Mauricare Limited

A S Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 23 and 24 August 2016 and was unannounced.

A S Care provides residential care for up to 25 people many of whom are living with dementia. At the time of our inspection there were 22 people in residence. Accommodation is provided over three floors with access via a stairwell or passenger lift. Communal living areas are located on the ground floor. The service provides both single and shared bedrooms, with some having en-suite facilities.

A S Care had a registered manager in post at the service at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager at the time of our inspection was on planned extended leave and the deputy manager was on planned leave. The provider arranged for a manager of another service they owned to facilitate the inspection.

The provider did not have in place systems or processes to assess the quality and safety of the service being provided and therefore had not identified that improvements were needed. The leadership and management of the service were not effective. This directly impacted on the quality of support and care people received and meant they did not experience the best possible health and quality of life outcomes.

People's opportunities to influence the development of the service were sought. We found no evidence that where comments were received, these had been acted upon by the provider. The provider and staff did not actively promote an open and inclusive environment for people, especially with regards to those living with dementia. People living with dementia were not supported by staff that had a good understanding of their needs and people's care plans and records reflected this. Information written as to the care people required or received did not show an awareness on the part of staff as to people's individual needs and how dementia affected people in all aspects of their day to day lives.

People did not receive person centred care; there were institutional approaches and practices to care being observed and documented, which meant people did not receive individualised care or care as detailed within their care plan. Our observations and the contents of records evidenced a lack of understanding as to the rights of people and demonstrated a lack of respect afforded to those living with dementia as their views were not listened to or acted upon.

Poor record keeping and communication contributed to staff not being effective in providing appropriate care and support, which included information shared amongst the staff team as to the needs of people as well as inconsistencies in the training, supervision and appraisal of staff.

People's safety could not be assured as records were not always accurate and information staff had access to promote people's safety, which included risk assessment and care plans did not contain sufficient or consistent information. Records that were to be accessed in an emergency were not always up to date having the potential to impact on people's safety and welfare.

People's records evidenced that the needs of some had been monitored, with appropriate referrals being made to health care professionals. Records reflected people's care plans were in some instances followed and measures taken where concerns had been identified by staff. However, this practice was not consistent to protect and promote everyone who used the service.

Systems for the management of people's medicine were not robust, which had the potential to put people's health and welfare at risk. A procedure for the administration of people's medicine was not in place. We found medicine administration records were not completed in full and there were no instructions for staff to follow when administering medicine that was prescribed to be taken as and when needed, which had the potential for people not to receive their medicines consistently.

The internal and external environment whilst maintained did not take into account the needs of people living with dementia and there were no plans to develop the service reflective of current good practice or guidance.

People's nutritional needs were met, however the dining experience of people was not optimised and people's involvement in decisions about their meals were not sought.

The approach and attitude of staff towards people was not consistent in promoting people's quality of life. We observed examples of staff working with people well, providing reassurance when they were distressed and encouraging them to take part in daily activities. However the opportunities for people to take part in the day to day living activity were very limited. Whilst some people did spent time in the garden a majority of people sat with their eyes shut in an armchair within one of the communal rooms.

People who used the service and visiting relatives spoke positively about the care provided and relatives told us they had made a decision to access the services of A S Care as they had confidence in the care their relative had received. Relatives told us they had been involved in the initial assessment of need and had met with the provider and manager who had welcomed them to the service.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff did not have sufficient knowledge or awareness as to the potential impact of their approach and attitude to people had on their well-being.

The management of risk was not sufficiently robust or reflective of the provider's policies with regards to supporting people whose behaviour could be challenging.

The deployment of staff was not a factor in ensuring the individual needs of people were met.

The system for the medicine management was not robust and had a potential for people not receiving their medicines at the right time to maintain their health.

Is the service effective?

Requires Improvement

The service was not consistently effective

People did not receive effective care as the knowledge and understanding of the provider and staff was supportive or reflective of the needs of people using the service.

Staff had an awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards and its implications for people using the service.

People's involvement in decisions about their food choices was limited.

People had access to health care professionals, however the monitoring of people's health was not always fully understood by staff as care plans were not reviewed and records not always completed accurately.

The external and internal environment was not reflective of good practice guidance in supporting people living with dementia.

Is the service caring?

Requires Improvement

The service was not consistently caring

Staff approach to people was not fully reflective of a caring relationship as staff understanding and knowledge on people's needs was not fully understood.

People's views were not always actively sought, listened to or acted upon, which meant the care they received was not tailored to their individual needs.

People's dignity was not always promoted as records and information evidenced a lack of knowledge and understanding by staff of people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

The day to day management and running of the service did not promote a personalised and individualised approach to care.

