Aston Care Limited

Downshire House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Downshire House is a residential care home without nursing, providing accommodation and personal care for up to 8 older people and younger adults living with a learning disability, autistic people, people living with mental health needs, dementia, sensory impairments and physical disabilities. At the time of our inspection there were 7 people using the service.

People's experience of using this service and what we found
This was a targeted inspection to follow up 2 warning notices served at the previous inspection about safeguarding people from abuse and proper treatment and the need for consent. We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Based on our inspection of safe and effective, we found aspects of the warning notices had not been met to ensure improvements were made in specific areas to evidence compliance with the regulations.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

At the last inspection the service was unable to demonstrate how they were meeting the underpinning principles of 'Right support, right care, right culture'. This had improved since the last inspection. However, the provider was still not able to demonstrate how they were meeting some of the underpinning principles of 'Right support, right care, right culture'.

Right Support:
The provider could not be assured that people were supported to have maximum choice and control of their lives and that staff supported people in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. All staff had not been trained to support people in the least restrictive way possible and in their best interests.

Right Care:
People's care did not always promote their human rights. The service was not consistently working within the principles of the Mental Capacity Act (MCA). The provider's policies and systems in did not always support this practice.

Right Culture:
Staff told us people and their families were supported to express their views and be actively involved in making decisions about their care, support and treatment as far as possible. However, the two record systems used by the provider did not record people's or their representative's involvement in the decision making process.

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 inadequate (report published 8 December 2022).

At the last inspection we served warning notices in respect of safeguarding people from abuse and improper treatment and the need for consent. At this inspection we found, although some improvements had been made, the provider had not met the warning notices in full and therefore remained in breach of regulations.

Why we inspected
We undertook this targeted inspection to check whether the Warning Notices we previously served in relation to Regulation 13 and Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 had been met. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

Enforcement
The provider remains in breach of regulations found at the last inspection. These relate to keeping people safe from potential abuse and obtaining lawful consent to their care.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains 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 of their 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.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Downshire House

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.

This was a targeted inspection to check whether the provider had met the requirements of Warning Notices in relation to Regulation 11 (need for consent) and Regulation 13 (safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
This inspection was carried out by one inspector.

Service and service type
Downshire 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. Downshire House is a care home without nursing care. Care Quality Commission (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 CQC 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 not a registered manager in post. The deputy manager had been recently appointed as the manager and had applied to register with the CQC. We are currently assessing this application.

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 reviewed notifications and information we had received about the service since the last inspection. We sought feedback from the local authority quality assurance and safeguarding team. We checked information held by the fire and rescue service, Companies House, the Food Standards Agency and the Information Commissioner's Office. We checked for any online reviews and relevant social media, and we looked at the content of the provider's website. We used all this information to plan our inspection. We took all of this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with one person who used the service. We spoke with 7 staff, including the manager, the area manager and 5 support workers. We spoke with local authority Provider Quality Officer and the Quality and Safeguarding Adults Team. We observed care in communal areas, for example, during mealtimes, to help us understand the experience of people who could not talk with us. We reviewed a range of documents, including seven people's care records and daily notes in two different records systems. We reviewed a variety of records relating to the management of the service, including the provider's policies, procedures, accidents and incidents and quality assurance audits.

Inspected but not rated

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 this key question was rated inadequate. This meant people were not safe and were at risk of avoidable harm. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served in relation to safeguarding people from abuse and improper treatment. We will assess the whole key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to operate robust procedures to protect people from avoidable abuse and improper treatment, and to ensure staff had completed safeguarding training. This was a breach of regulation 13(1)(2)(3)(4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served the provider a warning notice and told them to meet Regulation 13 by 12 January 2023. We went back to the service to check that the warning notice had been met.

Although some improvements had been made, the provider remained in breach of Regulation 13 (Safeguarding people from abuse and improper treatment).

● The provider had failed to ensure all staff had completed relevant safeguarding training. The provider's training records demonstrated that 8 of 22 staff (36.36%) had not completed safeguarding training relevant and at a suitable level for their role.

We found no evidence that people had been harmed. However, the provider could not be assured that all staff had been enabled to recognise and protect people from different types of abuse. All staff had not been made aware of their individual responsibilities to prevent, identify and report abuse when providing care and treatment. This was a continued breach of regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to ensure all staff had completed required training that is relevant to their role and at a suitable level to make sure any control, restraint or restrictive practices were only used when absolutely necessary, in line with current national guidance and good practice, and as a last resort. The provider's training records demonstrated that 9 of 22 staff (41%) had not completed such training.

