Aston Care Limited

Downshire House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

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 eight 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 eight people using the service.

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

The provider was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right Support
People's care was not consistently person-centred and did not always promote people's human rights. The service was not working within the principles of the Mental Capacity Act and the provider could not demonstrate that appropriate legal authorisations were in place to deprive people of their liberty.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

Recruitment procedures, staff supervision and training did not ensure enough suitably qualified staff were deployed to make sure people were always safe and received care that met their needs. The provider did not effectively use incidents and accidents to identify potential abuse and take preventative actions. Risks to people's safety were not always mitigated. Unexplained injuries had not always been investigated to identify any potential causes so that strategies could be implemented to reduce the risk of reoccurrence. Partnership working with other relevant bodies to contribute to individual risk assessments and develop plans for safeguarding was poor.

Staff were able to describe how to communicate with people. However, care plans indicated people may benefit from additional communication tools which were not always used.

Right Care
Care and support was not always effectively planned and delivered in line with current evidence-based guidance and best practice. However, people experienced good continuity and consistency of care from a

stable core staff team.

Staff engaged with other agencies to ensure people had access to the support they needed for their healthcare and wellbeing needs. The service made referrals and liaised with other healthcare professionals when the need arose.

Staff interacted with people with warmth and respect. However, when staff were task driven due to staffing levels, this compromised positive and meaningful interactions with people.

Right Culture
Quality assurance and performance management was not reliable and effective. Quality assurance processes had not effectively identified emerging risks to people and ensured they were managed safely.

The provider did not understand their responsibilities to inform people, or their representatives, when things went wrong. The provider had not conducted honest and transparent investigations to identify essential lessons to prevent further occurrences.

Staff supported people and their families to express their views and be actively involved in making decisions about their care, support and treatment as far as possible.

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

Rating at last inspection
The last rating for this service was good (report published 14 February 2018).

Why we inspected
The inspection was prompted due to concerns received about the other services operated by the provider. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this report.

The provider has begun to take action to mitigate the risks identified, though it is too soon evaluate whether this has been effective.

You can see what action we have asked the provider to take at the end of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the management and leadership of the service, the safe care and treatment of people, managing risks and protecting people from avoidable harm, consent to care, staffing levels, staff training, record keeping, quality assurance measures and failures to notify relevant authorities of notifiable incidents when required.

We issued Warning Notices to the provider regarding three breaches of regulation relating to good governance, safeguarding and consent to care. The provider is working with us with the support of the local authority care quality, safeguarding team and commissioners to address the issues raised.

Please see other action we have told the provider to take at the end of this 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 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.

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 of 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

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 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. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed notifications and information we had received about the service since the last inspection. We sought feedback from the local authority, safeguarding team and other professionals who work with the service. 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 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 took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with three people who use the service and four relatives of different people. We spoke with 12 staff including the nominated individual, the manager, the deputy manager, a director and eight support workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider. The nominated individual was also the main director of the provider care group.

We spoke with two visiting tissue viability nurses, a professional providing art therapy to people, a Deprivation of Liberty Safeguards assessor and two visitors from a local church. We observed care during mealtimes, social activities and medicine administration rounds to help us understand the experience of people who could not talk with us. We reviewed a range of documents, including eight people's care records, multiple medicine records and daily notes in three different records systems. We looked at six staff files in relation to recruitment, staff training and supervision. A variety of records relating to the management of the service were reviewed, including the provider's policies, procedures, accidents and incidents and quality assurance audits.

During the site visit the service safeguarding file could not be found. Staff records of the previous registered manager, administrative manager, digital record system trainer and staff subject to the provider's disciplinary proceedings were also missing.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with six health and social care professionals who engaged with the service.

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.