People's complaints had been listened to and responded to and visitors told us they would be confident to raise a concern.

Is the service well-led?

Inadequate

The service was not well-led

The provider was not proactive in providing opportunities for people using the service or other interested parties to influence the service provided to drive improvement.

The provider did not demonstrate good leadership and management of the service.

Governance and quality assurance systems were not robust and therefore the quality of the care being provided was not understood. This limited the provider's ability to ensure the appropriate resources were in place to bring about the necessary improvements, in a considered and measured manner.

A S Care

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 and 24 August 2016 and was unannounced.

The inspection was carried out by one inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was completed and returned.

We contacted commissioners for social care, responsible for funding some of the people that live at the service, and asked them for their views about the service. We also reviewed the information that the provider had sent to us which included notifications of significant events that affect the health and safety of people who used 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 to us.

We spoke with four people who used the service and five visiting relatives. We spoke with a manager. The manager was requested by the provider to facilitate the inspection. The manager facilitating the inspection worked at another service owned by the provider. We spoke with two senior care staff, three care staff and a cook. We looked at the records of five people, which included their plans of care, risk assessments and medication records. We also looked at a range of policies and procedures, maintenance records of equipment and the building and the minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe and when we asked them why they one person told us, "The girls [staff] are good to us." And another said, "There's nothing to worry about here."

People's relatives who were visiting told us they believed their relative to be safe and when we asked why they told us, "I have confidence in the staff to keep [person's name] safe." Another said "When I visited the home the staff I met with gave me confidence." They told us this was due to the friendliness and approach of staff when they visited.

We found evidence that people's safety and welfare meant they were not were not consistently protected from harm and potential abuse. Concerns identified by staff regarding aspects of people's health and welfare had been referred to health care professionals who had requested that the service monitor and record incidents of people's behaviour when challenging. Records completed showed that staff had not received guidance or any instructions on the completing of the forms. For example, the antecedent for a person's behaviour was in some instances recorded as the location the incident took place, such as 'hallway'. An example of a person's behaviour had been written as 'tried to get out the door and told not to, told to move away and hit a member of staff.' The consequence was written as 'told to sit in the annex and stay there'. This meant the approach of staff to identified risks were not appropriately managed and had the potential to affect people's safety as their freedom was not supported or respected.

Risk assessments were completed where people could be at risk of potential harm or abuse. Care plans to provide guidance for staff in the support of people when their behaviour became challenging, were reviewed. However there was no clear and individual guidance identified within the risk assessment or care plan as to the approach of staff. There was no recognition that people's behaviour should be considered as a method of communication. This meant people's welfare and safety was not supported as staff lacked guidance and understanding as to how to support people. Some guidance for staff was included within the care plan, such as encouraging the person to engage in everyday activities or distract them by suggesting a walk in the garden. Staff we spoke with told us where people's behaviour became challenging, they tried to distract them, by talking with them, taking them for a walk around the service or in the garden.

We found there to be unsafe practices in the management of people's medicine. Medicines had been prescribed by health care professionals to some people whose behaviour could at times be challenging, which was to be administered as and when required. We found there were no guidelines or procedures in place to direct staff on the administration of the medicine to ensure it was given consistently to promote its effectiveness for the person in question. We asked staff responsible for the administration of medicine as to when they administered the medicine. Staff said it was given when the person became agitated. However staff's interpretation as to how the person displayed agitation and at what stage in the person's agitation the medicine was administered to be inconsistent.

We found another concern regarding the medicines to be given as and when required. The lack of guidance around its administration meant no information was in place about the period of time to be left between the

administration of doses. The medicine administration records and other written records did not include a record of the time the medicine was administered. That meant people's health could be put at risk.

A person whose records we viewed had recently been prescribed antibiotics. The medicine record detailing the administration of the medicine contained errors. For example, the medicine records stipulated that the person had had three doses of the medicine; however only two capsules had been dispensed from the packaging. Staff on duty at the time of our inspection who were responsible for the administration of medicine could not provide an explanation as to the anomaly. The manager told us they would liaise with staff to establish what had occurred.

People where appropriate had been assessed as being at risk of falling when walking around, or moving from place to place. Risk assessments had been completed and information provided within the person's plan of care detailed how people's health, safety and welfare was to be promoted by the use of equipment. However, the care plans were not specific and lacked guidance for staff to follow. For example, care plans did not specify the size of the sling to be used, which had the potential for people to receive inconsistent or unsafe care. Care plans advised staff that in order to promote people's safety wheelchairs and frames should be checked, however no records were in place to evidence checks were being carried out. Records were in place to evidence outside contractors undertook safety inspections of hoist equipment, to ensure equipment was safe to use.

