Apple Homecare Limited

Apple Homecare

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection visit took place on 21st and 26th November 2018 and was announced.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. At the time of the inspection around 50 people were using the service.

Not everyone using Apple HomeCare receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager working at the service. 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.

At the last inspection of this service on 18 March 2016, we rated the service overall as good. Whilst there were positive elements to this inspection, the overall rating for the service has been changed to requires improvement. This is because the management of records did not consistently meet the Regulations or good practice guidance. The system in place to manage and administer people's medicines was not safe and risks to people had not always been identified and mitigated. There were also shortfalls in the quality assurance systems designed to monitor the quality of care. Staff supervision did not take place regularly and improved performance management measures are required. Staff training was not always effective especially in relation to safeguarding, medication and the Mental Capacity Act. There were shortfalls in the service's approach to person-centred care planning and end of life care planning.

For these reasons, the provider is in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have also made two recommendations to the provider regarding their application of the Mental Capacity Act and their approach to End of Life care planning.

We saw evidence of two medication errors in the past two years, one of which was due to a poor risk assessment. There were also recording errors on medicines charts and medication logs. In one case it was unclear what a relative was administering and signing for on the relevant medication records.

The service only assessed risks relating to medication, moving and handling, health and safety and the person's property. Some of the risk assessments we saw were lacking in detail so it was unclear whether safety concerns were routinely managed.

People received a person-centred service when supported by staff who knew them well. However, care

plans failed to consistently contain person centred information. This put people at risk of receiving care that did not meet their needs in the event they were supported by agency staff or staff that did not know them well.

Record management was not robust and quality assurance systems did not identify issues of concern.

Local authority requirements regarding the reporting of safeguarding concerns were not always followed.

Two of the files we reviewed lacked information concerning assessments conducted under the Mental Capacity Act 2005 (MCA) and related best interests decisions.

The provision of regular and robust training for staff needed to be improved. The service needed to strengthen its approach to performance management and ensure formal supervision and appraisals take place.

Staff enabled people using the service to express their needs and wishes and be involved in decisions relating to their care. However, we found one example where the service could have done more to support a person to communicate.

Staff were recruited safely and there were enough staff to complete all of the visits.

Staff worked well with other health professionals and agencies to ensure people received the support they needed.

People were supported to eat and drink and staff took care to ensure food was available to meet their diverse needs. People were routinely asked before any care was offered.

Staff were very caring and kind. They treated people with respect and promoted their dignity and independence. People's right to privacy was recognised.

The service promoted an open and caring culture and staff were motivated and dedicated. There was an inclusive approach and feedback was routinely sought from staff, people using the service and relatives. The registered manager was active in the community and involved in a number of related care groups.

People and relatives were happy with the service and care provided.

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.

The system in place to ensure people received their medicines safely and as prescribed did not follow good practice.

Safeguarding issues were not reported in line with local authority guidelines.

The service ensured there was consistently sufficient staff to cover visits.

Checks on staff before they started working for the service were robust.

Care staff maintained good infection control.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's needs were not routinely holistically assessed.

Staff training and supervision needed to be improved.

People received support to eat and drink to meet their needs.

Support for people's healthcare needs was provided.

Consent had not always been obtained in line with the relevant legislation

Is the service caring?

Good

The service was consistently caring.

People were treated with compassion and respect.

People were involved in making choices about their care.

People's independence was encouraged and their dignity was upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not contain enough person- centred information to ensure people consistently received individualised care that met their needs

People were involved in the assessment of their care.

People's complaints and concerns were investigated.

The service's end of life care policy needs revision to ensure end of life planning and care delivery is in line with best practice

Is the service well-led?

Requires Improvement

The governance systems in place to monitor the quality and safety of care provided were below the expected standard.

Record management was poor.

Management created an open and inclusive culture of care delivery.

Staff felt valued and involved in care delivery.

Service users and relatives were encouraged to provide feedback.

The service was actively involved in partnership working.

Apple Homecare

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.

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.

On 31 October and 1 November 2018 our expert by experience rang people to obtain their feedback about the service. On 21 November 2018, two inspectors visited the office to speak with the registered manager and view certain records. We gave the service 48 hours' notice of the inspection visit to the office because we needed to be sure that the registered manager would be available to talk with us. One inspector returned to the office on 26 November to continue the inspection. Follow-up communication with the registered manager and provider relating to the inspection occurred on 27 November.