Recruitment

● At our last inspection the provider had recruitment processes in place to ensure staff employed were suitable to support people living with a learning disability or autism. However, not all required security checks had been completed. The required security checks were completed before conclusion of the inspection and we were assured by the provider that full staff records would be stored in the future, in accordance with regulations. At this inspection we found there were no recruitment and training records for three staff employed since the last inspection.
● There were no recruitment and supervision files available for the office administrator who had recently left the service, a training manager responsible for implementing the provider's new digital records system and a senior support worker. The recruitment and supervision file of the previous registered manager was also unavailable.
● The provider confirmed the senior support worker had been dismissed under the provider's disciplinary procedures in connection with a safeguarding incident. However, there was no record in relation to the disciplinary proceedings, the dismissal or the safeguarding incident being reported to the relevant authorities.
● The lack of these records meant the provider had not effectively operated recruitment procedures to assure that all staff were of good character, had the qualifications, competence, skills and experience to support people living at Downshire House.
● The provider had not regularly reviewed the fitness of staff in accordance with legislation. We reviewed another safeguarding incident, where the provider had failed to take appropriate action to minimise the risk to people, whilst an investigation was undertaken in relation to a senior staff members' fitness to carry out their role. They had also failed to notify relevant authorities.
● Whilst the provider had begun a process to update staff Disclosure and Barring (DBS) checks, many were four or five years old. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. The provider was unable to confirm whether the circumstances of a staff dismissal under the provider's disciplinary procedures required to be notified to the DBS to ensure the person did not obtain another role in the care sector.

The provider's failure to assure and regularly review staff were of good character, suitably qualified to support people living with autism or a learning disability was a breach of Regulation 19(1)(a)(b)(c)(2)(a)(5)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing

● The provider did not deploy enough suitably qualified competent skilled and experienced staff to make sure that they can meet people's care and treatment needs safely. The provider's care records contained contradictory information. For example, some records assessed three people required two staff to support them to access the community safely, other records referred to the same people requiring three staff, without any clarification as to when or why.

● On the first day of inspection two people were accompanied by staff in the service minibus to go for a drive and visit a shop in the community. Each person required two staff to support them safely. However, we observed only three staff supporting the people, one being a relatively inexperienced staff member, the others being the nominated individual and a director of the provider care group. Neither the nominated individual or the director had experience working in the care sector and neither had completed the provider's mandatory training, particularly in relation to de-escalation techniques should people become frustrated or anxious. This meant people had been placed at risk of harm due to a lack of qualified, competent staff being available to support them.

● We discussed the circumstances with the nominated individual on their return, who agreed they had not considered the inherent risk created by their actions and potential compromise of the provider's insurance. At the time of these circumstances other staff were committed providing support to other people within the home.

● One person was subject to a Court of Protection order risk management plan to promote their safety. One of the specified conditions on external trips was that the person should only be escorted [supported] by a named individual, an engaged professional or a suitably qualified Downshire House staff member. On two occasions the company director had accompanied the person without other staff present to watch football matches, where they were potentially exposed to risks identified within the risk management plan. On one of these visits the nominated individual was also present. This meant the person had been placed at risk of harm, due to a lack of qualified, competent staff being available to support them safely in the community.

● The deployed staffing levels did not ensure there were enough staff to keep people safe. People who required one to one staff support within the home were frequently seen during the inspection wandering around the home unaccompanied. For example, we reviewed multiple entries in one such person's daily notes and incident records. The records demonstrated the person needed to be supported constantly to protect themselves and others from harm, should they experience an increase in anxiety.

● We reviewed the minutes of a staff meeting on 23 June 2022. One agenda item read, '[Nominated individual] visited the home and all service users were alone in the lounge.' The deputy manager told us people had just returned from activities and were left alone briefly whilst staff were completing tasks such as returning emergency medicines to the medicine's cabinet.

● Staffing levels were not continuously reviewed. The provider did not complete a dependency tool or staffing needs analysis to determine the number of staff and range of skills required to meet people's needs, keep them safe and achieve successful outcomes. This meant that staffing levels were not responsive to the changing needs and circumstances of people and were merely based on the hours of care commissioned. At the time of inspection, the nominated individual could not detail the staffing requirements to meet the needs of individual people.

● Staff told us that when people went out on activities, it was difficult to provide one to one support for people when required who remained, which rotas confirmed.

● Staff told us the previous registered manager rarely visited the service and stopped visiting in May 2022. The deputy manager had not been at the home since the last week in July 2022. Since that time there has been no qualified management staff at the home. The office administrator left the service in early August 2022. This meant the resilience provided by these staff to support unforeseen staff absence was no longer available.

● The provider deployed three staff during night shifts. Due to the assessed staffing ratios, the current staffing level deployed at night meant that people could not be evacuated safely, in accordance with the fire

safety evacuation plan. The manager agreed and undertook to review emergency evacuation plans and procedures.