People's safety and welfare was compromised through the lack of consistency and understanding of the needs of people and conflicting information within people's care plans. We found a person's care plan stated that the person could have biscuits providing they were dipped in a hot drink to soften them. This person had been assessed as requiring a soft diet and had thickeners added to their drinks to prevent choking. When we asked staff about their dietary needs, they told us the person did not have biscuits as they were at risk of choking.

We found people's records not to be accurate or fully understood by staff. For example, a person's record detailed they had diabetes, however there was no care plan in place detailing the support or care they required. Staff provided conflicting answers when asked about the persons care and whether they were diabetic. One member of staff stating that senior care staff checked the person's sugar levels in their blood regularly, whilst a senior carer told us the person was not diabetic as their medicine to manage their condition had been stopped by a health care professional. This had the potential to impact on the safe management of people's health and welfare of the person as their needs were not understood or monitored by staff consistently.

We asked staff about the needs of people whose records we had read and asked them whether the information provided within people's care plans was sufficient to enable them to meet people's needs safely. Staff responses were mixed, with some staff stating they found communication about people's needs to be ineffective; care plans not to be comprehensive and the daily records not being reflective of people's well-being. Staff evidenced an understanding of people's needs; however these on occasions differed to what we had read, which meant people were at risk or receiving inconsistent and unsafe care and support. Records of staff meetings had advised staff to provide greater detail as the care and support they provided.

People's health could be at risk as information provided by General Practitioners was not used to develop or review people's care. GP's who visited left a record of their visit, which included the outcome of their appointment, including a record of any observations they had undertaken. Staff recorded the visits of health care professionals and any recommendations; however it was unclear as to whether this information was always used to review and update care plans. For example, one person had recently been prescribed

medicine, this had not been communicated to all staff and a care plan to promote the person's recovery, which encouraged them to have sufficient fluids (drink) had not been put into place. This meant the person's was at risk of receiving unsafe care to promote their health.

We found personal emergency evacuation plans were not in place. This meant should staff or emergency services personnel have the need to evacuate people the provider had not identified the level of assistance each person required and determined the safest way to support each person to minimise risk.

In an emergency, should staff need to request the attendance of the emergency services, such as an ambulance, there were files which contained important information, which was readily accessible to staff. However we found the information within these records not to be accurate. For example for one person the DNAR (do not attempt resuscitation) form was not within their records, information as to the room people occupied was not always up to date whilst some people did not have any records within the emergency 'grab' file. This had the potential to compromise people's safety and welfare as staff would not have access to up to date and accurate information to share. This was discussed with a manager, who made some changes to the information held during the inspection.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's records included a dependency tool, which identified the number of staff that were required to meet people's needs with regards to their personal care safely. Our observations showed there were sufficient staff to meet people's needs safely, with regards to assisting them with personal care, which included the use of equipment when supporting people to move. As part of their recruitment staff told us they had provided certificates of training they had undertaken in their previous employment. However one member of staff said their induction had not included an assessment of their competence to carry out essential tasks, which included the moving and handling of people and the use of equipment.

During the day there were four members of staff on duty, which included a senior carer. Whilst at night there were three members of staff on duty, which included a senior carer. The provider in addition employed staff to undertake specific duties, which included, cleaning, cooking and laundry.

Requires Improvement

Is the service effective?

Our findings

Our observations found that people living with dementia were not supported on a daily basis, by the provider or staff because their needs were not fully recognised or understood. We saw many examples of staff interactions with people living with dementia, which showed how the staff's lack of knowledge and understanding had an impact on the quality of care people experienced.

We observed many instances where people's human rights were compromised. For example, when people got up from an arm chair staff would ask them what they wanted or where they were going. In most instances staff did not wait for a response but asked the person to sit down, advising the person they did not want them to fall. Staff had not considered that the activity of getting up out of the armchair could have been a form of communication and expressing a decision. And therefore did not consider what the person's getting up from their chair could potentially mean, for example their wish to go to the toilet or for a walk.

Records of staff training provided to us were out of date and we were advised by a senior carer that the record included staff that were no longer employed by the provider. The provider did not have access to up to date training records for staff. Staff we spoke with told us about the training they had received in the last 12 months, the details of training topics was unique to each member of staff. Staff told us they had recently registered to commence training in either the management of medicines or dementia care. We asked the provider upon the manager's return from planned leave for a more up to date record regarding staff training to be sent to CQC. We received no information to suggest a more up to date training record was available.