Prior to this inspection we reviewed the information we held about the service. This included important events the service must tell us about by law, previous inspection reports and feedback we received from the commissioners of the service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with ten people who used the service and five relatives, two supervisors, one care assistant and the registered manager. We also spoke with the provider's representative.

The records we viewed included six people's care records, six people's medicine records, four staff recruitment records and staff training records. We also viewed policies, complaints, compliments and quality assurance documents.

Requires Improvement

Is the service safe?

Our findings

Following our last inspection of this key question in May 2016, we rated safe as good. At this inspection we have rated safe as requires improvement. This is because the service did not consistently assess and manage safety risks, including those relating to medication management and administration. We also found that safeguarding issues were not reported in line with local authority policy.

We viewed the Medicines Administration Record (MAR) charts for six people who the service assisted with their medication administration. We also reviewed seven medication log entries and six medication audits.

A handwritten MAR chart was in use for one person. They had been prescribed an anti-inflammatory medication but their MAR chart gave staff no information on either the amount to give or how often. The same applied to a medication prescribed for constipation relief. Dosage information was provided on the MAR chart for other medications but there were no signatures to confirm that correct transcribing had taken place. There were gaps on the MAR chart so we could not be assured medication had been given as prescribed. We also noticed a family member's signature on the chart, which the registered manager was unaware of. They later told us that a member of staff had incorrectly permitted the person's relative to administer certain medications and to sign the MAR chart. However, due to the number of gaps in the chart and the unclear support plan, we could not establish which medications had been administered by care staff or the relative. If an error occurred, this practice would make it difficult to investigate.

This person mistakenly took an overdose yet the service reassessed the risks associated with their medication administration five months later. The reassessment contained contradictory information on how staff should assist this person with their medication. This demonstrated a poor approach to risk assessment and placed the person at risk of further medication errors. The registered manager accepted the shortfalls in this person's care management and immediately sought an urgent re-assessment of their care plan with the commissioning authority.

The records for a second person gave contradictory information on whether medications had been administered. Crosses on their MAR chart over a four-day period indicated that a medication, required to be administered twice a day, had not been given as prescribed. However, staff entries in a 'medication log' for some of the corresponding dates and times stated that this medication had been given. This contradictory information made it impossible to know if, and when the medication had been taken.

For a third person who the service was assisting with medication administration, staff were recording that 'medication had been given and taken' in medication logs. There were no MAR charts or any other safe system of recording this information in place to indicate which medicines were given and that they had been given as prescribed.

Four people's MAR charts showed instances where a cross had been entered, which indicated their medication had not been taken, but explanations for the crosses had not been provided.

The service had a protocol in place for medications that had been prescribed on a 'when required' basis (PRN) but from the records we looked at, this was not being consistently used. We did not see any information about PRN medications in the care files we looked at yet one person was being administered paracetamol as and when required.

The above findings demonstrated that the service put people at risk of harm as it failed to adhere to the local authority medication policy. It also failed to comply with its own written policies in relation to medication administration and management. Medication audits were ineffective as they had failed to identify the errors and inconsistencies.

The service received one complaint about a medication error last year. This involved the incorrect administration of medicines by care assistants. The registered manager told us this was due to the care package being taken on at short notice.

We found gaps in the approach used by the service to assess risk. Care files contained two risk assessment forms that covered areas of risk such as environmental factors, moving and handling and health and safety. The forms lacked detail about the identified risk and the measures care staff should take to mitigate the risks. We reviewed the 'Summary Risk Assessment' form for one person who had significant mobility difficulties. It provided insufficient detail and the corresponding support plan did not adequately instruct care staff how to mitigate the risk of this person coming to harm. We found an absence of individualised risk assessments and management strategies in three care plans we viewed. These related to two people with diabetes and one person who had English as a foreign language.

During our inspection we identified an incident that was a potential safeguarding concern. This should have been highlighted as a potential risk and promptly referred to the local authority safeguarding team. The registered manager also acknowledged that two medication errors that had occurred in the service should also have been referred. These referrals were made immediately after the inspection. These incidents indicated that two members of staff were not acting in accordance with the service's safeguarding policy. Another member of staff we spoke with was able to describe signs of potential abuse. They told us they would report any concerns to the registered manager. We noted that all staff had received recent training in safeguarding.

