Leyton Healthcare (No. 12) Limited

Apple Court Care Home

Inspection report

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Date of inspection visit: 13th and 16th April 2015
Date of publication: 13/07/2015

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?	**Requires improvement**

Overall summary

This inspection was unannounced and took place on the 13 April 2015. A second day of the inspection took place on the 16 April 2015 in order to gather additional information.

The home was previously inspected in February 2014 when it was found to be meeting all the regulatory requirements which were inspected at that time.

Apple Court Care Home is a purpose built care home located in the centre of Warrington. It offers accommodation, personal and / or nursing care for up to 67 older people with memory problems associated with dementia. At the time of our inspection the service was providing accommodation to 52 people.

The home has four units. The 'Rylands', 'Grosvenor' and 'Daresbury' units provide nursing care for up to 50 people. The 'Crossfields' unit provides personal care for up to 17 people. Each unit is equipped with a dining room and a lounge area.

People who live in the home are accommodated on both floors of the two storey building and access between the

Summary of findings

first and second floors is via passenger lift or by the stairway. Each unit is equipped with a dining room and a lounge area. Bedrooms are all single, with en-suite facilities that include a sink and toilet.

At the time of the inspection there was no registered manager at Apple Court Care Home. 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.

Apple Court was being managed by the regional manager at the time of our inspection pending the appointment of a new manager. We were informed that a replacement manager had been recruited and that the person would apply for registration with CQC as a matter of priority.

During the two days of our inspection, people living at Apple Court were observed to be comfortable and relaxed in their home environment and in the presence of staff.

People using the service and relatives spoken with were generally complimentary about the care provided at Apple Court. However we found that there were issues with how staff managed safeguarding incidents, training and supervision for staff, how complaints were managed and how the provider assessed and monitored the quality of care. You can see what action we told the provider to take at the back of the full report.

We have also made recommendations about the need to source a needs analysis tool and staff deployment tool. This will help to demonstrate that the staffing levels are adequate and being kept under review.

We also recommend that the care planning system is updated and reviewed to ensure it is more person-centred. In addition we recommend that the quality assurance system is updated to detail action taken in response to surveys, accidents and safeguarding incidents and other findings to provide a clear audit trail.

Summary of findings

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 always safe.

Adequate systems were not in place to demonstrate that the staffing levels in Apple Court were sufficient to meet the needs of people using the service.

Systems for reporting and responding to accidents, incidents and abuse were not sufficiently robust to safeguard people using the service.

Is the service effective?

Requires improvement

The service was not always effective.

Gaps in supervision practice and a range of key training areas were noted such as dysphasia, and challenging behaviour training for staff. Furthermore, clinical training such as CPR, venepuncture and investigation training for managers within Leyton Healthcare was in need of review to safeguard the welfare of people using the service.

Is the service caring?

Requires improvement

The service was not always caring.

On the day of our inspection we found interactions between staff and people using the service were positive, dignified and kind. Staff were observed to communicate and engage with people in an appropriate manner and people using the service were seen to be relaxed and at ease with the staff supporting them.

Concerns have however been received from several sources regarding people being left unsupervised; care plans not being acted upon; staff failing to respond to the needs of people and their calls for help; inappropriate feeding of people and staffing levels.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans were found to be standardised; there was scope for the development of a more personalised approach to care planning within Apple Court.

Systems were in place to seek feedback from people using the service and their representatives however there was no written summary of the findings of the survey or an action plan to demonstrate how the service would respond to constructive feedback.

Complaint records were incomplete and there were no details of the action taken, findings or how the outcomes had been communicated to complainants.

Summary of findings

Is the service well-led?

The service was not always well led.

Apple Court did not have a registered manager in post.

Concerns identified prior to and during the inspection highlighted weaknesses in the operation of Apple Court Care Home and the need for strong leadership to improve and develop the service.

Requires improvement

Apple Court Care Home

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 checked whether the provider was 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 was unannounced and took place on the 13 April 2015. A second day of the inspection took place on the 16 April 2015 in order to gather additional information.

The inspection was undertaken by two adult social care 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, in this case of people living with dementia.

Before the inspection the provider completed a Provider Information Return (PIR) which we reviewed in order to prepare for the inspection. This is a form that asks the provider to give some key information about Apple Court Care home. We also looked at all the information which the Care Quality Commission already held on the provider. This included previous inspections and any information the provider had to notify us about. We invited the local authority to provide us with any information they held about Apple Court Care Home. We took any information provided to us into account.

During the site visit we talked with seven people who used the service and nine visitors. We spent time with people in the communal lounges and in their bedrooms with their consent. The expert by experience also joined one group of people for lunch.

