

Mr Marko Raphael Korosso

Aston House

Inspection report

16 Queensberry Road
Kettering
Northamptonshire
NN15 7HL

Tel: 01536517716
Website: www.lifestylecaresupport.com

Date of inspection visit:
03 February 2022
10 February 2022

Date of publication:
05 May 2022

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

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.

Aston House is a residential care home providing personal care to five people at the time of the inspection. The service can support up to a maximum of five people.

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

Right Support

Risks in the environment had not always been assessed and mitigated. This meant people were at an increased risk of harm, such as scalding and fire.

Medicines were not always managed safely. Medicine risk assessments were not always in place and staff recording of medicines required some improvement.

People were not consistently protected from the risk of infection. The provider had not always ensured government guidance and their own policy and procedure was followed by staff.

A process for recording accidents and incidents meant the provider could monitor for trends and patterns and plan care accordingly.

There was a good supply of PPE in the service that staff were using appropriately.

Systems and processes were in place to protect people from the risk of abuse and staff had a good understanding of how to raise concerns. Relatives told us they felt people were safe and staff were kind, caring and knew people and their needs well. Staff were recruited safely and were checked for their suitability to work with vulnerable adults.

Right Care

Mental capacity assessments (MCA) had not always been completed to establish if people could or could not make some of the more complex decisions around care for themselves. We found deprivation of liberty safeguards (DoLS) had not been applied for in a timely manner. People were making decisions in other areas such as foods and drink, activities and washing and dressing.

People were assessed prior to moving into the service to ensure their needs could be met. The assessments

and care planning process considered people's health conditions, religion, relationships, culture, likes, dislikes and hobbies.

People were well supported with food and drinks and making their own choices. People were taking an active role in the kitchen and could access snacks and drinks whenever they wished.

The provider had worked in partnership with health and social care professionals to ensure people had timely access to health care and routine screening.

Right culture

The providers internal systems and processes had not been effective in identifying the concerns we found during the inspection.

Supervisions were not always conducted in line with the providers policy and some staff were overdue annual refresher training. However, we found staff to be knowledgeable around people's health and social care needs.

New staff told us they felt well supported with a training and induction process and were given time to get to know people.

The provider was open to feedback and started work on improvements immediately after the inspection.

People and their families were actively involved in the service. People's communication needs had been assessed and people were supported to communicate and express their opinions and choices.

The provider had started to refurbish the home, with some work already completed that included people's choice and preference. People were able to personalise the home to their preference including personal possessions and artwork.

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 (published 17 April 2020).

Why we inspected

This inspection was initially a targeted inspection looking at the IPC practices the provider had in place. However, during the inspection we found concerns with safety, MCA and managerial oversight of the service, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe, effective and well-led. We assessed if the service is applying the principles of right support right care right culture.

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.

Enforcement

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, well-led relevant sections of this full report.

We have identified three breaches in relation to safe care and treatment, need for consent and good governance at this inspection.

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

Following the inspection the provider made immediate improvements around fire safety to mitigate the risks.

Follow up

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Aston 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 Care Act 2014.

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

One Inspector and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Aston House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection

We gave the service 24 hours' notice of the inspection. This was because the service is small and people are often out and we wanted to be sure there would be people at home to speak with us.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan

to make. This information helps support our inspections. We requested information from the local authority. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We communicated with two people who used the service and three relatives about their experience of the care provided. People who used the service who were unable to talk with us used different ways of communicating including objects and their body language.

We spoke with the team leader who was supporting the service in the temporary absence of the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider, for this service the nominated individual is also the provider.

We reviewed a range of records. This included four people's care records and three people's medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data, electronic care records for people, policies and procedures and quality assurance records. We spoke with three care staff.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely

- People were not consistently protected from the risks of fire. During the inspection we found the emergency evacuation lighting was not working, fire exit keys were not easily accessible, and a fire escape staircase was covered with fallen leaves and moss. Fire safety checks such as fire alarm testing was found to be inconsistent. This meant people were at risk of not being able to evacuate safely in the event of a fire.
- Risks in the environment had not consistently been assessed and mitigated. For example, radiator protective covers were damaged, and people could easily access exposed hot water pipes meaning people were at increased risk of scalding. Not all windows were fitted with appropriate locking mechanisms to prevent falls from height.
- Medicines were not consistently managed safely and in line with best practice guidance. For example, we found that as and when required medicines did not always include a record of the reason they had been given. This meant that trends and patterns of pain could not be monitored.
- Risk assessments were not completed to support the safe management of flammable creams. This meant that people were at increased risk of burns.

Systems had not been effective in monitoring and mitigating risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, a fire protection officer visited the service to help the provider improve. The provider completed a risk assessment and arranged immediate repairs and improvements to ensure peoples safety.