The service needed to routinely ensure all issues arising were identified, reported and analysed to ensure lessons are learnt and future risks are mitigated. We noted that an accident and incident log was in use, however there were no entries in the log relating to medication errors.

The above findings, relating to medicine and risk management, meant the provider was in breach of regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care files of people using the service showed some good examples of risk management, however. In one case, a prompt re-assessment was undertaken when a person's symptoms of dementia progressed to the point they were no longer safe to self-medicate. The service used the Malnutrition Universal Screening Tool (MUST) for people at risk of malnutrition, and completed fluid charts as appropriate. The supervisors and the care assistant told us that they routinely undertook a one-minute risk assessment prior to delivering care. This was to check whether there were any obvious health and safety risks or factors in a person's home which could impact upon the delivery of safe care. Care staff also carried out and recorded the results of a pendant alarm check during each visit. These checks ensured that people using the service were always able to safely call for help.

All the people we spoke with said they felt safe being supported by the service. One person told us, "I'm very satisfied. I've no reason to not feel safe with them [Care assistant] around" and another person said, "I definitely feel safe when the carers are in my home." Relatives we spoke with expressed the same views. One relative told us, "Oh yes, I'm sure [relative] feels safe."

There was a robust staff recruitment process in place. The registered manager undertook appropriate checks with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. There was a good staff induction and training programme.

The registered manager told us it was difficult to consistently maintain optimum staffing numbers but explained that supervisors provided cover for care staff if needed. The registered manager also did care visits on occasions and said it was helpful for them to keep in touch with the people using the service.

Everyone we spoke with told us their carers came either on time, or within half an hour if they were running late and they would always be informed about late calls. One person told us "They usually do come on time. The only exceptions are if they are held up by the previous call." Another person said, "Someone either rings me if they're late or they send someone else in their place".

One person told us about a missed call but said the service ensured their relative still received their visit, albeit a few hours later. Staff routinely stayed for the duration of the planned visit and sometimes stayed longer voluntarily. A relative praised the service for its responsiveness "Apple HomeCare stepped in at extremely short notice to provide two additional visits around a doctor's visit".

People and relatives we spoke with were happy that they regularly saw the same person. One person told us, "I have the same half-dozen different ones and I haven't found any yet that I can't rely on." A relative said, "[Person] has very regular ones (care assistants). I'm so pleased because [Person] needs consistency now, they're very well organised and they're very good."

Staff had all been trained in infection control and there were no concerns raised about their practice. All the staff we spoke with told us they always wore gloves and an apron before delivering care.

Requires Improvement

Is the service effective?

Our findings

Following our last inspection of this area in March 2016, we rated effective as good. At this inspection we have rated effective as requires improvement. This is because some people's care records suggested that the assessment of their needs and preferences had not been thorough. Staff training was not always enabling staff to deliver safe care. Staff were not being formally supervised. Staff were not routinely acting in accordance with the principles of the Mental Capacity Act.

The care files we reviewed contained variable amounts of information. Some files demonstrated that people's care needs had been holistically assessed and contained information about their physical, mental and social needs. Some files contained a 'This is Me' document which gave information about the person's life history. In other files we found little information about the person other than their care and support needs. One person spoke English as a second language and their ability to communicate in English was limited. The service accepted that they should have done more to assess and support this person to communicate their needs and preferences.

Two members of staff told us they received a good induction with training, assessment and plenty of support from the registered manager. The registered manager told us that they delivered some of the training. Dementia training was delivered in a way which enabled staff to learn through experience. The registered manager explained to us that they gave staff glasses to wear with window cleaner sprayed on them. This helped staff to experience what some people's thought processes were like. The training focused on the use of appropriate language and responses.

According to records, three members of staff had not undertaken training on the Mental Capacity Act and two had not undertaken emergency first aid training. Re-training on the Mental Capacity Act and emergency first aid was overdue for six members of staff. Staff were not offered end of life training. We were told and saw evidence that refresher training questionnaires on topics such as safeguarding were given to staff however there were no records to show who had completed these or when. Records showed that staff had completed training on medication administration and they had been assessed as competent to administer safely. However, due to the medication errors identified during this inspection, the service could not demonstrate that the training and competency assessments were effective. The registered manager said that an enhanced training programme would commence in January 2019. The registered manager also confirmed that staff would undertake immediate focussed training to address the concerns identified in this inspection.