Furthermore, we met with a regional manager from Leyton Healthcare (the provider) who was managing in the home pending the appointment of a new manager. We also spoke with three staff, an activities coordinator, the handyman and a cook.

We undertook a Short Observational Framework for Inspection (SOFI) observation in one unit of Apple Court Care Home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at a range of records including: six care plans; four staff files; staff training; minutes of meetings; rotas; complaint and safeguarding records; medication; maintenance and audit documents.

Requires improvement

Is the service safe?

Our findings

We asked people who used the service or their relatives if they found the service provided at Apple Court Care Home to be safe.

People spoken with confirmed that they felt safe and some people qualified this. For example, we received comments such as: “Of course I feel safe here. They look after me very well”; “I get treated very well. There’s nobody nasty here. Nobody bullies me. I’d report them if they did”; “I’m okay. There’s no problems. I’m quite safe here”; “Everything’s fine, we’ve no qualms about her safety or care. My brother sees her much more often than I do and I know that he has no concerns” and “We feel happy that she’s safe here.”

The people living at Apple Court were observed to be comfortable and relaxed in their home environment and in the presence of staff. We observed staff to be friendly and attentive to the needs of the people living in the home. However, we did have concerns that staff were not always following the correct processes to fully protect people using the service from abuse or risk of harm.

The registered provider (Leyton Healthcare) had developed internal policies and procedures to provide guidance to staff on ‘Safeguarding Service User’s from Significant Risk of Harm’; Safeguarding Service Users from Abuse’ and ‘Staff Whistle Blowing’. A copy of the local authority's safeguarding procedures was also in place for staff to reference.

Discussion with the regional manager and staff together with examination of training

records confirmed the majority of staff had completed 'safeguarding’ training which was refreshed every three years. When we talked with staff they confirmed that they had received this training which had also been included in their induction.

The regional manager and staff spoken with demonstrated a satisfactory understanding of the concept of abuse, awareness of their duty of care to protect the people in their care and the action they should take in response to suspicion or evidence of abuse. Staff spoken with also demonstrated awareness of how to whistle blow, should the need arise.

Two whistle blower concerns had been received by the Care Quality Commission (CQC) in the past twelve months which were both unsubstantiated. Additionally, the Commission had received negative feedback on the service from six sources prior to the inspection.

Information received from the local authority prior to our inspection revealed that two safeguarding concerns had not been reported to the local authority. Furthermore, Leyton Healthcare had proceeded to undertake their own internal investigations. This meant that the welfare of people who used the service was not adequately protected.

We viewed the safeguarding file for Apple Court. There was no tracking form in place for 2014 and copies of referral forms and statutory notifications had been archived. Information on the action taken and outcomes of safeguarding referrals was also not available.

For 2015, the previous manager had developed a template to assist in tracking safeguarding incidents. We found copies of statutory notifications and referral forms. Brief details of the action taken had been recorded but outcomes were not clear. We raised this issue with the regional manager who agreed to review the records and provide a summary report to CQC.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to ensure that the people using the service were protected against the risks of unsafe or inappropriate care because appropriate action had not been taken in response to incidents.

We looked at six care plans for people who lived at Apple Court and we saw that they contained a range of risk assessments relating to different areas of care relevant to each person. We found that these had been kept under review so that staff were aware of current risks for people who lived in the home and the action they should take to minimise potential risks.

We saw that staff weighed and recorded people’s weights and completed nutritional intake and fluid charts where necessary so as to identify any nutritional risks. We also noted that action had been taken to involve multi-disciplinary team members such as GPs, speech and language therapists, dieticians and mental health practitioners when necessary.

Requires improvement

Is the service safe?

At the time of our inspection the service was providing accommodation and care to 52 people with residential or nursing needs for older people with memory problems associated with dementia.

We checked staff rotas which confirmed the information we received throughout the inspection about the numbers of staff on duty. Staffing levels across the four units had been set by the service at three registered nurses during the morning and evening shifts. During the morning, there was also one senior carer and 11 carers on duty. This reduced to one senior and eight carers in the afternoon.

During the night there were two nurses and six carers on duty covering the four units in the home.

The regional manager informed us that staffing hours had recently been increased by six hours on one unit in response to the needs of people using the service.

Individual dependency assessments were not available on files viewed and the regional manager was unable to locate the dependency tool which the service used to monitor dependency levels and calculate staff deployment hours. Information received from the local authority highlighted that the service used a staffing dependency tool that originated from Northern Ireland which did not reflect the design of the service for example nursing input or environmental factors.