Records regarding staff recruitment, induction, supervision and appraisal were not accessible during the inspection as they were locked in a cabinet to which the manager had the key; who was taking planned leave. Staff we spoke with told us they had attended an interview and provided information as to their previous experience and training.

Staff we spoke with staff with regards to their induction and supervision and found their views differed. A member of staff told us they had 'shadowed' other staff as part of their induction, however they had had no formal meeting to review their progress or been offered supervision. A second member of staff told us they had received regular support, when they had commenced their role, however confirmed they had received no recent formal supervision. The frequency of staff supervision was not consistent with the provider's policy and procedure, which stipulated staff were to take part in at least one formal supervision; of at least one hour duration every two months. The inconsistent approach to staff supervision and appraisal had the potential to affect the quality and consistency of care they received.

Staff told us they had received training within the last year in a range of topics, which included the moving and handling of people safely, health and safety and fire awareness. However there was no system in place to ensure the effectiveness of training as the approach to staff supervision and appraisal was not consistent.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found three people had a DoLS authorisation in place. We looked at one person's DoLS who had conditions attached. One of the conditions was for staff to provide appropriate activities and stimulation, which included the opportunity to sit in the garden to lessen the impact on the person of the restriction as detailed within the DoLS.

Records showed the person who had a DoLS in place had regularly meetings with a 'paid person's representative' (PPR). They monitored the implementation of the DoLS and as part of their role they spoke with staff and viewed the person's records which recorded how staff implemented the DoLS. The PPR had raised a number of issues on their most recent visit which they wanted addressed, which included care plans to be person centred, the development of risk assessment in some areas and information about planned activities being recorded. The person's care plan had been further developed, however we found no record of their involvement in planned activities within their daily records, therefore the service was not effective at evidencing their compliance with conditions identified within a person's DoLS

Staff we spoke with were aware of those people who had a DoLS in place and what this represented in relation to the care and support staff provided.

We spoke with people and asked them for their views on the meals provided. People's comments reflected their satisfaction with the food; "The food is lovely" and, "It's usually quite nice." Visiting relatives when we asked them about the meals replied; "Happy with food, extra available and fresh vegetables are served."

Cold drinks in jugs along with beakers were available in all communal rooms for people to serve themselves, however there were no snacks readily available for people. During the morning and afternoon hot drinks and biscuits were served and brought around by staff on a trolley.

We spent time with people at lunchtime on the second day of our inspection. The lunchtime meal was served onto plates in the kitchen and taken through via a trolley to the dining room. We asked a cook why meals were not served in the dining room, with people being given a choice as to what they wanted. They told us a trolley which used to keep food warm had broken several years ago. Twelve people ate their meal in the dining room, whilst two people sat in the small lounge and four people in the main lounge remaining in their armchair with a table in front of them. We brought to the attention of a manager that the seating position for some people did not promote or enable people to eat their meal with comfort or ease. We asked a member of staff why the four people remained in the lounge to eat their meal. They told us sometimes by choice or the decision of staff. This highlighted that people were not always encouraged or supported to make decisions about where they sat for their meals.

People sat at small dining tables, which were laid with a table cloth, cutlery, a sheet of disposable kitchen towel and coloured plastic beakers. Tables did not include condiments, nor were these offered. Staff offered

a choice of a cold drink, orange or blackcurrant. The main meal for the day was a choice of chicken casserole or sausage served with green beans, boiled potato and gravy. Staff distributed the meals, in some instances people were not asked what they wanted, this was highlighted at the previous inspection which took place in September 2015.

Two people we observed, who earlier in the day had spoken positively about the food, made comments that they were not happy with the food. One person, with their fork moved around the chicken casserole, saying they didn't like gravy, whilst one person said they didn't want meat. We brought this to the attention of a member of staff, who asked the person if they wanted the sausage. The person accepted the change of meal option. Dessert was served in the kitchen and taken through to the dining room. We asked a cook whether people were routinely asked what they wanted to eat each day, they told us they were asked, however due to people living with dementia they often forgot what they had requested or changed their mind. The cook went onto say they cooked a sufficient quantity of food to enable people to make a choice when their meal was served.

We asked for the planned menus and were advised these did not exist. A cook confirmed that they wrote menus retrospectively of what had been served each day. The records of food prepared and served showed that a number of meals were served regularly, which included sausages and chicken casserole and sandwiches. We asked a cook if food was prepared fresh on site. They told us that on the instruction of the provider food was purchased from a supermarket and that a majority of meals were not prepared fresh within the kitchen. Frozen foods including savoury and desserts along with prepared cakes being purchased. Vegetarian meals were purchased to meet people's preferences. They told us there had been no baking at the service for six years. Sandwiches for tea were prepared in advance by the cook, to be served by care staff at teatime. An alternative of a warm tea time snack was available.