Everyone we spoke with said they felt their care staff were sufficiently trained and able to deliver effective care. One person told us, "They are very competent. I'm not very steady on my feet; they certainly alleviate any fears of falling." Another person said, "They seem to know exactly what they're doing." Further examples we heard were, "Oh yes we remarked in amazement at how quickly [Care assistant] put them (DVT socks) on when it had taken my wife ages. "and "They all seem to know what they're doing and they are very friendly with it." A relative told us, "They can get him to do things I can't, he responds to them, I've been very satisfied."

Staff confirmed they received written updates in the form of memos but said they had supervisions infrequently. It was recognised by management that a more structured approach to regular supervisions and the introduction of appraisals was needed. The issues highlighted in this report underline the need for more robust performance management of staff.

Staff and the registered manager told us that they regularly discussed people's care delivery. They said that working closely together in a small team enabled them to have conversations frequently. Supervisors undertook spot checks on care staff to monitor the quality of care delivery. The issues highlighted in this inspection relating to medication support and record-keeping highlighted the need for these checks to be strengthened. Supervisors also monitored the arrival and departure times of care staff and ensured they were completing their time sheets accurately.

People who were assisted by the staff with their eating, drinking and healthcare told us they were well supported in these areas to meet their needs. Everybody was happy with the assistance they received. People were offered choice in what they ate. One person told us, "[Care assistant] asks what I would like and we look in the cupboard together. Once I know what's there I say I wouldn't mind such and such. They do it well, always." Another person said, "It's routine now. I tell them what I'd like, it's usually a microwave meal or a salad. [Care assistant] is very good at doing it all."

We viewed the care records for a person who the service assisted with eating and drinking. The person's care plan did not contain any information about their meal preferences but the visit log indicated that they were being offered a choice of food options. It also showed that a good variety of food was being prepared for them. One person's care file demonstrated that the service monitored their food intake by the appropriate use of the Malnutrition Universal Screening Tool (MUST). We saw completed fluid intake charts for a person assessed at being at risk of dehydration. There were no concerns from the people and relatives we spoke with about weight management and maintenance of hydration levels.

The service worked well to ensure that the people obtained support from healthcare professionals. For example, we were told by one relative that staff arranged for their family member to see a doctor regarding their developing continence difficulties. The registered manager assisted the person to attend the continence clinic and was also actively involved in ensuring they received their continence pads. The relative of this person told us they were so grateful as they did not know that they could access this type of support.

This relative also told that us the service regularly kept them informed about their family member's declining health. Staff recognised when it was necessary for the person using the service to be assessed by the doctor. On the advice of the service, the relative subsequently took their family member to the doctor and the person was diagnosed with a condition that affected their capacity. The registered manager assisted the person's relative to ensure the person was referred to a falls clinic. They also liaised with the Occupational Therapy service on behalf of that person's relative to ensure a handrail was fitted in their shower room.

People and their relatives told us that the service supported them with medical appointments. For example, one person told us, "I had to ask them about what the doctor said once, they were so helpful, nothing is too much for them." A relative told us, "If there is anything we don't understand, they help, for example when [relative] had a hospital appointment a while back they went out of their way to find out what things meant."

All the people we spoke with told us that staff always asked for consent before performing a task. We heard positive examples from people using the service, including the following: "They do check I'm ready to have

my feet and legs washed, they don't assume anything.", "I choose, I tell them what I'd like, then they get on and get it ready, they are very good." Another person told us, "It's a routine we have, they don't just do it though, they chat first and ask if it's what I want. If I want something done differently, they are very obliging."

One relative told us, "'When they come in they always say what needs doing, they check with me and with [family member] before they do anything at all." Another relative told us, "[care staff member] talks to [family member] all the time and explains what they would like to do next, [care staff member] always checks [family member] is ready and if [family member] agrees."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

Two members of care staff told us they helped people who lacked capacity to make decisions relating to their care and support. They told us they did this by offering them choice and explaining why the task in question needed to be completed. One staff member said they gave people choices when preparing their breakfast or tea. This could involve showing people different meal options and describing them to the person to help them make their choice. Both staff members understood that people's capacity fluctuated and that sometimes more support was needed to help reach a decision that at other times. This evidence suggested that care staff were aware of some of the principles of the MCA.