We found no evidence that people had been harmed. However, the provider could not be assured if staff were using restraint, it was only used when absolutely necessary, proportionate to the risk of harm to the person, considered the person's needs and their capacity to consent to such treatment and followed current legislation and guidance. This was a continued breach of regulation 13(4) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

● Since our last inspection, the deputy manager and a designated team leader had completed advanced training in relation to safeguarding and the reduction of restrictive practices.
● The deputy manager provided evidence which confirmed that outstanding staff training relevant to safeguarding people from abuse and improper treatment had been arranged for 28 April 2023. The deputy manager was able to demonstrate that outstanding staff training in relation to the reduction of restrictive practices had been arranged for 22 May 2023.
● At our last inspection the provider had failed to report safeguarding incidents to relevant authorities. This meant the local safeguarding authority did not have oversight of the circumstances to ensure the provider had taken the required action to keep people safe. At this inspection we found the deputy manager had appropriately reported incidents where required, which enabled relevant authorities to ensure the provider had taken necessary action to protect people from avoidable harm.
● Health and social care professionals told us they were now more assured the management team at Downshire House understood their role and responsibilities to protect people from avoidable harm.

Inspected but not rated

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes. We have not changed the rating as we have not looked at all of the effective key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served in relation to the need for consent. We will assess the whole key question at the next comprehensive inspection of the service.

Ensuring consent to care and treatment in line with law and guidance
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 MCA. In care homes this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection, the provider could not demonstrate that people's consent to their care and treatment was always sought in line with legislation and guidance. This was a breach of Regulation 11(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served the provider a warning notice and told them to meet Regulation 11 by 12 January 2023. We went back to the service to check that the warning notice had been met.

Although some improvements had been made, the provider remained in breach of Regulation 11 (Need for consent).

- The service was not working within the principles of the MCA. There were no decision specific assessments relating to people, in line with legislation.
- People's care records in relation to MCA and best interest decisions had not been completed. At our last inspection, multiple sections in the provider's digital record system detailing people's decisions in relation to consent had not been completed. This meant the provider could not assure people had lawfully

consented to their care and treatment.
● At this inspection, there had been no improvement. People's digital care records stated their consent to care was not recorded within the digital system. The field to provide a reason why the person's consent had not been recorded had not been completed. The deputy manager and area manager confirmed people's consent and best interests' decisions were not recorded in the other paper care records.
● People's care records did not demonstrate they were supported to express their views and be actively involved in making decisions about their care, support and treatment as far as possible. Staff confirmed they did consult people and where appropriate their family or representatives.
● The provider could not demonstrate a clear commitment to minimising the use of restrictive interventions. For example, unplanned use of restrictive strategies had not triggered reviews of people's support plans or generated staff supervisions to promote reducing restrictive practice.
● There was poor or absent monitoring on the use of restrictive interventions. When restrictive interventions had occurred, for example, when staff engaged with people who were experiencing extreme anxieties to protect them and others, staff and people had not completed reflective sessions to identify learning.
● Not all staff had completed the provider's mental capacity act training. The provider's training matrix demonstrated that 8 out of 22 staff (36.36%) had not completed this training. This meant the provider could not be assured that all staff acted in accordance with the MCA and associated code of practice when a person lacked mental capacity to make an informed decision or give consent.
● There were no mental capacity assessments or best interest decisions recorded detailing key decisions, for example those relating to people's medicines, accessing the community and personal care.

The provider could not demonstrate that people's consent to their care and treatment was always sought in line with legislation and guidance. This was a breach of Regulation 11(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our last inspection, the provider could not demonstrate that appropriate legal authorisations were in place to deprive people of their liberty. At this inspection there were relevant authorisations to show people were living at Downshire House legally, in line with regulations.
● The deputy manager effectively operated a DoLS tracking system which ensured future applications were submitted well before current authorisations expired.
● Since our last inspection the deputy manager and a designated team leader had completed enhanced training in relation to the MCA. At the time of inspection the deputy manager was in the process of confirming the date for outstanding staff training in relation to the MCA to be completed.
● The deputy manager was in the process of arranging reviews of people's consent to their care and arranging best interest meetings where appropriate. The deputy manager and area manager had prioritised this work to be completed in April 2023.
● Staff understood their responsibility to support people to make choices and decisions they were able to.

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 11 HSCA RA Regulations 2014 Need for consent How the regulation was not being met: The provider could not demonstrate that people's consent to their care and treatment was always sought in line with legislation and guidance. Regulation 11(1)(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: The provider had failed to ensure that all staff had had received appropriate training to enable them to recognise and protect people from different types of abuse and only use restrictive practices when absolutely necessary, in accordance with current legislation and guidance. Regulation 13(2)(4)