We found positive examples of where people's needs were monitored and met, consistent with their care plans for their physical and nutritional health. Records detailed where people's appetite had decreased and additional checks were carried out, with staff encouraging people to eat their meals. Records of a person we viewed showed that staff had noted an improvement to the person's appetite and noted their weight had remained stable.

Where it had been identified people had experienced difficulties with swallowing food and drink, referrals had been made to the appropriate health care professional. Advice from speech and language therapists had been incorporated into people's nutritional care plans, which specified where 'thickeners' were to be added to people's drinks and where people's food was to be 'soft' or 'mashed' to reduce the risk of choking. However we found inconsistent information as to the support people required to prevent their choking which meant there was a potential for people's care not to be effective as staff's approach had the potential to be inconsistent.

Visitors to people using the service told us that as their relatives they were kept informed about the person's health and well-being and advised when they were unwell. Records showed people had where referred where appropriate to health care professionals which included domiciliary services such as opticians.

At our previous inspection we found that the environment in which people resided was not reflective of the needs of people living with dementia. This was discussed with the registered manager who spoke of their hopes to develop the environment. We found changes had not been made and no plans were in place to develop the environment reflective of good practice or guidance. An environment adapted to support people living with dementia would enable people to find their way around the home independently, maintain and promote their independence, through changes to lighting, décor and furnishings. Whilst the

personalisation of people's rooms and décor to communal rooms would promote their sense of identity and links with the local area and their past and support staff in the provision of effective care.

A S Care had a large garden to the rear of the property, which we observed a number of people sitting outside during our inspection. People sitting outside, sat on one of a few benches, with others sitting on chairs brought from inside the service. We sat with a small group of people, who sat on a bench on a pathway. They told us they sat there as it provided shade from the sun. The bench was directly sited underneath a washing line, which caused distress for one person, as the line kept touching their hair, and they had that morning had their hair attended to by the visiting hairdresser.

The grounds had not been developed reflective of the needs of older people or those living with dementia, as a large portion of the garden were not easily accessible to people as the grounds were laid to lawn, with limited flat services for people to walk around and enjoy the garden. There were no areas of interest for people to view and there were no opportunities for people to garden as all beds were of ground height. We spoke with a manager and senior carer about the garden who acknowledged improvements could be made to make the outside space accessible, enjoyable and interactive for people. The environment both internal and external limited the staff's ability to provide effective care reflective of good practice guidance for people living with dementia and for people with physical or sensory impairments.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us staff were kind and considerate and provided help and support when they needed it. "It's very nice here, we're well looked after. They [staff] always fetch things if we want something. The girls [staff] are very nice and helpful." We asked people what they liked about living at A S Care. They told us, "Very nice people" [referring to others in residence] and "It's close to where I used to live."

Visiting relatives spoke positively about the staff and the care provided, telling us this was a key factor in their decision in choosing the service for their relatives' care. Their comments included, "When I visited I thought it was lovely. Staff don't just look after my [relative] but all of us." A group of relatives told us that they often brought the family dog into A S Care to see their relative; this was something they appreciated as the dog was a significant part of their relative's life prior to moving into the service.

Our observations showed that the attitude and approach of staff to people, was not always reflective of people's needs. Some staffs responses showed they had a lack of knowledge, understanding and compassion in the care they provided to those living with dementia. In some instances staff's approach to supporting people was focussed on tasks and not always promoting people's choice of lifestyle, with regards to their personal care or their involvement, or involvement in an activity to give a sense of purpose to their day. On one occasion a member of staff asked the person when they stood up and looked at someone else's drink if they wanted a drink, they advised the person they would get them a drink. However, over a period of twenty minutes we saw the person was not provided with a drink but the member of staff continued to be seated at the table communicating with other staff whilst having a drink themselves. We brought this to the attention of a manager.

As staff walked through communal areas of the service they would ask people if they were alright and said hello. In some instances staff sat with people for a few minutes and spoke with them. A member of staff spent time talking with a person about something which was important to them. We also observed a member of staff supporting someone who had become upset when their relatives had left following their visit. The staff member spoke with the person, providing reassurance and distracted them by steering the conversation to a different topic. The person who was living with dementia forgot they had been upset and became cheerful and enjoyed speaking with staff. Where people required assistance in the eating of their meal, this was provided by staff.

People we spoke with shared aspects of their lives with us, with great enthusiasm and laughter. Talking about their experiences of World War II, their childhood, and their experiences of meals and the accessibility of food in the childhood and younger adult lives. They told us in the main vegetables and fruit were grown in their garden and spoke about the keeping of chickens. They also told us about their parent's lives, which included their work and the size of their family.