The provider's failure to deploy enough suitably qualified, competent, skilled and experienced staff to meet people's needs and keep them safe was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The provider had not assumed overall responsibility or ensured they had implemented, robust procedures and processes that protected people from avoidable harm and abuse. The provider did not understand their roles and associated responsibilities in relation to policies and procedures to prevent abuse. For example, we reviewed three safeguarding incidents, involving a potential scalding, alleged emotional and psychological abuse by a member of the management team and the disappearance of a substantial quantity of a person's prescribed controlled drugs. The provider had not followed local safeguarding arrangements to make sure that allegations were investigated without delay.
● The provider had failed to make sure that they responded without delay to the findings of any investigations. One of these incidents required an investigation directed by the local safeguarding authority. The provider failed to make sure a person was protected from further potential abuse by not removing the staff member accused of abusing the person from the service, whilst the allegations were investigated. The investigation concluded the senior staff involved required development and additional training to fulfil the responsibilities of their role and in relation to how they communicated with people and staff. This senior staff member then failed to undergo any of the required training. This meant that people were still at risk of emotional and psychological abuse from this staff member. This staff member has since left the service.
● The incidents regarding the potential scalding and disappearance of a person's prescribed controlled drugs were not reported to the local safeguarding authority, in accordance with their agreed procedures. The failure to report these incidents meant the local authority safeguarding authority did not have oversight of the circumstances to ensure the provider took the required action to keep people safe.
● Unexplained injuries recorded within the digital system had not always been investigated to identify any potential causes, so that strategies could be implemented to reduce the risk of reoccurrence. For example, bruises on a person's neck.
● We could not be assured that staff safeguarding training was up to date. The provider's safeguarding file was not available. The staff training file contained sparse information which demonstrated safeguarding training had either not been completed or was out of date. We reviewed two provider's training schedules which showed that staff safeguarding training was out of date or had not been refreshed for two years. Staff told us that the provider had recently put a process in place encouraging staff to complete relevant on-line training.
● The provider had not worked well in partnership with other relevant bodies to contribute to individual risk assessments, developing plans for safeguarding adults at risk, and when implementing these plans. For example, the provider had not engaged with care managers and commissioners for over 18 months to review outcomes for people using the service.

The provider had failed to maintain effective scrutiny over safeguarding issues and had not effectively implemented and operated robust procedures to protect people from abuse and improper treatment. This was a breach of regulation 13(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives consistently told us they felt safe and experienced good continuity and consistency of

care from regular staff, who knew them well. One person told us, "Yes. I am happy here." A relative told us, "The staff turnover is really low and they [staff] really understand [person]." Another relative told us, "I have always seen [person] treated with respect and have never seen anything that was discriminatory in the home in general."
● Staff knew how to recognise different types of abuse and understood how to record, and report concerns internally. Some staff were unsure how to report concerns externally.
● Staff consistently told us that under the leadership of the deputy manager they felt confident to raise safeguarding concerns and that they would be listened to.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● At the time of inspection, it was not clear which record system should be referred to. There were original paper-based records, which had been superseded by a digital system. These records were in the process of being updated by the administrative assistant, who left before this was completed. A director had begun to create further paper-based records in response to feedback from other care group inspections.
● The digital system was used by staff to record changes to people's needs, health conditions and risk assessments. However, these records were never reviewed. The provider told us this was a technical issue which prevented managers from completing reviews within the system. The deputy manager endeavoured to complete reviews when required, although records did not demonstrate required action had been taken. We could not be assured that risk assessments contained up to date information to enable staff to deliver care to meet people's changing needs.
● We reviewed all three systems, which contained contradictory information. For example, one person's risk assessment on the digital system showed they had no allergies. However, the medicines management file demonstrated they were allergic to penicillin. We confirmed the person was allergic to penicillin and the manager removed records contradicting this. Until the removal of the contrary risk assessment the person was at risk of harm from being prescribed and administered penicillin.
● We reviewed a person's risk assessments, which identified they were allergic to walnuts. Whilst the risk assessment identified the person's allergy correctly, the provider had not implemented a comprehensive risk management plan to ensure the person was protected from harm through the food preparation for and by other people.
● The provider did not effectively use incidents to identify potential abuse and take preventative actions. We reviewed the service digital records system. The system highlighted multiple incidents where people had either been injured or become distressed, when other people's frustrations and anxieties had escalated. The digital records system indicated that none of these incidents had been reviewed by the provider or a senior manager. We were therefore unable to ascertain whether the provider had investigated these incidents and taken the required action to keep people safe and protect them from a further occurrence.
● Risks to people's safety during major incidents and emergency situations in case of events such as fires and floods, were not effectively mitigated. For example, there was no contingency plan as to where people should be transferred after an emergency evacuation when required.
● The provider had not recorded any evacuation drills to identify and mitigate risks to people's safety from staff failings. No night-time fire drills had been completed.
● The service did not have an appointed fire marshal and there was confusion amongst staff as to where the emergency grab bag and people's emergency evacuation plans (PEEPs) were kept. These were eventually found in a file within the manager's office separate from other fire emergency information.
● We found a beige linen fashion bag in the medicines room which was not readily identifiable as the emergency grab bag. This bag did contain some building plans. However, this bag did not contain other necessary information and equipment required during an emergency.
● The last fire safety audit we were shown was dated January 2018 and did not address any of these issues.

