DoLS assessment is appropriate.

People who used the service were assessed in hospital to ensure that the service was suitable for them. People told us that they were aware why they had moved into Ascot House and one person told us, "A lady had visited me in hospital, she was very nice and explained what would happen to help me get back on my feet." We saw that admissions records showed any allergies. Baseline observations were completed such as blood pressure, temperatures, pulse and skin condition.

Weekly weights were undertaken and we saw food and fluids records in place to monitor and raise any concerns quickly. The district nurse and the GP told us that any changes in people's conditions were discussed at a weekly multi-disciplinary team meeting (MDT) and any referrals made for other services such as a dietician. This helped prevent re-admission to hospital.

We saw for one person that they were required to drink 2500mls of fluid per day. We saw a fluid balance chart In place which regularly documented the fluid intake.

We saw in each care file that people had their nutrition assessed using the MUST nutrition tool. MUST is a tool which helps to identify adults who are at risk of malnutrition. We saw that anyone at risk of malnutrition was seen by the GP and appropriate referrals made. We saw that some people were given fortified diets and others nutritional drinks. This told us that people's nutrition was closely monitored and managed appropriately.

We saw risk assessments in place for people who required their fluids to be thickened to prevent choking. This meant people at risk of choking and aspirations had been assessed and appropriate measures put into place to reduce the risk.

Staff told us they received handover at the start of each shift and discussed the support each person requires. This meant staff were aware of any changes in people's health and wellbeing.

Two care staff told us that they did not receive many supervisions and felt they needed more. We observed that supervision records in staff files were not regular in line with the organisational policy of being held monthly. We saw in one staff file that the staff members had only received four supervisions in a two year period. This meant that staff may not have been getting the support they needed. Staff told us that they did not know when their next supervision would be. The therapy staff told is that they received monthly supervisions and an annual appraisal outlining the training for the coming year, however, these records were not available for us to view as they are held with another organisation. This meant that staff did not always have the supervision to carry out their role.

Care staff told that they did not have team meetings, one said they felt that "Communication could be better", as they did not always know what was happening and heard information from other staff or the therapy staff. The registered manager told us that the deputy manager holds smaller groups meetings with staff teams, but these were not recorded. We did see minutes available from regular team meetings with senior staff and therapy staff actions recorded.

People we spoke with told us that the food is very good; one person said "The food is very good, I can't fault the food", "I've got diabetes, there is always something on the menu that I can choose.". Another person said, "I found the food awesome, especially after nine weeks in hospital." A third person said "I have no complaints, there is a choice of two meals, and I've not lost any weight."

We observed lunch on one of the units. Staff were friendly and offered choice of meals. One person said "I eat all my food, my plate is always empty." We saw that different diets were catered for. One person was

receiving a gluten free diet and had been provided their own bread and cereal. The person told us that the service had offered to purchase bread and cereal, but the person preferred to have her family bring it into the service. The service was providing a gluten free frozen meal, but the person said that the meal did not always taste nice and would prefer a wider range of meals to be available. Another person had a vegetarian diet but this wasn't recorded in the care plan, however staff told us that they were aware of the person's dietary needs.

We saw that people's dietary needs were recorded in the person's care plan. This included information for people using food thickeners, any fortification of food and any equipment needed such as different cutlery to assist the person to eat. One person said "They offered me thick handled cutlery but I wanted to keep the normal ones and try to use them." This meant that the staff team were aware of people's nutritional needs and what actions needed to be taken for people to maintain a healthy weight.

We saw that there were district nurses available at the service throughout our visit. They told us that they were there to support the service with wound management, people with diabetes, dressings, additional skin integrity assessments and on-going referrals. The nurses were based at the service from Monday to Friday each week. At the weekend, community district nurses visited the service. This meant that people could receive on-going nursing input while staying at Ascot House.

People staying at Ascot House were registered with a temporary GP. As part of the registration, people met the GP within 24 hours and any referrals made for additional health related support such as dietician support were completed. Prescribing and reviews of medicines were also undertaken. The GP led a weekly multi-disciplinary meeting (MDT) with the therapy staff and other professionals and the registered manager. The GP told us "The meeting is a coordinated approach to try and prevent re-admission to hospital. We look at all issues and ensure appropriate referrals are made for people returning home." A GP was available to visit the service over five days of the week which meant there was continuity for people to manage their health concerns. The GP told us "There is a good structure of the staff team, we have a good relationship with staff and there is good teamwork." We saw medical visits records kept in peoples care files. This meant that people were receiving appropriate medical care during their stay as Ascot House.