CQC had received information of concern from a number of sources since our last inspection regarding the maintenance of adequate staffing levels; availability of staff; staff failing to respond to the personal care needs of people and their calls for help; management of accidents and incidents within the service; moving and handling techniques and equipment used by staff and inappropriate support for people at mealtimes. During our inspection, we found no evidence of staff failing to respond to the needs of people using the service.

One staff member spoken with had recently commenced employment at Apple Court and was able to confirm that they had undergone robust pre-employment checks. We looked at a sample of files for four staff who were employed at Apple Court. We saw there were thorough recruitment and selection procedures in place which met the requirements of the current regulations. In all files we found that there were application forms, references, health questionnaires, disclosure and barring service checks and proofs of identity including photographs. All the staff files we reviewed provided evidence that the necessary checks had been undertaken before people were employed to work at Apple Court. This helped protect people against the risks of unsuitable staff.

We checked the arrangements for medicines in the home with a registered nurse. We saw that there were seven policies and procedures in place relating to the administration of medication and the use of oxygen and medical gases dated April 2015.

At the time of our visit we could not locate a list of staff responsible for administering medication, together with sample signatures. This was raised with the nurse and the regional manager who agreed to take action to replace the missing form.

We saw that photographs of the people using the service had been attached to medication administration records to assist staff in the correct identification of people who required medication.

The nurse informed us that she had her competency to administer medication assessed prior to administering medication but we were unable to see any records to confirm this information. Training records viewed confirmed that staff responsible for the management and administration of medication had received medication training that was refreshed every three years.

We observed the administration of medicines by a nurse during our visit. Medication was found to be stored within a lockable trolley that was secured to a wall in the nurses' office when not in use.

Separate storage facilities were in place for medication requiring cold storage and for controlled drugs.

We saw that a record of administration was completed following the administration of medication in each instance on the medicines administration record (MAR). We also checked the arrangements for the storage, recording and administration of controlled drugs and found that this was satisfactory.

Systems were also in place to record fridge temperature checks and medication no longer required / destroyed. Additionally, 'random medication audits' and detailed 'medication audits' were completed periodically. We noted that the detailed version had not been completed for over 12 months.

Requires improvement

Is the service safe?

We recommend that a needs analysis tool and staff deployment tool is sourced or developed that is suitable for the layout of Apple Court and the needs of the people using the service. This will help to demonstrate that the staffing levels are adequate and being kept under review.

Requires improvement

Is the service effective?

Our findings

We asked people who used the service or their relatives if they found the service provided at Apple Court Care Home to be effective. We received positive feedback which confirmed people spoken with were of the opinion that their care needs were met by the provider.

Comments received included: "I'm happy here, things are good"; "I'd rather not be here, but if I've got to be anywhere, it's okay here"; "The food is good, I like everything. I'm putting on weight"; "The food is excellent, very good. There's plenty and snacks and drinks when you want"; "The food's okay. There's not a lot of choice but it's okay. The staff come into my room and check that I'm okay they're pretty good"; "The food's okay. It's wholesome, not posh, but I wasn't brought up on posh food so it suits me"; "The carers seem competent and well trained and they take an interest in the family. We have an informal review every 6 months"; We're not made to feel as if we're interfering"; "She likes it here. The staff are very good, very friendly. They make me feel welcome. I feel at home here" and "The staff do listen to me and take notice of what I say."

However, although people were positive about their care we had concerns that staff had not received sufficient training to ensure that they could safely meet the needs of all the people living at the home.

Examination of training records and discussions with staff confirmed staff had access to a range of induction, mandatory and other training that was relevant to individual roles and responsibilities. The training was delivered via e-learning or face to face sessions via one training provider.

Training available included Induction; Food Hygiene, Fire; Medication; First Aid; Health and Safety; Moving and Handling; Infection Control; Challenging Behaviour; Dementia Care; Dementia Care; Nutrition; Safeguarding; Mental Capacity and Deprivation of Liberty; falls, pressure sores; Equality and Diversity; Control of Substances Hazardous to Health; Fire Warden; National Vocational Qualifications, Dysphasia and Person Centred Care.

We checked the records of training and found that there notable gaps in a number of areas especially in Dysphasia and Challenging Behaviour training. CQC had received information of concern from a health care professional prior to the inspection regarding the high number of hospital admissions and chest infections that should be avoidable, failure to respond to training opportunities offered to nursing and care staff by the Clinical Commissioning Group (CCG) and poor recognition of swallowing problems in people living with dementia. We raised these issues with the regional manager who agreed to liaise more closely with health care professionals and to take advantage of training opportunities provided by the CCG.

We also raised the need to address two training recommendations made by a coroner following a recent inquest. These concerned the need to review staff training including CPR and investigation training for senior managers of Leyton Healthcare.