● The provider had not always ensured the safety of their premises and the equipment within it. For example, there were no thermostatic mixing valves within the home. Thermostatic Mixing Valves (TMVs) reduce the discharge temperature of stored hot water to protect people from scalding. The manager took immediate action to arrange for TMV's to be fitted as soon as practicable. The manager implemented further safety measures and monitoring to ensure people were protected from the risk of scalding in the interim.

The provider had failed to establish and effectively operate systems to assess, monitor and mitigate risks to people to ensure their safety. This was a breach of Regulation 12 (1)(2)(a)(b)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People, relatives and visiting professionals told us they thought staff delivered care in accordance with their assessed needs and followed professional guidance.

Using medicines safely

● We observed people receiving their prescribed medicines in accordance with their medicine management plans, from staff who had been trained to manage medicines safely. However, staff had not had their competency to administer medicines reassessed by the provider. This meant the provider could not be assured that staff administered medicines safely and in accordance with their training and legislation.
● People's medicines management plans had not been reviewed. For example, one person's epilepsy protocol, including the safe use of a medicine to stop seizures had not been reviewed since 4 June 2019.
● Where people had medicines 'as required' (PRN), for example for pain or for anxiety, there were no PRN protocols in place. This meant staff were not provided with required information to administer these safely, including signs and indications for their use, maximum doses, when to seek professional support and advice and about how to record their use. This meant we could not be assured that people consistently received their PRN medicines when they needed them.

The provider had failed to establish and effectively operate systems to assess, monitor and mitigate risks to people to ensure their safety. This was a breach of Regulation 12(1)(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

● We observed people were treated with dignity and respect by staff when supported with their prescribed medicines. For example, people were asked if they were ready to take their medicines and their wishes were respected if they wished to take medicines later, if they were not time critical.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● We were assured the provider was facilitating visits for people living in the home in accordance with current guidance. Staff carried out relevant checks before the visitors were allowed to enter the premises.

Inadequate

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 good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff did not receive appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties they were employed to perform. This meant the provider could not be assured that staff were suitably skilled and experienced to deliver care to meet people's needs.
- The provider had not established a competency framework to assess and monitor the quality and safety of the care delivered by staff. This meant the provider could not be assured that staff delivered care and support in accordance with their training.
- We were not assured that staff training was up to date. The provider's training file contained little information which demonstrated staff training had either not been completed or was out of date. We reviewed two provider's training schedules which showed that staff training was out of date or had not been refreshed for over two years. Staff told us that the provider had recently put a process in place encouraging staff to complete relevant on-line training.
- The provider's training records did not demonstrate that staff had completed a comprehensive induction programme, in accordance with the Care Certificate standards. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
- Staff files only contained one or two certificates to demonstrate training completed.
- Staff consistently told us they had received training in how to interact with and support people with a learning disability and autistic people, although they thought this needed to be more detailed and at a higher level.
- Staff told us they had not had any supervisions or appraisals under the previous registered manager, which records confirmed. The provider had begun to implement supervisions based on feedback from inspections at other services within the providers care. However, these supervisions did not address staff development or identify any actions to be completed moving forward, such as required training.
- In the service PIR, the provider stated they had supported staff to obtain appropriate further qualifications that would enable them to continue to perform their role. However, staff records did not corroborate this.