We saw therapy staff engaging people in rehabilitation throughout our visits. One person told us "[Name] and [name] are keeping me busy; they keep me on my toes."

The service employed patient support workers who were trained to continue with therapy when therapy staff were not available. The patient support workers are able to complete home visits following a discharge to continue with therapy at home, support people to gain confidence once back in their own home, and support people to begin to access their local shops. The service had also recently been allocated a social care assessor to help in speeding up assessments and identifying suitable placements for people to be discharged to from the step down unit. This was to prevent people remaining at the service unnecessarily.

The service worked closely with the care at home team and they visited people at Ascot House to introduce themselves and learn about people's needs. This helped in providing continuity to the person on their return home.

Ascot House had a large kitchen where all meals were cooked. Staff told us that peoples dietary preferences were communicated to the cook on admission. There was a separate laundry and each bedroom has a numbered laundry basket to ensure peoples personal belongings did not go missing. We observed domestic staff working at the service throughout the inspection.

Good

# Is the service caring?

## Our findings

People told us that they found the home to be caring. One person told us, "I've had a lovely stay here, the staff are very nice, pleasant and helpful. The carers are very good; they talk to me and are very caring." Another person said, "It's fantastic here, the staff as much as anything else from the top right to the cleaner and laundry the staff are superb." "I couldn't be better looked after. They always do what they are asked to do, they have been so kind and good natured."

One relative said, "Miraculous is the word. Mum couldn't walk three metres without support before, her recovery is remarkable. It has been person centred to mum's particular needs, both mentally and emotionally. The staff are all very professional, nothing is too much trouble, they are really caring and compassionate."

We saw that visiting times at the service were restricted to particular times of the day. However, the registered manager told us as long as visitors did not interfere with therapy, there was flexibility about visits. One visitor we spoke to confirmed this.

We saw kind interactions from staff to people throughout the inspection. Staff engaged people in conversation about everyday topics such as the football, TV programmes and going to the theatre. Staff were seen to prompt and encourage people to use the skills that the occupational and physio therapist had taught them such as which leg to use first to help them turn around and how to feel for the chair before sitting down. This meant that people were continuing to improve their independence skills. The main ethos of the service was for people to become independent and return to their own home. We saw that people were encouraged to make their own breakfast and drinks as they became stronger. One person said, "I made my own breakfast today, I'm trying to get to be independent." This was the first time the person had managed to make their own breakfast and staff were seen to praise this achievement. One person told us "Staff are really nice and helpful, I really struggled with losing my independence and I was horrible to staff and I was going against their advice. They were kind and accepting of what I wanted to do and tried to advise me and eventually I learned to accept that I needed the help."

One staff member told us that use people's preferred names. We saw staff refer to people by their first names or as Mr or Mrs [name]. Another staff member told us that they try to encourage people's privacy and dignity. One staff member told us "If possible, I leave people to wash themselves, I get everything ready for them but if I need to stay, I encourage them to wash as much of themselves as they can." This meant that staff were observing people's privacy and dignity while enabling them to be independent.

A relative told us "A priest has visited Mum, this was important to her." We saw that people were asked about their religion, spirituality and culture on admission and this was recorded in the care file. A staff member told us "We have had people here whose family have brought in Kosher food." Another staff member said "Same sex partners visiting has never been an issue, everyone is equal." This told us that the service treated people with equality and respect.

Staff we spoke with were knowledgeable about people's needs and could describe people's plans of care, preferences and abilities. One person told us that they preferred to have a female care worker and although this wasn't documented in the person care file, staff we spoke to were aware of this. The person said "I am getting well looked after, it is a nice place."

We saw there were daily notes kept on each person recording what care had been offered and undertaken. We saw for one person that they didn't respond to rehabilitation and a reassessment of needs was completed for future care needs. This person was awaiting a 24 hour residential placement elsewhere and was being supported on the step down unit. Social care delays had meant that people are staying longer than anticipated.

Good

# Is the service responsive?

## Our findings

Referrals for rehabilitation at Ascot House are primarily received from hospitals. An initial screening call is made to the therapist at the hospital to check if people are fit for discharge and if they have the capacity to consent to the support they will receive at Ascot House. Once people are ready for discharge, Ascot House therapist visits the person for a face to face assessment. This is to ensure that the person can understand the programme of rehabilitation and gain consent.