- People had personal emergency evacuation plans (PEEP's) in place which provided guidance for staff on how to support people to evacuate the building in an emergency.
- Risks to people associated with healthcare conditions had been assessed and mitigated. For example, people at risk from seizures or choking had individualised risk assessments and protocols in place for staff guidance.
- Staff had received training in supporting people with medicines. Staff could competently explain consent and best practice guidance around the administration of medicines.

Preventing and controlling infection

- People were not always protected from the risk of infection. At the time of the inspection staff COVID- 19 testing was not being conducted in line with government guidance, the providers policy did not reflect the

requirement in place at the time.

- Clinical waste was not being managed in line with current guidance or the providers policy. We found clinical waste was being disposed of in bins that were not lined, and the contracted waste bin was easily accessible from the highway and remained unlocked throughout the inspection.
- Cleaning records were not consistently completed to evidence regular cleaning was taking place. We found that one of the bathroom floors had ingrained dirt, a dirty bathmat and the hand soap had not been replenished. Another bathroom was found to be visibly unclean on the walls and surfaces.
- Staff were unaware of the requirement to check the COVID-19 vaccination status of visiting professionals which was in place at the time of the inspection. The inspector was not asked for evidence of vaccination or evidence of a negative COVID-19 lateral flow device test result. However, family visitors had been required to provide negative COVID-19 lateral flow device test results prior to accessing the home.

Systems had not been effective in monitoring and mitigating risks to the health and safety of people using the service. This placed people at risk of harm. This was a breach of regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider was using PPE effectively and safely.

We have also signposted the provider to resources to develop their approach.

Staffing and recruitment

- There were enough staff to meet people's needs. Some people required one to one or two to one support, we observed this was well organised. Staff told us that there was always the correct number of staff on each shift to meet people's needs.
- Safe recruitment processes ensured only suitable staff were employed by the service. Disclosure and Barring Service (DBS) checks were completed prior to staff working at the home and these were regularly updated. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

- Systems and processes were in place to protect people from the risk of abuse. Relatives told us they felt people were safe and staff were kind and caring. One relative said, "I know [relative] is safe there and they feel it, if [relative] was unhappy they would cry when it was time to go back and they don't [relative] happily goes."
- Staff had a good understanding of how to escalate concerns through internal systems as well as how to whistleblow outside of the organisation.
- There were protocols in place to protect people during periods of heightened anxiety. Staff were able to explain how they would ensure people were protected and supported.

Learning lessons when things go wrong

- Staff had a good understanding of managing accidents and incidents and the importance of recording for the monitoring of trends and patterns. The provider kept records of incidents and care and support was adapted as required to prevent reoccurrence as much as possible.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- There was limited evidence that mental capacity assessments (MCA) were taking place. Where they were completed, they did not evidence that best interest decisions had been made with the person, their relative or advocates involvement. For example, we found people were being tested for COVID-19 and had received COVID-19 vaccinations without MCA's and best interest decisions being recorded. Relatives could not recall being consulted around COVID-19 testing but had been asked to give consent for vaccinations. A mental capacity assessment would have helped establish if people were able to make this decision for themselves. This meant people were experiencing care that may not be their choice or in their best interest.
- The provider had not ensured DoLS applications for people had been made in a timely manner. We found that all peoples DoLS had expired prior to reapplication and for one person the provider could not provide evidence of a previous DoLS, despite the person having lived in the service for a number of years. This meant people were at risk of being deprived of their liberty without the legal authority in place for the provider to do so.

Systems had not been effective in ensuring consent to care and treatment. This placed people at risk of receiving care and treatment without the legal authority required to do so. This was a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed this with the provider who acknowledged a need for improvement in this area and advised

they had started improvements following our feedback.

- Staff had a good understanding of what consent to care means, and were able to tell us how they sought consent to care and treatment via various communication methods prior to delivery. One staff member told us of the importance of "Not forcing people to do anything they don't want to do." Another staff member told us they were respectful of people's private space and seeking consent before entering rooms by knocking and waiting to be invited in.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People had a thorough assessment of their needs before moving into the home. This included the involvement of relatives, advocates and other members of the person's multi-disciplinary team.
- People's health conditions, religion, relationships, culture, likes, dislikes and hobbies were all included in the assessment process. This information was used to plan people's care and support.

Staff support: induction, training, skills and experience

- Some training updates were overdue. The provider was taking steps to address this and staff told us they were completing training frequently to ensure they were compliant.
- Staff told us they felt well supported by the management team. One staff member told us the provider visited the home regularly and they felt able to discuss any ideas or concerns with them.
- An induction process was in place for new staff which included mandatory training and shadowing of experienced staff. One staff member told us they felt they were given time during induction to get to know people using the service and their individual needs. Relatives told us staff were knowledgeable around their relative's needs. One relative told us, "Their knowledge of my [relatives] and their needs mean they know them inside out."