People were not supported by staff who were adequately trained and supported to meet people's assessed needs. This was a breach of regulation 18(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

● The service was not working within the principles of the MCA and the provider could not demonstrate that appropriate legal authorisations were in place to deprive people of their liberty. We reviewed the service DoLS tracker, which demonstrated that DoLS applications had been authorised for five people in 2022 and three people in 2021, for whom new authorities had been applied.
● However, during the inspection the provider could not produce any evidence of such authorities or applications since 2018. This meant we were unable to assess and assure whether people were being deprived of their liberty lawfully and supported in accordance with any conditions specified in the DoLS authorities. For example, conditions to enrich the quality of people's lives and to keep people safe.
● Staff had not received any appraisal of their performance in their role from an appropriately skilled and experienced person and had not had any training, learning and development needs identified, planned for and supported.
● People's care records in relation to MCA, best interest decisions, DoLS had not been completed. Multiple sections in the 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.
● Some wording within care records demonstrated a lack of understanding of the MCA by the managers of the service. For example, one person's care plan recorded a blanket assessment, "'[Person] does not have capacity to make any decisions'." There were no decision specific assessments relating to this person, in line with legislation.
● Staff were unable to demonstrate a clear understanding of the MCA, best interest decision making processes and DoLS. However, staff understood their responsibility to support people to make choices and decisions they were able to.
● Staff were not aware that one person living at Downshire House was authorised to do so by a Court of Protection Order under the MCA and another was subject to a Community Treatment Order (CTO). Care records relating to the person's CTO contained contradictory information. For example, one record stated – 'My CTO lapsed and was not renewed, but the home has been advised to follow the same principle of my CTO and DoLs'. There were no other documents available, including DoLS, to confirm the person was lawfully living at Downshire House.
● 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, that staff and people had not completed reflective sessions to identify learning.

● 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.
● We spoke with visiting tissue viability nurses who attended to dress a persons' pressure ulcer on their leg. The pressure ulcer was taking a long time to heal due to self- injurious behaviour when the person was anxious. This exposed the person to the risk of developing sepsis. The tissue viability nurses praised staff for their support of the individual and prompt referrals. However, the tissue viability nurses were concerned best interest decisions had not been considered in relation to the person repeatedly declining to have the wound dressed. We informed the provider who contacted relevant stakeholders to undertake a best interests process.
● Some people had 'Consent to care' documents which stated there should be a capacity assessment and best interest decision if a person lacked capacity. This had not been done for these people.
● People who lacked capacity did not always have their liberty restricted in line with current legislation. No assessments were completed for restrictive practices such as locked doors around the home. The service had locks on doors including bedrooms and the kitchen door which were not documented. There was no evidence that these were the least restrictive options and, in each person's best interests. The provider and previous registered manager had not recognised these were restrictions of people's liberty.

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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support
● The service was not consistently meeting some of the underpinning principles of
Right support, Right care, Right culture. For example, people's care plans did not identify any goals or aspirations.
● Due to the confusion created by the use of three record systems it was difficult to confirm that people's needs had been fully assessed. People's care and support plans were not regularly reviewed and updated to ensure they contained up to date information to enable staff to deliver effective care.
● Care and support was not planned and delivered in line with current evidence-based guidance and best practice. For example, epilepsy protocols did not follow NICE guidelines. NICE is the National Institute for Health and Care Excellence whose role is to improve outcomes for people using health and social care services by producing evidence-based guidance and advice for health and social care practitioners.
● The absence of any consistent management for an extended period meant we could not be assured people's care was planned and delivered in accordance with required standards. For example, there was a lack of specialist training for staff to meet individual needs.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to have enough to eat and drink and were encouraged to maintain a balanced, healthy diet. People were offered a choice of food that met their personal preferences.
● People and relatives told us they enjoyed the food.
● People were protected from the risk of poor nutrition, dehydration, swallowing problems and other medical conditions because staff consistently followed guidance from relevant healthcare professionals. For example, people identified to be at risk due to weight gain or loss, had been successfully supported by staff to achieve their desired outcomes.
● We observed staff regularly encouraging people to have their preferred drinks, to protect them from the risk of dehydration.

Staff working with other agencies to provide consistent, effective, timely care

● Staff engaged with other agencies to ensure people had access to the support they needed for their health and wellbeing needs. The service made referrals and liaised with other healthcare professionals when the need arose.
● People and relatives told staff ensured people kept their health appointments. For example, one relative told us, "[Person] regularly attends the doctors or practice nurse for check-ups, and she also visits the dentist and optician with lots of support from staff."
● Staff maintained records of people's healthcare appointments and confirmed information was shared between staff during handovers and through communication books, which we observed during morning and evening handovers. Staff were able to explain how they supported people to engage with healthcare professionals.