We looked at three care files and found they contained an overview of people's needs which included nutrition and weight management, skin integrity, mobility and transfers, medication, vision and hearing, communication and cognition. The main focus was on people's therapy and independence. The service does not accept people who require transfers by a hoist as the service aims the rehabilitation at a three week turn around.

Occupational therapy assessments were kept in people's care files. There is an initial physiotherapy assessment within 48 hours of the person arriving at Ascot House. This looks at the person's baseline level of mobility before they were admitted to hospital and then the person and therapy staff agree realistic goals for the therapy. One person said "At first you can't get up or go to the toilet on your own as they are assessing that you are safe." Another person said "I get assistance in the night if I need the commode and help with getting dressed but I am prompted to do it myself."

We saw that people had exercise programmes in their care files. One person said, "I've been doing walking exercises, I'm stronger now." Another person said "I've done exercises every day, I asked to have another go this afternoon and the physio said no problem. They seem to find time for everyone."

A third person said they felt they should have done more exercises. They were going home on the day of the inspection and had been assessed as being strong enough to do so. The person said the physios came every two or three days. The lead physio told us, "I see the more complex patients every day. The patient support workers complete the exercises every day and inform us at handover. I see people who are doing well every other day." We saw that a goal sheet was in place when the exercise programme commenced which was agreed with the person.

Staff told us that they were given people's care files to read when they arrived and were provided with enough information about people's needs. We saw that there was additional information on white boards in peoples bedrooms which gave directions for how people used equipment, how many staff were needed for support and identified what the person could do for themselves. This helped staff to quickly respond to the person. Staff told us and we saw that there was a handover at the start of each shift. Staff also told us that they would sit with people when they arrived and ask questions about peoples routines throughout the day, what's important to them, how can staff support them and likes and dislikes. We saw that this information was documented in the care file.

Staff told us and we saw that on admission, a body chart was completed of each person to check for any

marks or pressure areas. A moving and handling risk assessments and falls management plan was completed and shared with the staff team. This meant the staff team know how to support people with moving and handling needs and have in place plans to support and minimise the risk of people who are at high risk of falls. The physiotherapist told us that there is a cut off from admission from hospital at five pm to enable assessment to be completed. However, the therapy lead told us that the hospital did not always follow this and the service then ensures that anyone arriving after this time has the support of two staff members until an assessment can take place. This meant that people were supported to stay safe during admission.

We saw that care files contained a discharge summary sheet which involved the person and their family. The sheet gave a list of actions to be undertaken before discharge. This included that therapy staff would visit the person's home with their permission to complete a home safety environmental check and ensure that the person could safely access their home and equipment in the home such as heating controls, food and drink making facilities, telephone and bathroom and bedroom. One person said, "They [therapy staff] went to my flat and came back and asked me if they could bolt things (grab rails) into the bathroom." The person went on to say that the occupational therapist had fully explained everything to them when they came back from the home visit.

The home safety checks would check for if any additional aids would be required to support the person in their own home. This could include grab rails or washing and dressing aids. Additional aids were ordered by the therapy team through social services such as toilet seat raisers. We saw that all equipment was ordered into the service and was ready to go home with the person on discharge or could be delivered to the person property before discharge.

One person said, "I talked to the physio's about how I feel. I said I didn't feel fully balanced so they reviewed me and were looking at my discharge date (as in put it back)." We also saw that any additional referrals were made for people prior to going home. This included social care assessments, referrals to district nurses for wound care or diabetic care and referrals to community rehabilitation services. We saw that discharge prescription and medication was ordered and each person was supported to go home with a member of the therapy team and was followed up with a phone call 24 hours after discharge. The service also organised a safe and well check by the fire brigade and would liaise with social services should properties need cleaning and would also follow up the person two to three weeks after discharge to assist in preventing re-admission to hospital. This told us that the service worked to ensure that people were involved in their discharge planning and to ensure that people returned home to a safe environment.

We saw kind interactions between the staff and people staying at Ascot House. We saw staff carrying out rehabilitation activities with people and using appropriate language. We observed that staff gave lots of encouragement to people. We saw that care plans had agreed goals with people. One person told us "I have got to learn to hop on one foot before I can go home, I am trying all the time and the staff help me."

The service didn't have a regular activities timetable but instead undertook activities appropriate to what the service offers. This was physical games such as bowling or sit to stand activities such as playing a large connect 4 game.