We were not assured that the service was working in accordance with the MCA from our review of care files though. We reviewed two care files where people's care and support decisions were being taken by relatives. Neither person had had a mental capacity assessment to determine their level of capacity. In one case, a person with a condition which affected capacity had indicated to the service that they could not manage their medication but there was no evidence to show they lacked capacity to make other decisions. In a second case, the person had mental health needs and the services' medication risk assessment stated it was unsafe for them to take their own medicines. It was, however, again unclear whether the person had capacity to make decisions about their own care. No best interest decisions had been taken for either person. Furthermore, in both cases, the relatives did not have legal power of attorney for health and welfare to take decisions on behalf of their family member.

We recommend that the service seek advice and guidance from a reputable source, to ensure that they are acting in accordance with the principles of the Mental Capacity Act 2005

Good

Is the service caring?

Our findings

Following our last inspection of this area in March 2016, we rated caring as good. At this inspection we have continued to rate caring as good.

All the people and their relatives we spoke with told us the staff were very kind, caring and compassionate. This was in part because staff knew the people well and were considerate of and attentive to their personal needs and circumstances. People explained the positive impact this had on them. One person told us, "They're very good, they seem to understand what I need. I've got osteoarthritis, they know when it hurts and are very gentle and patient. I feel confident when they are there" Another person said their carer "Understands what I want and why. I broke the vertebrae in my back, [carer] really does understand what help I need."

Care staff were clear how to provide personalised support and care and they knew people well. One care assistant told us, "[Person] forgets to eat and drink - so I always make sure they are ok - I know when [Person] isn't ok. I sit them down, get their feet up and as soon as I've given them a drink and something to eat, [Person] feels better."

All the staff we spoke with showed a genuine desire to care for the people using the service as well as they possibly could. Members of staff displayed real warmth and compassion. One care assistant told us, "They could be my mum or my dad. I want them to be treated just the same. [Person] calls me her best friend, and [person] is my best friend. I'd love to take them out. I sit with them for an extra five mins - that's my choice, I don't want a thank you, I choose to do it."

People told us their care was never rushed. A relative told us care staff always looked after their family member in a way they felt comfortable with. People and relatives told us how friendly care staff were and how beneficial this was to them. One person told us the thing they like best about the service is "the carers coming in and being cheerful and helpful. I know when they're coming, they bring the outside world in to me." One relative told us, "[Family member] likes them, they make him smile, they chat to them all the time and laugh. It cheers [Family member] up."

A member of staff understood the need to make people feel happy. They told us, "I like to make [Person] smile, I try to be light-hearted with [Person]." They said that they tried to spark memories by chatting to people and told us that one of the people said in response, "Thank you for making me remember".

People and their relatives all spoke about how were willing staff were to support in any way they could. One person told us "They [carers] are very kind, if I've got any washing to hang on the line, they always hang it out for me. They empty my handy bins, they'll do anything." A relative told us, "No job is a problem to Apple HomeCare and they have gone beyond their remit on occasion, by shopping locally for milk and bread when my [relative] has run out, or offering [relative] a lift home from the doctor's surgery" Another relative told us, 'Nothing seems to be too much for them."

The registered manager demonstrated a very caring and empathetic nature and we heard several examples where they went above and beyond simply out of desire to make those using the service feel better. When speaking about them, one person told us, "[registered manager] is excellent, does things beyond the call of duty. Before I could order online (food) [registered manager] ordered it for me it was on their account at Sainsbury's and they had it delivered to me." A further person told us, "[Registered Manager] even gives little tea parties about once a month, the fuss they make is beyond their work, they do it out of the goodness of their heart. The registered manager also provided significant support to the person's family member in helping them understand and deal with the symptoms of their family member's illness. This thoughtful act was again carried out voluntarily. A relative told us about a similar example, "They did send me literature about dementia, I got lots of tips from it. They respond to everything. it's excellent."

The desire to provide a special, personalised touch was also evident in people's care folders that they kept at home. The first thing in the folder was a list of reminders to care staff entitled 'Finishing Touches'. This included things such as 'Clear a Service User's glasses to remove the smears' and 'Listen to what the person is telling you, we are guests in their home'.