Adapting service, design, decoration to meet people's needs
● Downshire House was situated near to local shops, public amenities and transport links to support people's inclusion and integration within the community and promote people's independence.
● People had been supported to personalise their rooms. Relatives told us they had been consulted in this process and when communal areas had been adapted or decorated.
● People had access to a lounge and a communal dining room. We observed people making use of these spaces.
● Relatives told us their family members really enjoyed the sensory room and sensory garden created by the provider, which enabled people living with autism and learning disabilities to reduce their anxieties.
● The provider had recently responded to feedback from inspections at other homes within the provider group and had removed a hot tub and covered exposed radiators, to eliminate identified risks.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People were consistently treated by staff with kindness and compassion in their day-to-day care and support. This was overwhelmingly reflected in the positive feedback from people who use the service, their families, friends, visitors and professionals who consistently praised the caring attitude of the staff. For example, one relative said, "It's a really good place. [Person] is really happy there. They [staff] know [person] so well and really care for him." Another relative told us, "I would say all of the staff are very caring, they treat [person] with kindness and respect. I visit weekly and have always seen kind and caring behaviour across the home" and "I have always seen [person] treated with respect and have never seen anything that was discriminatory in the home."
- Staff had built open relationships with people and their families, who were made to feel welcome in the home. There was a positive, cheerful atmosphere in the home, which was consistently noted by people's relatives.
- Relatives told us their family member experienced good continuity and consistency of care from regular staff, with whom they shared a special bond. Visiting professionals told us they observed sensitive staff interactions with people, which were consistently kind and gentle.
- Staff engaged with people with warmth and respect. However, due to staffing deployment, sometimes we observed staff being task driven which compromised positive and meaningful interactions with people. For example, we observed one person who had been left in a chair watching television. Eventually the person was engaged by the manager who ascertained they would like to watch some football. The manager requested a staff member to find the relevant channel. Staff were then deflected supporting another person and when staff eventually returned the person said they wanted to go back to bed.
- People were not always supported in a person-centred way whilst eating. We saw one staff standing next to a person whilst they were eating, rather than sitting with them. Staff told us they were concerned about a potential interaction with another person who was walking around without support. We told the manager who agreed to look into staff deployments to resolve this issue.

Supporting people to express their views and be involved in making decisions about their care

- Staff supported people and their families to express their views and be actively involved in making decisions about their care, support and treatment as far as possible. For example, a relative told us, "I have always been informed about [person's] care and what plans are in place and I am happy with them." Another person's relative told us, "I am fully involved in all decisions and reviews and feel my views are listened to and respected."
- Some people experienced impaired communication and staff were skilled at supporting them to express

their wishes. We observed staff interact in an appropriate, patient and inclusive way, in accordance with people's communication strategies.
● Throughout the inspection we observed staff providing reassuring information and explanations to people whilst delivering their care, particularly when administering medicines and supporting them to move.

Respecting and promoting people's privacy, dignity and independence
● Staff were attentive and empathetic to people's moods and emotional support needs, including sensory sensitivities. We observed staff sensitively engage with people when they identified potential triggers to people's anxieties to prevent them escalating.
● Staff consistently treated people with dignity and respect and maintained their privacy. For example, we observed staff discretely support people to rearrange their dress when required, to maintain their personal dignity.
● Staff behaved and spoke in a respectful manner with people. When people were confused or disorientated, staff immediately provided reassurance, which eased their anxieties and improved their wellbeing.
● When people were approached by staff, they responded to them with smiles and known gestures, which showed people were comfortable and relaxed with staff.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider was unaware of the AIS and there was no policy or specific staff training in place to ensure they were implemented.
- Each person had a communication profile and support plan. For example, some people communicated personalised gestures, objects of reference, pictures and body language.
- However, we observed staff supporting a person with tissue viability nurses explaining the need for a pressure ulcer to be dressed. Staff were not using communication aides detailed within the person's treatment order, in accordance with the AIS.

We recommend the provider implements policies and procedures from a reputable source in relation to the AIS and arranges for staff training in relation to communication to be augmented to encompass the AIS.