We saw that most activities were based around exercise and rehabilitation. There were sit to stand games and people were encourage to complete the therapy exercises as often as possible with patient support workers, other staff or on their own where safe to do so. We observed that people were chatting in small groups and newspapers were delivered daily. One person said they had a couple of quizzes and had played dominos. There was free Wi-Fi throughout the building should people want to connect a device to it. One

staff member said "The weekends are quieter as there are no physios or GP visiting, people tend to chill out and get up a bit later. We support them to walk and do their exercises."

We didn't see any activities on the step down unit. One person said, "I like to keep myself to myself. I have been to the library." There was no evidence of activities in daily notes and the people on this unit did not receive any therapy as they were mainly waiting for a package of care or residential placement.

The range of activities on the rehabilitation units were suitable for the needs of the people as the focus of their stay at Ascot House was for rehabilitation. However, further work around activities on the step down unit would benefit those who are waiting for a longer term care package or placement.

Staff we spoke to said they knew how to respond in the event of someone making a complaint. One staff member told us they would try and resolve the complaint themselves and if it was something they could not help with, they would offer reassurance and then inform a more senior person. Another staff member said that they would inform a deputy who was working. This meant that staff new what action to take in the event of a complaint occurring.

Staff told us that people often came from the hospital with an Adult Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR). A Do Not Attempt Resuscitation form is a document issued and signed by a doctor, which requests a medical team not to attempt cardiopulmonary resuscitation (CPR). The form is designed to be easily recognised and verifiable, allowing healthcare professionals to make decisions quickly about how to treat a person. Staff and the GP told us that these are reviewed with the person to ensure they are still valid and the person wishes remain the same. There was no one at the service who was receiving end of life care.

Requires Improvement

# Is the service well-led?

## Our findings

The service had a registered manager in post as required by their registration with the Care Quality Commission (CQC). The registered manager was supported by a therapy lead and four deputy managers.

One staff member told us, "I like it here, due to the staff team. They are very professional and we have an extremely good manager who you can speak with whenever you want to." Another staff member said, "I enjoy here most of the time, the interaction with the patients; I enjoy being able to have time to chat with people." All the staff members we spoke with were positive about the service and the quality of care being provided, for example, one staff member told us "I would recommend here for my family member."

We observed the registered manager to be approachable to staff members, service users and visitors and communicated in a professional and friendly manner.

We saw that there was a system of internal audits and checks made by the registered manager, this included the monitoring of care files, falls, accidents and incidents, nurse call timings, and safeguarding.

The registered manager told us that the deputy managers were responsible for overseeing the management of medicines. However, during the first day of inspection, we found there were errors relating to the amount of boxed medicines kept in stock at the service and medicine quantities were not adequately recorded on the medication administration record (MAR). We raised this with the registered manager during the inspection and on the second day of inspection, the registered manager told us that they had put in place a new form for recording quantities of medicines coming into, being administered and leaving the service. However, we felt that the registered manager lacked oversight of the management of medicines.

Services providing regulated activities have a statutory duty to report certain incidents and accident to the Care Quality Commission (CQC). We checked our records and looked at records during the inspection and found that all events had been notified to us as required.

The registered manager told us that there are plans to provide the therapy input seven days a week in the future to further enhance the service. Additionally the registered manager told us that the Care at Home service would be operating from Ascot House, this meant that people receiving rehabilitation at Ascot House would be followed up in the community to prevent readmission to hospital. The registered manager told us that she will be supported to manage both services and that having the services together meant there was continuity for people using the services.

The register manager told us that the service does use regular agency staff but they receive training and support from the service. We saw this confirmed on the rota. This meant that the staff supporting people knew their needs despite not being employed directly by the organisation.
We saw that complaints are addressed by the Patient Advice and Liaison Service (PALS).Pals offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carer workers. The registered manager told us and we saw that they were

visible within the service and both people staying at Ascot House and their representatives we spoke with said they were confident they could approach the registered manager with any concerns they had.

We saw a record of compliments which read "It has been so beneficial to stay at Ascot House, the support workers, the physio, cooks, cleaners have been so good, you can see people improving." Another compliment said "All the lovely staff made me smile and helped me, I am on the mend." A third compliment said "Hard working staff doing their best in not always the easiest of circumstances in a friendly and professional way."

The registered manager told that due to the fast turnaround in the service, it is not possible to hold group meetings although we were assured that people felt confident to raise any concerns they had and each person we spoke to rated the service very highly.

We saw the record of provider visits to the service which was detailed and contained information for the registered manager to follow up. We also saw that the registered manager had acted on recommendations from the local authority infection control audit which identified additional control measures for sluice facilities.

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<br><br>Medicines were not managed safely. The provider did not ensure that balances of medicines were accounted for. |