Mauricare Limited

A S Care

Inspection report

138 Westcotes Drive
Leicester
Leicestershire
LE3 0QS

Tel: 01162334300
Website: www.mauricare.com

Date of inspection visit:
09 August 2022
10 August 2022

Date of publication:
02 March 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
A S Care is a residential care home providing the regulated activity personal care to up to 25 people in one adapted building. The service provided support to older people with dementia, mental health concerns, physical disability and sensory impairment. At the time of our inspection there were 20 people using the service.

People's experience of using this service and what we found
The environment was not always safe. The provider's own systems and processes to review the environment had not identified all the concerns we found at inspection.

Medicines management was not always safe. Care plans were not always up to date and sometimes lacked detail. People's communication needs were not always addressed. End of life care planning was not always thorough.

There were not always sufficient suitably trained and recruited staff working at A S Care.

Infection prevention and control measures were sometimes lacking.

People were not provided with person-centred activities. They were not asked for their feedback and were not included in care plan reviews routinely.

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

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 24 December 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
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.

This inspection was carried out to follow up on action we told the provider to take at the last inspection. We also received concerns in relation to staffing and the environment. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only. We inspected and found there was a concern with person centred care, so we widened the scope of the inspection and included the key questions of Responsive.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed to Inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe, Responsive and Well-led sections of this full report.

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

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

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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, safeguarding service users from harm, maintenance and upkeep of premises and equipment, good governance, staffing and fit and proper persons employed, at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. The appeals period has now ended for this, and we have issued the provider with conditions.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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

If the provider has not made enough improvement within this timeframe. And there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below

Inadequate

A S Care

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
The inspection was carried out by two inspectors. An Expert by Experience made phone calls to people's relatives, to gather feedback on the care provided. 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
A S Care is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. A S Care 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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with seven people who use the service, and ten relatives about their experiences of the care provided. We spoke with three external health or social care professionals who were involved in people's care at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with nine members of staff including care staff, cook, laundry worker, registered manager, director and quality lead. We reviewed a range of records. This included six people's care records and multiple medicine records. We looked at four staff files in relation to recruitment. A variety of records relating to the management of the service, including staff training records, policies and procedures were reviewed.

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

Inadequate

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.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- General upkeep of the building was lacking. There were several areas where the home needed decorative repair and replacement of broken windows. For example, the carpet on one staircase was ripped which was a tripping hazard.
- Maintenance of the property was not satisfactory and put people at risk of harm. For example, we identified one wardrobe not fitted to the wall to prevent it toppling.
- Risks to people had not always been addressed. An emergency call alarm button was broken in one person's room, meaning people were at risk of harm if the alarm needed to be sounded in an emergency.
- Window restrictors were not effective in two windows in the floors above ground floor. One was not fully attached to the window frame and in another the restrictor had too much freedom to move making it ineffective. This put people at risk of falling out of the window.
- The environment was not always kept clean. Whilst cleaning schedules were in place, cleaning was not always being completed and the cleaning schedules showed this because there were lots of gaps on the records, for example communal toilets had not been cleaned daily. There was also leaks in two bathrooms, which meant it was hard for staff to keep the bathrooms adequately clean. Also, we saw soft furnishings which were heavily worn and stained, meaning cleaning staff were unable to fully clean these armchairs.

As a result of the poor maintenance of premises, people were at risk of harm. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Infection prevention and control measures were not always in place. For example, we saw hand towels were available in communal bathrooms rather than disposable paper towels. Where paper towels were available in some communal bathrooms, there was not always a bin to dispose of this waste.
- We observed staff did not always wear facemasks in line with the government guidance. Sometimes staff had their facemasks below their nose or chin. This put people at risk of respiratory infections, such as COVID-19.
- People were at risk of using a water supply colonised with legionella. Despite regular water flushes being recorded, a water test had shown a colonisation of legionella and some taps had a build-up of limescale at

their opening. This put people at increased risk of legionnaire's disease.
● Care plans were not always up to date and sometimes lacked detail. This meant care workers did not always have sufficient information to guide them to the way best to support a person. For example, care workers were not clearly guided what to do in the care plan for people with epilepsy, should the person have a seizure.
● Personal emergency evacuation plans lacked detail about people's emotional needs. This meant in an emergency those evacuating people from the service may not be equipped to support the people in the most appropriate way.

Infection prevention and control measures were not fully embedded and there were risks to the health, safety and welfare of people using the service. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Visiting was facilitated in the care home. People were encouraged to have visitors and visitors felt the home was generally clean when they visited.
● A ground floor fire exit was blocked by a device which was not in use, which was usually used to help people to stand so they could move, for example when transferring from wheelchair to armchair. This was moved straight away when brought to the attention of staff. The provider took action to address the concerns with the two ineffective window restrictors during the inspection and with the water supply, and maintenance following the inspection.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Using medicines safely
● Medicines management was not always safe. Medicines which were taken 'as required' (PRN) did not always have sufficient information to guide staff to the correct timing between doses. This put people at risk of over or under dosing of their PRN medicines.
● Medicines records were not always completed consistently. Where PRN medicines had been given, staff did not always record the reason why the PRN had been given and its effectiveness.
● The medicines room temperature was recorded daily, however the temperature was frequently outside the recommended ranges for medicines. The regular cooling system in the medicines room was not working, and a plug-in air cooler system was in use, but this was ineffective. This put people at risk of receiving medicines which were stored outside the recommended therapeutic range.