Supporting people to eat and drink enough to maintain a balanced diet

- People were well supported with food and drink. People were making their own choices around what they ate and were supported to ensure they maintained a balanced diet. Cultural food choices were planned into menus' and where people had food allergies this was assessed and managed to keep them safe. Snacks were available when people wanted them. A relative told us, "As well as a menu with pictures there are cards with pictures of snacks on which they can choose when they feel peckish."
- People's individual needs were met around mealtimes. For example, where people enjoyed the social experience of eating together in a communal dining room, their preference of where they sat and with whom was respected and supported.

Adapting service, design, decoration to meet people's needs

- People's rooms were decorated to their preference and we saw that personal possessions and artwork were displayed. People had also decorated communal areas with their own art.
- Pictorial charts were placed around the home to support people with communication and activity where required.
- Two of the home's bathrooms had recently been refurbished. One person was able to communicate with us via objects of reference and body language that they preferred a shower and showed us that they had a shower fitted in their bathroom which pleased them.

Supporting people to live healthier lives, access healthcare services and support

- People had access to regular NHS health screening checks and dentistry. Access to a G.P when needed had been well supported and there was regular pharmacy input to ensure people received the medicines they needed. A relative told us, "Staff let us know about regular appointments and they accompany them at

the Dentist, opticians and Drs, if [relative] is ill or has a fall they always let [next of kin] know."

- Staff demonstrated a good understanding of people's health care needs and what action to take in an emergency. Emergency grab sheets were available to ensure a smooth transition for people between services.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Systems and processes had failed to identify the concerns we found during inspection. For example, where regular audits of people's files had taken place, they had failed to identify that a number of outdated records remained in place that no longer reflected the care people received. The risk to people was somewhat mitigated as staff knew people well. Despite regular visits and reports from the provider, risks in the environment had not been identified and acted upon in a timely manner.
- Policies and procedures had not consistently been updated to reflect current government guidance and were not available to staff in the home to support them in their role.
- Staff had not consistently received a supervision in the line with the providers policy and procedure and a number of training updates had gone over their renewal due date.

Systems and processes had not been effective in maintaining oversight of the safety and quality of the service. This placed people at risk of harm. This was a breach of regulation 17 good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had understood the need to inform the Care Quality Commission of significant events and had completed statutory notifications when required.

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

- The provider had not always ensured people were empowered and included in decisions about their care. The lack of mental capacity assessments meant we were not reassured that the provider had fully considered all decisions people could or could not make for themselves with support. However, care plans were written in a person-centred manner and included people's preferences likes and dislikes and there was evidence that staff supported people's choices around the care and support they received.
- Staff told us there was a positive atmosphere in the home with people and staff getting along well. During the inspection we observed people to be comfortable and relaxed around staff, seeking support when they needed it. Staff encouraged people to be as independent as possible and there was evidence of positive outcomes for people. For example, one person had been encouraged to manage a health condition with support from staff and there had been an improvement in this condition for them.

Continuous learning and improving care; Working in partnership with others

- The provider and management team were open and transparent throughout the inspection. Following the inspection, the provider acknowledged where improvements were required and began to implement these immediately.
- The provider was in the process of transferring record keeping to an electronic system to help them maintain oversight of people's care.
- A refurbishment plan was underway with some works completed; this would need to be continued to ensure a good standard of accommodation for people was achieved.
- There was evidence of the provider and management team working in partnership with health and social care professionals such as social workers, GP's and the community learning disability team.

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

- The provider had a good understanding of the duty of candour. Relatives told us they were kept well informed of concerns, incidents and accidents and the provider and staff were open and transparent.

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

- Staff told us they felt well supported by the provider and management team and were able to raise concerns and share ideas. One staff member told us regular meetings took place and where this involved discussions about people and their care, people, their relative or advocate attended.
- Relatives felt included as partners in their relative's care. Relatives received regular updates about their relative's life in the home which included photos and videos of activities achievements and daily life. A relative told us, "We have regular zoom meetings with his key worker and the manager." Another relative said, "The communication is excellent, about important things but also about everyday life."
- People's communication needs had been assessed and systems put in place to help with communication such as, objects of reference or pictorial cards. This helped people engage with staff and express their wishes. A relative told us, "Staff try everything to try and communicate, from communication boards to picture boards or items of reference." We saw that people were involved in the running of the home from helping with cooking to carrying out their own domestic tasks.

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 The provider had not consistently ensured consent to care and treatment in line with law and guidance.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not consistently ensured that the service was safe and risks to people were mitigated.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not consistently maintained effective oversight of the safety and quality of the service.