- Relatives and health and social care professionals consistently told us that the continuity of staff maximised the communication of information between people and staff.
- Information was provided in formats to meet people's individual needs. Staff mostly ensured people received information in a way they could understand and process, allowing for disability or impairment, such as poor eyesight or hearing.
- Relatives and health and social care professionals consistently told us that the continuity of staff maximised the communication of information between people and staff.
- Staff ensured people received information in a way they could understand and process, allowing for disability or impairment, such as poor eyesight or hearing.
- Information was provided in formats to meet people's individual needs.

End of life care and support

- There were some older people living at Downshire House. Some people's end of life care had not been fully considered to ensure their end of life support plan was personalised and respected their wishes.

We recommend that the provider researches current best practice and guidance around end of life planning for autistic people and people with disabilities and then applies it to their practice.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People and their families where appropriate were involved in developing their care, support and treatment plans to ensure they had choice and control over their care.
● People's care and support plans were not always person-centred. For example, people's goals and aspirations had not been fully considered. Care plans lacked information regarding long-term planning and progress.
● People had designated keyworkers who completed monthly reports. These reports were lacked detail. Staff consistently told us they would like more time to enhance the impact of their key working relationship.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● Relatives overwhelmingly told us they were warmly welcomed at anytime to visit their family member and often turned up unannounced, which they found very reassuring.
● People, relatives and friends told us the staff proactively supported and encouraged people to maintain relationships with people important to them.
● People and their relatives consistently told us told us they felt staff had a good understanding of people's needs and adapted their approach based on people's personal preferences, cultural background and individual needs. One relative said, "There is a plan to meet [person's] needs that is discussed with me. They [staff] realise [person] can be very anxious and have a plan in place to support her. For example, [person] gets very anxious about going out especially if it's raining because the pavement is shiny and she thinks she'll slip so they [staff] have organised indoor activities like art therapy and bible study, both of which she loves." We observed the positive impact on this persons' well-being whilst engaged in these activities.
● People's cultural and religious needs were explored with them and the service ensured these were met. Support in the community was encouraged since government guidelines around COVID-19 had eased. People regularly went out to the shops and for drives including stopping at cafes for a drink.
● People had programmed weekly activities. However, one person's programme repeatedly showed watching television as an activity.
● The provider demonstrated they were in the process of recruiting an activities coordinator to implement more structured and organised activities.

Improving care quality in response to complaints or concerns
● There had been to complaints raised since our last inspection.
● People and families felt able to make complaints if they wished. People and their relatives knew staff by name and spoke with them regularly. People and relatives knew what to do and who they would talk to if they had any concerns. They were confident action would be taken if they did raise concerns.
● People and their relatives were given the opportunity to give their feedback on the service during care reviews, meetings and surveys. This feedback was consistently positive, with many complimentary comments about the support provided.

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 good. 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; Continuous learning and improving care

- The service has a condition of registration that it must have a registered manager. The registered manager was also a director of the provider's care group also oversaw three other homes in the care group, resigned on 19 July 2022.
- The provider was unaware of the registered manager's resignation until we confirmed cancellation of their registration with us. On 12 September 2022, a new manager was appointed who had begun the process to become the registered manager of the service. The deputy manager has been on leave since the end of July 2022.
- The nominated individual and another director assumed management of the service after learning of the registered manager's resignation. Neither had experience or qualifications relevant to managing a care home or supporting people living with a learning disability or autistic people. This meant the service had no management oversight by a person with the required knowledge and experience for six weeks.
- The provider had not supervised the previous registered manager and had not completed supervisions, competency assessments or appraisals to monitor and quality assure their performance. The previous registered manager had not completed quality assurance audits or reports for the provider. This meant the provider had failed to fulfil their responsibility for management of the service on behalf of the provider.
- Governance and performance management was not reliable and effective. Quality assurance processes had not effectively identified emerging risks to people and ensured they were managed safely.
- The provider's processes had failed to identify breaches of regulation found during this inspection.
- The provider's systems and processes had not enabled the registered person to identify where quality and safety were being compromised and to respond appropriately and without delay.
- The registered person had not always identified risks and introduced measures to mitigate the risks in a timely manner that reflected the level of risk and impact on people using the service.
- The provider had not kept abreast of developments in regulatory requirements and the responsibilities. For example, the provider had no policies and procedures in relation to the Duty of Candour or Accessible Information Standards. This meant that managers and staff were unaware of their responsibilities. Other policies and procedures had not been reviewed and required updating.
- The provider did not effectively operate quality assurance and governance systems to drive continuous improvement in the service.
- There was no evidence of reflective practice and service improvement. Information to support performance monitoring and decision making was unreliable and out of date.