Staff respected people's dignity and provided respectful care. One of the support plan routines we looked at stated 'place towels on [Person] when assisting with personal care'. One member of staff told us, "I look after people using the service as if I would look after my parents. I treat them with dignity – for example, when you wash them, cover them up so they are not naked, put clothes and towels on radiator to be heated and wrap them up warm before dressing them." Another member of staff told us, "I don't want [Person] to feel like they are five, I don't want them to feel that I'm telling them off, but I just say nicely you need to drink [Person]." They also said, "I always ask before I offer some care. I give a choice between shower and wash. I just want [Person] to be clean and smart and leave the house nice for them. When I leave each house, I know they're happy and they're clean, I know their safe. That's what gives me job satisfaction."

The service encouraged people to be independent and routinely sought to empower people to take their own decisions and undertake tasks themselves. We were told by one member of staff, "We always say to him, come on [Person] you can do this – so [Person] combs their hair, sits there shaving, and puts their slippers on." Another member of staff said, "I always ask what they need help with. We're not there to take their independence away, we're there to help. If they want to wash themselves they do and then we may help a bit more afterwards."

Relatives told us that staff accommodated peoples' individual communication abilities and preferences well. One relative told us, "Carers are always calm [Family member] responds to them more than they respond to me." One other relative commented, "Sometimes [Family member] is difficult to respond to because of their dementia, they [Care assistants] really do know how to handle him."

A member of staff told us that one person living with dementia finds it hard to say things and didn't know what the toilet was. The care assistant explained how they spoke quietly to explain and reassure the person and reminded them that their routine was very important. We were told that staff were trained to use simple language and closed questions when speaking with people living with dementia. One person using the service had pictorial prompts and the use of an electronic tablet to aid communication.

Requires Improvement

Is the service responsive?

Our findings

Following our last inspection of this area in March 2016, we rated responsive as good. At this inspection we have rated responsive as requires improvement. This is because the service could not demonstrate robust person-centred care planning. Also, the service's end of life policy did not enable good end of life care planning to ensure that peoples wishes were always met.

People or their relatives told us they were involved in developing their care, support and treatment plans. One person told us, "Initially, I had a supervisor come, she did a risk assessment. I felt I was giving my opinion then and agreeing to what they were offering." Another person said, "Yes, I was involved, I told them what I needed help with most." One relative told us that both her [Family member] and herself were involved in making the initial decisions about what care [Family member] needed. They told us, "They came and listened, they told us what they could provide." The registered manager said that their approach was to ask how people's needs could be put 'centre stage'.

Information relating to initial assessments was not routinely recorded in people's care files. Some care files did not contain up to date risk assessments or care plans. Some care plans we viewed did not provide enough information to ensure person-centred care delivery. We spoke with the care staff and registered manager to establish how they ensured people received personalised care. They told us that this was achieved by regular verbal communication with service users and between members of staff. The registered manager told us staff were updated with any new information before their visits. Each member of staff also told us that daily visit sheets enabled them to provide personalised care. The registered manager showed us examples of visit sheets and told us that these were generated electronically each week. They explained that information pertaining to people's care and support needs was held electronically as well as in their care files.

Care staff were given visit sheets for each of the people they were due to see over the coming week. The visit sheets contained information relating to people's health conditions and other key details, such as whether they were at risk of falls or had had a recent operation. The sheets we saw provided a record of people's care needs and stated how their care and support should be delivered in line with their preferences. Staff said that if they had any questions about the care package they would speak to the registered manager or a supervisor.

The people we spoke with told us that care staff knew how to meet their care and support needs. One person told us, "They know what I like and how I like things done" and another one said, "They meet all my needs and more." A relative told us "I think the carers do know how to meet [Family member] needs."

Staff we spoke with demonstrated that they knew the specific needs of people they cared for. For example, one member of staff told us about a person who need to drink regularly. They told us, "I always make sure [Person] has a drink left in every room and that [Person] drinks when I am there. I explained that if [Person] is lightheaded they might fall."

Another member of staff explained that one person they cared for often got the time of the day wrong so they suggested to the person's relative to move their shoes away from the door in the evening. This prevented the person from thinking it was time to go out and helped lessen their confusion.

The registered manager acknowledged that they needed to re-assess the communication skills of a person who did not speak English as their first language. The person's relative had been required to interpret when the person was initially assessed. The service ought to have explored the implications of the person speaking only limited English. The registered manager acknowledged that this might have affected their ability to express their needs and wishes to care staff.