There was a risk that medicines might not have been administered safely or effectively. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines issues were addressed by the registered manager following the inspection.

Staffing and recruitment

● Staff were not always up to date with training. With the exception of one staff member, staff were not up to date with their annual training and ten staff had not completed competency checks in moving and handling last 12 months. One resident told us, "I wonder if they (staff) are trained."

● Staff were not all up to date with safeguarding training. Five staff out of a total of 20 had not completed annual safeguarding training within the 12 months before the inspection took place.

● Staff told us there were some areas they felt they would benefit from more training on. This included diabetes and end of life care. One senior staff member was recorded as having completed the annual training in the last 12 months on diabetes but told us they had not had any training in diabetes. This suggested the training provided was not sufficient and staff were not all able to describe the symptoms if someone was becoming unwell with diabetes.

● There were not always enough staff to support people. For example, the rota provided showed over a three-week period there were three shifts where staffing did not meet the service's own calculated minimum safe staffing levels. For example, on one-night shift there was one senior care worker and one care worker on shift. When a person needed support from two staff to reposition them or support their continence needs, there would have been no other staff available to support other people or answer call bells. Three relatives told us there were not enough staff. One told us, "It's not a criticism of the staff, there are just not enough staff."

This lack of sufficient numbers of suitably qualified, competent and skilled staffing was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recruitment files were not always complete. They did not always contain a full employment history, and some lacked the minimum of two references as set out in the provider's own policy for recruitment. The provider had failed to ensure safe recruitment practices.

The lack of safe recruitment practices put people at risk of receiving care from staff who were not suitable. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Disclosure and Barring Service (DBS) checks had been completed. DBS checks provided information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

At the last inspection, accident and incident management and oversight was not fully effective, which meant the records, management and learning opportunities from safeguarding issues was missed. This placed people at risk of harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

●Learning opportunities from safeguarding incidents had improved and safeguarding was discussed at team meetings.

● Staff we spoke to were aware of safeguarding processes and how to report abuse should it occur.

Learning lessons when things go wrong

● Action following incidents had not always been taken. For example, one service user had an unwitnessed fall out of bed. There had been no observations completed or additional notes about the follow up after the incident. This placed the person at risk of harm as they may have had an injury which was not identified, and lessons could not be learnt as full reflection had not been completed.

● The registered manager and provider were quick to address urgent concerns we identified at inspection by getting a maintenance person from the provider to attend A S Care, for example the two window restrictors were fixed the same day to reduce risks to people.

Requires Improvement

Our findings

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

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

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were not always addressed. Where people had communication needs, care plans, which guide staff to the way to support people, lacked detail about the types of activities people could take part in despite their communication needs. One relative said, "[Name] can make [their] own decisions, when [they] are able to hear, but [they] don't have any hearing aids and [they] need better glasses. I tried to raise it, but nothing was done. I will try and raise it again today. It makes [them] separated from everyone."
● Following the inspection, staff were supported to access training. Where staff were unable to access training online due to difficulties with understanding the online training for example where communication issues had occurred, the registered manager arranged face to face group staff training.
● We heard about one service user whose needs were met with picture cards to support staff to interact with a person where a barrier to communication was present.

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
● There was a lack of activities. Relatives told us there were not many activities that took place at the service. One relative said, "I don't see too much happening that way." Whilst another relative told us, "There used to be a board up, it's still there, but (there is) not much on it now. I thought they don't do a lot of activities."
● People at the service told us they have no activities provided to them in their bedrooms and those who were in the lounge told us they sit around the outside of the room and watch television. One person said, "Nobody's bothered much, you can see it now and nothing else other than that telly. It's on all the time".

● Social isolation was reduced by the encouragement of visitors to the home and for relatives to take people out. Also, a recent summer fete was held, which relatives were invited to.
● We found, one person was supported to attend a culturally relevant day centre.

Improving care quality in response to complaints or concerns
● Concerns were not always dealt with effectively. We were told by people and relatives they had raised concerns verbally, but there was no record of concerns reported informally to the service.
● One formal complaint had been received by the service since the last inspection. The registered manager failed to identify the complaint as possible neglect and so had not informed CQC until prompted by the inspection. Family told us they were satisfied with the outcomes the service took and following this complaint, the service had put things in place to reduce the likelihood of the situation being repeated.
● People and their relatives gave us mixed feedback about how concerns are dealt with. One person told us following them sharing concerns, "Things are said but not followed through." Whilst a relative told us, "If I have any concerns, I am more than happy to go to them, and they sort it out."