We spoke with a manager and senior carer about our conversations with people, along with information provided by staff when we asked them about people's lives. We asked as to why this information was not included within people's records, to provide an insight for all staff as to people's lives and be used to

develop person centred care, which could include the opportunity to engage in activities of interest. The manager and senior carer facilitating the inspection could not provide a rationale as to why information was not included as they did not have the responsibility for the development of care plans.

People's privacy and dignity was not promoted or respected in how information about people was recorded. Their involvement in decisions about their care was not actively sought in the development of their care plans. People's care plans suggested they were written from the person's perspective and with their involvement. However, the terminology used, for example to describe a person's behaviour when challenging, was reflective of how their behaviour had been interpreted by staff as opposed to words expressed by the person. For example, 'I tend to become quite agitated and frustrated when I have been in doors for a while, I begin to pace up and down at quite a rapid pace and there usually is no reasoning with me.'

In the morning on the first day of our inspection, we saw people being asked if they wanted a biscuit. The staff member selected biscuits for them, serving them to people on a sheet of paper kitchen towel. We brought this to the attention of the provider and a manager, raising concerns as to people's choice and promotion of the dignity, eating biscuits served on kitchen towel. No rationale was provided or what action they would take.

These were breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

Visiting relatives told us that as part of the assessment process their views had been sought about the care of their family member, which for one family had involved their meeting with them in their own home. Whilst other visiting relatives had not been involved in the development of a care plan but were confident that the care provided met their relative's needs. At our previous inspection visit we had highlighted people's involvement in the development and reviewing of care plans was limited and we were advised by the registered manager they people's views would be recorded, however this had not been actioned.

We spoke with a group of people sitting outside in the rear garden. Two people told us they would welcome the opportunity to occupy their time by polishing, washing up and cleaning. The provider and staff showed a lack of understanding and awareness of the needs of people living with dementia. There was a lack of opportunities made available for people to interact and make a positive contribution to the environment in which they lived, which included their ability to engage in meaningful activities, reflective of their interests.

Our observations and the reading of people's records found staffing numbers and the deployment of staff not to be managed in a way that enabled staff or encourage staff to provide responsive and person centred care, reflective of people's individual preferences, choices and social needs. Our observations showed a majority of people spent their time sitting in one of the communal rooms, many with their eyes shut. Two rooms had a television whilst a third had a radio playing, however our observations found very few people took interest in the programme on the television. This further supported our findings that the provider and staff did not recognise how people living with dementia may interpret television programmes and its impact on their well-being. On one occasion the radio and television were on at the same time in the main communal lounge, which was not identified by staff to have a potential impact on people's welfare.

We found the staff member's practice was not consistent with the provider's policy, 'behaviour that presents risk policy', which stated, 'understand the value of a stimulating environment, meaningful activity and effective communication in preventing behaviour that presents a risk.' We spoke with the provider, manager and senior carer as to our initial findings of the inspection. The provider acknowledged improvements were needed.

People's care plans were not person centred and were similar in content. Whilst the wording within the care plans suggested they had been written from the person's perspective, the language and terminology used did not support this. Care plans which provided guidance for staff on supporting people whose behaviour may be challenging had the expected outcome of the care plan to be 'To ensure [person's name] behaviour is kept at an acceptable level.' An example of a description of a person's behaviour was recorded as 'can be in patient, little tolerance for care interventions, verbally challenging and can kick out.' This was not consistent with the provider's policy, 'behaviour that presents risk policy', which stated, 'have the skills and knowledge to respond at an early stage and do so to reduce the likelihood'. This showed that people were not in receipt of support tailored to their needs.

People's dining experiences regarding all aspects of their food and drink were not reflective of a person

centred approach to care. In some instances, staff focused on the tasks to be completed. The provider and staff did not support people in making decisions about their food or considered whether their dining experience was enjoyable. We noted examples where staff had not considered the comfort of people or the ease of which they could eat their meal. We observed one person sitting in a wheelchair at the dining table, their position in the wheelchair meant they had to lean forward to eat their meal. Whilst a second person who sat in an armchair with a table, had to reach some distance for their food, due to the height difference of the table and chair and its distance from them.

We found care plans were not followed with regards to people's preferences and their views about how they wished to be care for were not respected. One person's care plan for personal care stipulated they preferred a shower alternate days. Daily notes recorded that personal care had been provided but did not specify what this entailed. Further investigation of a range of records, with the involvement of a manager found the person had not had a shower since November 2015. This also highlighted the ineffective monitoring of people's care and that the staff had not raised concerns about the lack of support provided to meet the person's needs.