People told us the service was responsive if their needs changed. We saw some evidence of this; the service had re-assessed one person's medication risk when they became aware that they were not routinely self-medicating. The Registered Manager told us, "We asked how we could help [Person] to take self-control so now the medicines are in a blister pack. We have found a way to help them take control safely."

People told us their care records had recently been reviewed and updated with their involvement. One person using the service said, "They have been at least once or twice in the last year, we talked about it all." and another said, "They assess yearly, I think."

The service supported people's emotional and psychological wellbeing and helped prevent people from experiencing social isolation. The did this by organising a monthly social event which they helped people to attend. A relative told us about the benefit of this initiative, "They provide a once monthly social event and my [relative] absolutely loves going to these. There is singing and music and lots of interaction with others, which for some of the elderly may even be their only social event of the month."

People we spoke with told us they had no reason to complain about the service but they knew how to complain if they needed to. One person told us, "They are top class. I can categorically say that I've had no complaints whatsoever, they are so caring." One person told us they raised an issue relating to the day they received their care and it was resolved immediately. Records showed the service received three complaints over the past 12 months and those we reviewed had been appropriately investigated and responded to. The service received 26 compliments this year.

We did not see details in people's care files about their preferences relating to end of life care. The service's end of life policy stated that care preferences and arrangements were discussed when a person was recognised to be reaching the end of life. However, we reviewed the file of a person who was being given palliative care and there were no records relating to their end of life care preferences. We were told this was because the person's health suddenly deteriorated and there was no opportunity for this discussion to take place. We recommend that the service seeks advice from a reputable source, to ensure that end of life planning and care delivery is in line with best practice.

The service received compliments from relatives thanking the service for their support during the passing of their family members. One compliment stated, "I would like to thank everyone at Apple Homecare who were so kind and caring of my [relative] in their final days. I was overwhelmed by how they treated [relative] with great respect and compassion. I am sure [relative] was always comfortable after their care." Another relative wrote to the service, "Seeing [Care assistant] and [Care assistant] say goodbye to [relative] was like watching family. You can't fake that kind of thing and I know they really cared for [relative]."

Requires Improvement

Is the service well-led?

Our findings

Following our last inspection of this key question in May 2016, we rated well led as good. At this inspection we have rated well led as requires improvement.

Whilst the service at the point of delivery was good, there were shortfalls in the management of care records and the quality assurance systems for monitoring the service. Record-keeping in relation to medication, care assessment, care plans, consent and risk assessment needed improvement. Some of the documents we found in files were out of date and some contained inaccurate information. Staff started to update the files during our inspection however the provider's system to monitor and improve the service had failed to identify them prior to our inspection.

The registered manager told us that care plans should be reviewed at least annually or when a person's needs changed. From the care files we reviewed, people's care plans had not been routinely reviewed on an annual basis. This meant that some of the care plans were lacking in key information. We were told that staff were working hard to ensure all care plan reviews were up to date.

People's care file records did not routinely contain information about the medication they were taking or confirm whether the service was providing the person with medication support. Two support plans made no mention of medication support, even though it was being provided by the service. It was also unclear whether care assistants should prompt the person to take their own medicine or administer it to them. As the service had not completed care plan audits for over 12 months, they had failed to identify this prior to our inspection.

Records relating to people's capacity to make decisions about their care were poor. One person's care file contained a form where it was recorded that a person diagnosed with dementia said they could not manage their medication and that their relative held the medical reports. There was no indication whether a mental capacity assessment had been undertaken or if a best interests decision had been made. In another case, a relative signed a Service User Agreement and took decisions on behalf of their family member but there was no information to show that the relative had the legal authority to do so.

Although the provider said that staff were routinely asked to undertake refresher training, there were no records available to demonstrate that this had happened. The service needed to ensure full and up-to-date records of staff training and assessment were maintained.

The service did not have effective systems in place to audit the quality of care that people received. A member of staff was responsible for monitoring the provision of care by randomly auditing task sheets, medication logs and pendant alarm check sheets. Task sheets showed the times staff had visited people, how long they had stayed and what tasks they had completed. A box of unchecked task sheets contained sheets dating back to March 2018. A member of staff told us the reason for this was that they didn't have time to look at them. We were told that supervisors and registered managers checked completed sheets in people's homes when they went out to do visits or spot checks on carers.

