Apple Homecare Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Apple Homecare is a domiciliary care agency providing personal care to younger and older adults in their own homes. The service was supporting 51 people at the time of this inspection. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The provider's failure to keep accurate records, demonstrate appropriate knowledge of legislation and regulation and effectively monitor the service in order to drive improvement had resulted in widespread and significant concerns for the third consecutive inspection. This meant we could not be assured that the provider was able to act on feedback in order to improve the safety and quality of the service, or have effective systems in place to do so, and this put people at risk of harm or receiving inappropriate care. We again identified breaches in regulations.

Although the people who used the service told us their needs were met by caring and respectful staff, the provider could not assure themselves that their staff had the right skills, experience, knowledge or competency. This was because not all staff had received the training they required for the role or had their competency to deliver care assessed. Furthermore, full recruitment checks as required by law had not been completed on all staff further contributing to the failure of the provider in seeking assurances on the suitability of staff and ensuring a safe service.

People were not always supported to have maximum choice and control of their lives and staff did not consistently support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. The service could not demonstrate they were adhering to the Mental Capacity Act 2005 (MCA); the associated knowledge of the staff and registered manager was poor.

However, the people who used the service, and their relatives, told us the service met needs and did so in a compassionate and consistent manner. They told us the registered manager was accessible, approachable and helpful as were staff. People were supported by consistent staff teams who demonstrated they knew people's needs well, met the principles of care and demonstrated, through discussion with inspectors, dedication, compassion and a caring approach.

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 (report published 18 March 2020) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. They had failed to meet this action plan and at this inspection

enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We carried out an announced comprehensive inspection of this service in February 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve their compliance in relation to safe care and treatment, meeting the Mental Capacity Act 2005 (MCA) and governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions safe, effective and well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Apple Homecare 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, MCA, recruitment processes and governance at this inspection.

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.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The 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 effective? The service was not always effective. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our safe findings below.	**Inadequate**

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Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of two inspectors and an Expert by Experience. 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
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection to be sure there would be people available to accommodate the inspection.

Inspection activity started on 07 June 2021 and ended on 15 June 2021. We visited the office location on 08 June 2021.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, and we reviewed the action plan the provider sent us following the last inspection completed in February 2020. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with 11 members of staff including the registered manager, operations manager, supervisor and care workers. We also spoke with nine people who used the service and three relatives.

We reviewed a range of records. This included six people's care records and the medication records for four people. We looked at three staff files in relation to recruitment and staff support. A variety of records relating to the management of the service, including accidents and incidents and quality monitoring audits were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and policies and procedures.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection the provider had failed to assess and manage the risk to people in relation to the safe handling and administration of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider remained in breach of regulation 12.

- We were not assured that people received their medicines safely or as prescribed. The provider's medicines management system could not demonstrate this.
- The medicines administration record (MAR) chart for one person showed they had not consistently received all of their medicines as prescribed. Associated documents had failed to fully record the reason for this, or any action taken as a result.
- For another person, staff were leaving medicines out for the person to take after their visit however records showed this person was often confused. No assessment had been completed regarding the risk of the medicines not being taken.
- We identified instances where drug allergies had not been consistently recorded across all care documents risking error.
- Whilst the majority of staff had received recent training in medicines administration, the provider had failed to assess their competency to do so as required by best practice guidance.

The above concerns constituted a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- We were not assured that people received the care and support they required as care plans and risk assessments were inaccurate or out of date.
- The majority of the care plans we reviewed contained out of date information including around risk. For example, for one person who now required care in bed due to an advanced health condition, the care plan recorded they were still able to mobilise.
- For another person who had a history of losing weight, the care plan gave conflicting information on what was required from staff to manage this risk. No associated risk assessment was in place.
- For a third person, the provider had failed to risk assess the risk of burns and scalds associated with the

care staff delivered.
● Where people had specific health conditions, such as diabetes or dementia, there was no information in place regarding this to provide staff with guidance on how to safely manage these conditions. Furthermore, staff had not consistently received training in specific health conditions.

The above concerns constituted a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider had not met the legal requirements in relation to the recruitment of staff.
● We could not be assured the provider had satisfied themselves of the conduct of staff in their previous roles that involved work with vulnerable adults.
● Full employment histories of staff had not been consistently sought and gaps had not been explored as required by legislation.
● For one staff member, their application form was poorly completed, there were gaps in their employment history and no written evidence of interview was present. Whilst we identified no concerns with this staff member's performance, the provider had put people who used the service at risk of receiving care and support from a person potentially inappropriate to work with them.

The above concerns constituted a breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● We could not be fully assured that systems were in place to safeguard people from the risk of abuse.
● Whilst we saw that the service had reported identified safeguarding concerns to the local authority as per local protocol, not all staff had received training in safeguarding or failed to satisfactorily explain their knowledge to us through discussion.
● However, the people who used the service, and their relatives, told us they had no concerns and felt safe with the staff that supported them.

Preventing and controlling infection
● We were not fully assured that the provider's policies relating to infection prevention and control (IPC), and specifically COVID-19, were up to date. The provider's COVID-19 policy had been due for review in February 2021 and this had not been completed. Furthermore, information around the use of personal protective equipment (PPE) was not in line with government guidance.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks could be effectively prevented or managed.

Learning lessons when things go wrong
● Some lessons have been learnt when things have gone wrong however this has not been consistently and widely applied.
● Records from staff meetings show concerns have been discussed with the view of improvement however no staff meetings have taken place since September 2020 meaning the opportunity for wider discussion and problem-solving has been missed.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support risked not always achieving good outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

At our last inspection the provider had failed to consistently work within the principles of the MCA. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider remained in breach of regulation 11.