● Investigations into accidents, incidents and near misses lacked the full rigour needed to identify any required learning.

The provider had failed to fulfil the legal requirements of their role, to ensure compliance with regulations, to assess, monitor and improve the service to ensure that quality and safety were not compromised and to mitigate risks to people was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Providers must notify CQC of all incidents that affect the health, safety and welfare of people who use services. The provider did not fully understand their regulatory responsibilities and had failed to notify the CQC of two incidents involving the psychological and physical abuse of two different people.

The failure to notify CQC of these incidents was a breach of Regulation 18(1)(2) of the Care Quality Commission (Registration) Regulations 2009

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 did not have a policy in relation to the duty of candour policy which identified the actions the registered manager and staff must take, in situations where the duty of candour applied.

● The provider and management team did not clearly understand their responsibilities to inform people, or their representatives, when things went wrong, and the importance of conducting honest and transparent investigations to identify essential lessons to prevent further occurrences.

● Reporting of incidents, risks, issues and concerns was unreliable or inconsistent, and may have been discouraged. People, their families and staff had not always been told about incidents, or how the service has responded to them.

● Where concerns had been raised or accidents and incidents had occurred, the management team had not completed thorough investigations or spoken directly to people to explain the circumstances, action they had taken and to apologise.

● We reviewed an incident of neglect and an incident of abuse which met the criteria of a notifiable safety incident. The registered manager had not provided an accurate account of all the facts about these incidents. They had not advised the relevant people what further enquiries into the incidents the registered person believed were appropriate, had not offered a verbal apology, followed by a written apology, and had not kept a written record of the actions taken which showed their compliance with the regulation.

The provider had not complied with their duty of candour in relation to these notifiable safety incidents, which breached Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff consistently told us the service had experienced poor leadership until the deputy manager assumed responsibility for managing the service. Staff told us the service was now demonstrating significant signs of improvement due to the commitment and dedication of the provider and deputy manager. The deputy manager and provider had begun to develop an open positive culture within service, which was supportive and inclusive.

● Staff told us now felt confident to raise concerns with the provider who was approachable and made them feel supported and valued.

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

● Relatives consistently told us they felt the communication with staff made them feel part of 'the team' and their contributions were valued.

● Relatives felt fully involved with the care and support being delivered and felt they could provide their views when required. One relative told us "I have always felt comfortable raising any concerns with management. As I visit weekly, I've always found them very approachable."

● Staff consistently told us they now felt empowered and were working together with the new management team for the benefit of the people living at Downshire House. For example, staff said the nominated individual, new manager and deputy manager were approachable and responsive to new ideas. One member of staff told us, "The atmosphere has changed like a cloud lifting from over our heads. We [staff] are now listened to and feel part of a team."

● Staff were enthusiastic about their role in supporting people and spoke with pride about people they supported.

Working in partnership with others

● We found there was poor collaboration with external stakeholders and other services. Information was not shared as required and there was little evidence of partnership working.

● The provider was not effectively engaged with community learning disability or mental health teams.

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 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met: The provider failed to notify CQC of notifiable incidents Regulation 18 (1)(2) Care Quality Commission (Registration) Regulations 2009: Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had failed to establish and effectively operate systems to assess, monitor and mitigate risks to people to ensure their safety. Regulation 12 (1)(2)(a)(b)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider had failed to assure and regularly review staff were of good character, suitably qualified to support people living with autism

	or a learning disability. Regulation 19(1)(a)(b)(c) (2)(a)(5)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour How the regulation was not being met: The provider had not complied with their duty of candour in relation to notifiable safety incidents. Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: The provider failed to deploy enough suitably qualified, competent, skilled and experienced staff to meet people's needs and keep them safe . Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice

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 maintain effective scrutiny over safeguarding issues and had not effectively implemented and operated robust procedures to protect people from abuse and improper treatment. Regulation 13(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met

The provider had failed to fulfil the legal requirements of their role, to ensure compliance with regulations, to assess, monitor and improve the service to ensure that quality and safety were not compromised and to mitigate risks to people.

Regulation 17 (1) (2) (a)(b)(c) (d) (f) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning Notice