Had there been a more robust approach to checking these records, some of the medication recording errors, described earlier in the report, would have been identified. More robust auditing of MAR charts would have also exposed the inaccuracies and errors we found. The fact this was not identified promptly put people at risk of receiving unsafe care. The registered manager immediately arranged for another member of staff to complete the auditing of medication records as a result of our findings.

The provider immediately demonstrated a firm commitment to improving the issues highlighted in the inspection.

The poor record keeping and monitoring constituted a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's vision was to create a small, local, friendly and high-quality service. The registered manager told us they were not pressurised to grow the business and that packages of care were not accepted unless the service was sufficiently resourced to provide high quality care. The provider was visible and supportive in the running of the service and familiar with all the staff. Staff confirmed the service had an open and enabling culture. Those we spoke with were happy working there and told us the management team were approachable and supportive. One member of staff said, "You can talk and things get done, you're listened to and you are all just as important as each other. There is no hierarchy. We can talk openly and try and sort out problems." They said they felt valued and their opinions were respected.

The registered manager played a significant part in creating an inclusive workforce. They had an open-door policy and we saw staff accessing the office freely and comfortably. When asked how they retained staff, the registered manager replied, "I never ask staff to do something I wouldn't, I treat staff with respect, I always make staff feel welcome, I look after them and I buy them wine for example – to say I appreciate what they do". The registered manager led by example. They consistently demonstrated a kind, thoughtful and considerate approach. One person told us, "[registered manager] is absolutely superb, nothing is too much trouble, they really are top marks." Everyone we spoke with was complimentary about the service. One relative told us, "The service has been so good, it's a very caring team, the manager is marvellous. I have already mentioned it to someone who is thinking they might need some help." Another relative said, "Apple Homecare are wonderful and I rate them very highly indeed."

Although care delivery was not routinely measured against relevant policies and best practice guidance, the people and relatives we spoke with were unable to tell us of any improvements that they felt were needed. One person told us, "The service was good at first, it's excellent now. It doesn't need to improve". By recognising the contribution of the care staff, the registered manager fostered a motivated and committed workforce which achieved a high level of customer satisfaction. The provider told us that improvement was driven through regular communication with the people and their relatives.

The service conducted annual surveys, which were sent to people or their relatives. This enabled them to gain the views of people on the quality of the service. Staff were in regular communication during visits and on the telephone and obtained informal feedback in this way as well. People, relatives and staff had confidence the registered manager would listen to their concerns and that concerns would be dealt with appropriately. People told us, "I'd speak to the manager if I had any worries (registered manager) is very good so far, I haven't had to." A relative told us they raised an issue about one of the carers near the start and that the staff were very obliging. They told us they were "good at listening and reacting". Another person told us, "There is always someone there to speak to, they're very helpful."

The staff we spoke to said they were happy to give feedback and raise any concerns with the registered

manager or provider, if the need arose, and they felt confident that any concerns would be addressed quickly.

The registered manager was actively involved in local organisations, and used this to enhance care delivery. They were involved in the Norfolk and Suffolk Dementia Steering Group and as a result were able to use their knowledge to provide interactive training to staff. The registered manager was also involved in the Norfolk Independent Homecare Group and they chaired a Norfolk Medications Group. The registered manager led on home care for the Norfolk Care Association, an organisation which the provider told us he had previously chaired. This involvement enabled informal relationships with other providers and mutual learning. We noted that the service had a good business contingency plan in place. The provider also told us that the service had an agreement with another similar care agency, whereby in the event of an emergency occurring in one of the services, the other would provide support. The registered manager demonstrated their commitment to rewarding and supporting staff who have just entered the profession by instigating a new Norfolk Care award called the Rising Star award. The service won a Norfolk Care Award for End of Life care in 2017.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment had not always been provided in a safe way. The provider had not ensured the proper and safe management of medicines. Risks to people's health and safety had not always been adequately assessed and steps had not always been taken to mitigate risks as reasonably practicable. Regulation 12 (1), (2) (a), (b) and (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes were not in place to assess, monitor and improve the quality and safety of the care provided or to mitigate risks relating to the health, safety and welfare of service users. Accurate, complete and contemporaneous records had not been kept in relation to each service users care and treatment. Regulation 17 (1), (2) (a), (b), (c)