- The provider could not evidence that people's human rights were being protected due to failure to consistently meet the requirements of the MCA.
- We continued to see family members signing consent to care delivery when they had no legal authority to do so.
- The provider continued to fail to assess people's capacity to make decisions regarding care provision. For example, restrictive practices were in place for one person without the provider having assessed the person's capacity regarding this task.
- Only six out of the 20 employed staff had received training in MCA of which all was historic. Staff could not demonstrate knowledge of the principles of the MCA when this was discussed.

The above concerns constituted a continued breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The people who used the service told us staff sought their verbal consent before assisting them and gave

them choice. One person said, "We have done things so often we do them automatically, but staff follow my lead."

Staff support: induction, training, skills and experience
● The provider had failed to ensure staff had received the training they deemed both mandatory and person-specific for the delivery of good quality care. For example, not one staff member had received training in health and safety or person-centred care, topics the provider deemed mandatory. Staff told us formal training had not been received during the pandemic.
● Although the people who used the service told us staff had the skills to meet their needs, lack of staff training put people at risk of harm or receiving inappropriate care and support.

The above concerns constituted a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The staff we spoke with talked consistently and positively about the induction and support they received. One staff member said, "Everyone at the office is nice, they go out of their way to make everything as easy and less stressful as they can."
● The people who used the service, and their relatives, told us staff had caring attributes and the appropriate skills to assist them. One person who used the service said, "Staff are cheerful, they sit a minute to talk before they start. I had a [safety incident] recently and they knew how to treat me."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had been holistically assessed however care plans were consistently inaccurate. Nonetheless, staff knew people's needs and the people who used the service told us their needs were met with one person commenting, "Staff are there to motivate and support me. They are very communicative… they allow me to be independent".
● However, the provider could not evidence that standard-wide assessment tools had been used to support care delivery. For example, for one person who we were told had a history of weight loss, no malnutrition assessment tool, such as the Malnutrition Universal Screening Tool, was being used.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us their nutritional needs were met. One person who used the service said, "Staff make me healthy food every day and I am happy." Another person told us, "Staff cook whatever I want and there is always enough." Their relatives agreed.
● However, for one person we found that the service had failed to appropriately record their needs in relation to nutrition and the associated risks.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Whilst there lacked care plans for specific health conditions and records were poor regarding what action was taken, the people who used the service told us staff assisted them to access healthcare as required. Their relatives agreed.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to effective quality monitoring systems in place. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider remained in breach of regulation 17

- The provider has failed to meet regulations for three consecutive inspections, and this is the third time they have been in breach of regulation 17. We cannot, therefore, be assured that the provider and registered manager fully understand their regulatory responsibilities.
- The provider had failed to act on the previous findings of CQC and the action plans they have submitted in response, explaining what action they planned to take to make improvements, had not been met. We did not have confidence the provider had mechanisms in place to drive improvement.
- The provider's own Statement of Purpose, a description of what service they provide and how, had not been met. For example, accurate care plans were not in place nor had they been regularly updated.
- The system the provider had in place to assess, monitor and improve the quality and safety of the service, and mitigate risk, had been ineffective at identifying and rectifying those concerns found at this inspection. For example, the provider completed regular medicines audits however these had not identified safety concerns.
- Accurate, complete and contemporaneous records detailing the care and treatment provided to people had not been maintained and decisions relating to those were not effectively recorded. Nor had records been maintained in relation to the employment of staff.
- Although reported to other stakeholders, we found one safety incident that had not been reported to CQC as required by law. The registered manager, through discussion, was unable to tell us what type of safety incidents needed to be reported to CQC.
- At our last inspection we identified that staff had not consistently received refresher training. The registered manager told us a plan was in place to address this. At this inspection, we found continued and serious shortfalls in staff training. We found no staff had completed training in some topics the provider

deemed mandatory risking the care provided to people.
● We could not be assured that the registered manager had the skills and knowledge to effectively lead the service. They were unable to fully demonstrate their knowledge in regulatory responsibilities and the history of non-compliance validated this.

The above concerns constituted a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The people who used the service, their relatives and staff told us they felt supported by the registered manager and that they were available and approachable.
● Staff demonstrated, through discussion, that they worked well as a team, were committed to their role and worked collaboratively.
● The people who used the service told us that staff delivered care in a way that met the aims and objectives of the provider, that care was delivered in a respectful manner that upheld their dignity and promoted their independence. One person said, "For me, staff have listened to, and met, my needs."

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 people who used the service, and their relatives, felt involved in the care delivered and told us the service kept them updated in all aspects including when things went wrong.
● However, through discussion, the registered manager was unable to clearly describe her responsibilities around this requirement.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● All of the people we spoke with felt involved in their care and told us the service consistently kept them updated regarding such aspects as which staff would be assisting them and timings.
● The provider regularly sought feedback from those that used the service, and their relatives, on an informal and formal basis through surveys, care reviews and verbal/written communication.

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
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to work within the principles of the Mental Capacity Act 2005 (MCA) and consent to care and treatment had not been consistently given by the relevant persons. Regulation 11 (1)(2)(3)(4)(5)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Effective recruitment procedures were not in place and the provider had failed to meet the requirements of schedule 3 of the Health and Social Care Act 2008 (Regulated Activities (Regulations) 214. Regulation 19 (1)(a)(b)(2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities. Regulation 18 (1)(2)(a)

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to the health and safety of service users of receiving care and treatment and do all that is reasonably practicable to mitigate any such risks. Regulation 12 (1)(2)(a)(b)(g)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the quality and safety of the service were ineffective. Regulation 17 (1)(2)(a)(b)(c)(d)(e)(f)

The enforcement action we took:

Notice of Proposal to impose conditions on registration