End of life care and support; Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● When we inspected the service there was no-one being cared for at the end of their lives. However, when we spoke with staff about training on end of life care, one staff member said, "I could do with a bit more training on that. I don't think they give you a lot of training." This meant when people move to the end of their lives staff might not feel able to support people appropriately.
● Care plans did not contain sufficient information about people's wishes for their end of life care. This meant when people moved to that end stage in their lives, staff may not be informed about individual's wishes about how they should be cared for.
● People and relatives told us they were not involved in reviewing care plans and we did not see evidence of people/relatives being involved in care plan reviews.
● Care plans contained person-centred information. An example was one person's eating and drinking care plan stated they liked to eat their meals in the quiet room as being around too many people made them anxious. The care plan went on to describe clearly steps staff should take to assist the person with their meal if they become distressed and we saw evidence staff followed this guidance.

Inadequate

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

At the last inspection, the provider's governance and oversight systems were either not in place or robust enough to demonstrate all aspects of the care and safety in the service was effectively managed. 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.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The providers systems and process had failed to ensure the safety and quality of service provision. Governance audits had not identified the concerns found on inspection meaning people were at risk. For example, we found environmental concerns with a lack of effective window restrictors which had not been addressed until the inspection. This had put people at risk of falls from height.
● Systems and processes were not in place to ensure effective communication to staff. For example, people's dietary requirements were not communicated to staff effectively. Whilst we did not see anyone receive an incorrect diet, the registered manager told us they had a file the kitchen displaying dietary requirements for people, but staff were not aware of this information. This put people at risk of receiving the incorrect diet.
●Your systems and processes failed to identify personal emergency evacuation plans (PEEP) lacked detail about people's emotional needs. This meant people who may become distressed during an emergency evacuation had not been identified and person-centred actions had not been included within the PEEP.

● Oversight of care plans was lacking, this meant we found information within a care plan that had not been updated to show the up to date needs of a person. This meant staff may not have the most up to date information available to them, to guide the correct care.
● During a SOFI (Short Observational Framework for Inspection), we observed some poor interactions between staff and service users. Staff were observed to leave a person mid-conversation and to close the curtains in the lounge on a sunny day, presumably to provide shade, without informing people what they were doing. This culture would make people feel like they are not valued, and it was not picked up by the provider.
● Relatives did not feedback positively about the provider. One relative said, "The people who own the home, could take a bit more interest," and, "The owner of the actual place doesn't treat the staff with respect, it's the way [they] talk to them. I have witnessed it for myself." There was a lack of system and process in place to obtain feedback from people and relatives. Most relatives told us they had not been asked for their feedback about the service. One relative told us they had not been asked for their views, they said, "No views (and) no care plan is talked about." We found there had been no structured feedback sought from people who live at the service since the last inspection.
● Incident records lacked detail. This included a witness statement, follow up actions, and on one form a signature and date of the person completing the form was missing. This had not been identified by the provider's own oversight processes. This meant lessons may have been missed about how to improve care.
● There was a lack of oversight for staff training. Whilst a system was in place to identify where gaps in annual training were, this was not acted upon by the registered manager in a timely way. This meant staff did not always have up to date training for their role.
● Staff recruitment processes were not followed in line with the service's own policy around recruitment. For example, there were not always two references obtained before employment for each staff member. This placed people at risk of care from people who were not suitable for the role.

Systems and processes to monitor the quality and safety of the service were ineffective. Oversight of the service was lacking. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Two relatives we spoke to did not know who the registered manager was. The remaining relatives who know who the registered manager was, spoke about the registered manager in a positive way. One relative said, "[Registered Manager] is very lovely, very approachable very caring and informative."
● Staff meetings were held regularly. We saw evidence of a range of supportive topics being discussed with staff, such as COVID-19 and moving and handling.

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 registered manager was able to tell us what the duty of candour meant.
● The registered manager was able to provide examples where they had applied the duty of candour. We heard from relatives where this had been applied, who told us, "I am happy with the outcome, I really liked they tried to ring me, and they were open about this." The relative confirmed the registered manager had spoken to them.

Working in partnership with others
● The staff work well with other organisations. One professional who works with the staff told us, "Communication is really good - if anything is recommended, they do listen and take it on board."
● The registered manager seeks help from professionals in a timely way for any areas of pressure damage.

We were told by a visiting professional, "When they notice anything, they phone, and we come out. Usually it is very superficial and caught early."

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure safe recruitment practices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there was sufficient numbers of adequately trained staff, which placed people at risk of unsafe care.

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure safe care and treatment was always provided at the service. This placed people at risk of harm.

The enforcement action we took:

Imposed a condition on their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the premises and equipment were clean, suitable for the intended purpose, maintined and appropriately located. This placed people at risk of harm.

The enforcement action we took:

Imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to effectively monitor and improve the quality and safety of the service. This placed people at risk of harm.

The enforcement action we took:

Imposed a condition on the provider's registration.