We and a manager looked at records relating to other people's personal care and found people had not had a bath or shower, for long periods of time. This was discussed with the senior carers and care staff. The manager asked a senior carer to find out if anyone had had a bath on the morning of our inspection, they were told no. We asked staff about the bathing or showering of people, and were told baths usually took place in the afternoon, when instructed to do so by the senior carer. This was inconsistent with the provider's policy 'respecting and involving service users'. The policy stated 'avoiding where possible treating the individual as part of a group.' And went on to say, 'ensuring flexibility of routines for day to day tasks.' Based on our finding it was evident that people's care needs were fully not met for an extensive period of time.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An activity organiser worked in the afternoons, providing one to one interactions, which included hand massage and manicures. Activities, such as bingo which a member of staff discussed with one person, were kept in the activity cupboard. We saw two people were comforted by the holding of a doll or cuddly toy, however no other objects were accessible to people for them to interact with. One person, who had additional funding allocated to them to provide them with one to one staffing for a number of hours each day. We saw them going out for walks and spending time in the garden, where they actively enjoyed hanging up items of clothing, moving them from washing line to washing line. People who smoked were supported to go outside into the garden to have a cigarette by staff.

The provider had received one complaint since from someone's relative in July 2016. The complainant had recorded their concerns within a letter. The provider and deputy manager had met with the complainant to discuss their concerns. We found the record of the meeting did not fully reflect all aspects of the person's concern. There was no evidence to support the provider had written to the complainant following the meeting confirming the points discussed or agreed. Improvements to the recording and monitoring of concerns and complains would assist the provider in the monitoring and development of the service.

Inadequate

Is the service well-led?

Our findings

The provider was unable to demonstrate robust management and leadership, which had a direct impact on the quality of the service provided. The provider had not taken action following our previous inspection which had found the service to require improvement. We found people had not contributed to their care plan or their views as detailed were not acted upon. For example a person's care plan stated they preferred to have a bath or shower alternate days. Records we looked at with the involvement of a manager found the person had not had a bath or shower since November 2015.
We found no formal system to be in place to monitor the quality of the service. No records were available to evidence whether any improvements had been identified by the provider or whether these had been actioned.

Improvements to support the quality of life of those living with dementia had not been addressed as people's access to individual interests had not been explored, which meant people were not encouraged to continue to pursue areas that interested them. A person we spoke with told us how they would like to be involved in keeping the service clean by dusting. Adaptations to the environment had not been pursued, reflective of good practice guidance, which meant people's independence and a sense of purpose to their day to days lives had not been created enabling people to interact with their environment, which resulted in many people sitting and unstimulated within communal areas of the service.

The provider visited the service regularly, however there were no records of their visits available for us to view to evidence any issues identified and any improvements required. The provider told us electronic records were sent from their phone to the manager advising them of improvements they wished them to make following their visits. However there were no records detailing what improvements had been identified, the action to be taken, the person responsible or the timescale for changes to be made. There was no record to evidence whether the provider monitored the issues identified to ensure improvements had been made and whether the improvements had had a positive impact on people using the service. The provider told us they spoke with the manager upon subsequent visits to ask whether action had been taken.

The provider's lack of governance, oversight and the poor leadership of the service meant that people were not supported or encouraged to make choices and experience the best possible health and quality of life at A S Care. Nor did they experience care from staff that always treated them with dignity, respect and compassion through encouragement to comment on the care they receive through consultation in their care and the development of the service. Our observations and discussion with staff and the reviewing of people's care records showed staff lacked an understanding of how to care for people living with dementia or those whose behaviours challenges others in a positive and pro-active manner. We heard a member of staff speaking with a visiting relative and were heard to say that in their view people's behaviour that was challenging was in their opinion a result of people's boredom. Opportunities for people to engage in worthwhile activities of interest, within a stimulating environment would support those living with dementia to experience positive outcomes. And have the potential to reduce occasions when their behaviour becomes challenging to others.

The provider sought people's views through resident meetings. Whilst meetings were held, the most recent being in March 2016, which had involved a small number of people, we found there was no system to incorporate people's comments to develop the service and therefore people using the service could not be confident that any action would be taken.

We found seven completed questionnaires entitled 'living in the home' had been completed, however these were not dated and there was no evidence to support whether comments had been acknowledged by the provider. Two requests written on the questionnaire were, 'bath once a week' and 'to go out shopping.'

Minutes of meetings, the most recent held in March 2016, which had involved a small number of people recorded their views on the meals provided. Minutes showed one person had asked for smaller portions and more variety in sandwiches and less gravy. Whilst a second person stated they would like more mushy peas. A menu was not in place for us to view and the provider could not evidence that people's views had been listened to or acted upon.

We found seven questionnaires had been completed by people or their relatives, these were not dated and therefore we could draw no conclusion as to whether they had been acted upon and there were no records to support whether any action had been taken by the provider. Additional comments regarding food, included access to fresh fruit and more gravy and drinks. People could not access fresh fruit independently as this was stored in the kitchen, which meant people would need to ask staff if they wanted fruit.

We found the system for communication between the staff team to be ineffective and did not reflect a holistic approach to care as not all information was shared. We listened to the handover of information in the afternoon, when there was a change in staff on duty. A senior carer completed a handover sheet and provided a verbal handover providing information as to the happenings of that morning. Each person using the service was spoken of briefly, in many instances their well-being was described as 'fine' and recorded as such on the handover sheet. Basic information about people's well-being was provided verbally, which included whether they had had visitors, whether they had eaten or had been given medicine prescribed for them to be given as and when required. We identified that information was not always shared and therefore people's well-being may not be fully understood by staff. For example one person had become upset when their relatives who had been visiting them had left. The person had been comforted by a member of staff; however this was not shared with other staff.

We found where staff returned to work following non-working days; a system had not been established to provide effective communication to ensure staff had information as to people's well-being since they were last on duty. This meant staff did not have a full understanding as to people's well-being. This had the potential for people's care not to be consistently provided and their needs not to be met or understood by staff. For example, we spoke with a senior carer who had returned to work following their days off and asked them about a person's medicine that had been prescribed. They advised us until we had mentioned the medicine they had not been aware that it had been prescribed.

Staff meetings had taken place in January and July 2016, with senior care meeting having taken place in September 2015 and June 2016. The record of the meetings were reflective of an approach to people's care that did not support person centred care. The issues discussed at the most recent senior staff meeting being, [name of three people] to be put to bed at 3pm'. 'Bath list being put in place.' And, 'Observations of wandering residents.' This was discussed with a manager and a senior carer who acknowledged this did not reflect person centred care and did not fully capture the issues discussed at the meeting. A staff meeting had noted a request from staff for the purchasing of bed sheets. We asked a senior carer whether people had their own personalised bed linen, we were advised that a majority did not and that bedding and bed linen

was communal and therefore shared. This supported an approach to care that did not promote choice by encouraging people in making decisions to personalise their rooms and promote their well-being.

A registered manager was in post; however they were on extended planned leave and the deputy manager was on planned leave. The manager of another service owned by the same provider therefore facilitated the inspection at the provider's request.

The manager who facilitated the inspection advised us they had completed the Provider Information Return (PIR) upon the instruction of the provider. The PIR asked the provider how they assured themselves of the quality of the service, the response provided detailed this was assured through the provision of a well-trained manager along with appropriately trained staff. They recorded that the manager had an open door policy for staff to raise concerns, with a clear management structure being in place. Management of the service would ensure all parties including the CQC would be apprised of relevant information and staff would attend meetings that were regularly held, with minutes being available for staff to reflect and implement changes. However, our evidence reflects that the provider does not fully understand the principles of good quality assurance to ensure AS Care provides quality care.

Information provided within the PIR was limited in its content. In some instances information within the PIR was found not to be accurate. For example the PIR stated regular staff supervisions and appraisals were carried out, and that person centred care plans were implemented. The PIR went onto say that quality assurance surveys for staff and those using the service were carried out every six months. These points were not evidenced as part of the inspection and we found the provider's policies were not implemented or up to date as they referred to outdated regulations.

These were breaches of Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure people using the service received person centred care and treatment that was appropriate to their needs, or consult or act on people's preferences with regards to their care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure that the care and treatment provided to people who use the service by staff promoted people's dignity and respect at all times and did not take account or encourage people's involvement within the service in which they lived.

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 records detailing the care, treatment and support of people using the service were adequately or appropriately completed. Communication systems to promote people's safety and well-being were not effective. Medicine management was not safe as instructions and guidance were not in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure an adequate induction programme reflective of the Care Certificate standards or ensure the continued training, learning and development of staff. The provider did not ensure staff were periodically supervised and had their work appraised. .

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 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system or process in place to monitor the quality of the service or have plans to improve the quality and safety of the service. Information to support effective leadership and management was not up to date. Records to be accessed in an emergency were not accurate or up to date, which included people's advanced decisions. Policies and procedures were not reflective of current legislation and were not implemented by the provider or staff.

The enforcement action we took:

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