We noted that unit staff and nursing staff meetings had taken place periodically. Likewise, staff had accessed formal supervision meetings with the previous registered manager. Examination of the minutes of meetings / supervision sessions revealed that the same minutes had been used for more than one meeting or staff supervision. This raises concerns regarding the quality of records, meetings and supervision within the home.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Please refer to the back of the report for action taken. The registered person had failed to ensure that the people using the service were protected against the risks of unsafe or inappropriate care because staff lacked competence or training in key areas related to their roles and responsibilities.

Each of the four units within Apple Court had dining areas which were provided with food from a central kitchen. Meals were transported to each of the units via hot trolleys.

The most recent local authority food hygiene inspection for Apple Court was in November 2013 and the home had been given a rating of 5 stars.

We spoke with the cook on duty and noted that information on the preferences and special dietary requirements of the people living in the home had been recorded for daily meals.

Requires improvement

Is the service effective?

We noted that a three-week rolling menu was in operation which offered a choice of meal at each sitting. Mid-morning and afternoon snacks and an evening supper were also provided and people were observed to have refreshments throughout the day.

The menu for the day was on display in the dining rooms on a chalk board and a pictorial menu was available to help people with cognition and communication difficulties make meal choices.

We observed lunch time meals being served in two units. Tables were attractively laid with a floral decoration, together with salt, pepper, vinegar, ketchup and brown sauce bottles. Each setting had a place mat with cutlery and napkin. The dining room was spacious, light and pleasantly decorated. There was some background music which was not obtrusive.

People were offered drinks and a choice of pork steak or cheese and onion pasty, with chips or mash and carrots and peas. For dessert, there was mousse. People were offered another drink when they had finished their main course and asked if they had

finished before their plates were taken. We noted that staff were available to offer encouragement and support to people requiring assistance.

Most of the food we saw served was attractively presented and appeared tasty. However, we had concerns about how people who required a soft or pureed diet were being cared for. The pureed meals did not look appetising and consisted of a large mound of mashed potato with meat puree and pea puree poured over it.

Staff told us that had recently received training from a speech and language therapist in how to support people with swallowing problems. Despite this we observed staff supporting people with swallowing difficulties at mealtimes using large metal spoons piled with food and placing the food at the front of the tongue. This has the potential to place vulnerable people at risk of food or liquid entering their airway which can cause respiratory problems such as pneumonia or upper respiratory infections. As previously stated, concerns had been raised with us regarding the high number of hospital admissions and chest infections that should be avoidable.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to ensure that the necessary support for people to eat and drink was at all times provided to maintain their health and safety.

Although there was not much conversation between people using the service, there was friendly chatter between the care staff and each diner. Overall, there appeared a pleasant ambience during the mealtime.

We noted that the corridors within the units of Apple Court had been decorated with collages on the wall and were themed around topics chosen by residents such as Coronation Street, Chester Zoo and Blackpool. Toilet and bathroom doors had also been painted in bright colours to help people orientate around the home. In addition memory boxes (door signage frames) had been fitted to doors to help people identify their rooms.

We saw that people's rooms were also personalised with pictures, photographs, blankets and throws; ornaments and other memorabilia.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. DoLS are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

We saw that there were corporate policies in place relating to the Mental Capacity Act 2005 and DoLS and that staff had access to training in this area.

Discussion with the regional manager and examination of records indicated that 51 mental capacity assessments had been completed for people living at Apple Court. Records detailed that 12 people were subject to a DoLS authorisation at the time of our visit. Several additional DoLS applications had also been made, which the service was waiting to hear the outcome of from the local authority.

Staff spoken with were able to describe where DoLS might be applicable and confirmed they had received training. Staff were less sure which people using the service were subject to a DoLS authorisation. This uncertainty meant

Requires improvement

Is the service effective?

that these safeguards might be applied to the wrong person or might not be applied correctly. This was raised with the regional manager who agreed to address the matter.

Care plan records viewed provided evidence that people using the service had accessed a range of health care professionals including: GPs; district nurses; speech and language therapists and podiatrists.

Requires improvement

Is the service caring?

Our findings

We asked people who used the service or their relatives if they found the service provided at Apple Court Care Home to be caring. Feedback received was positive and confirmed people spoken with were of the opinion that the service they received was generally caring.

For example, comments received included: "I don't need much help. The staff are kind and caring though. They treat me with respect and dignity. They're very friendly"; "I know the staff and everyone cares"; "The staff are really friendly. There is a nice atmosphere. The residents are well looked after"; "The staff are good. It's a good team"; "The staff are kind and caring. I get on well with all of them. You can have your say and they listen to you"; "All the staff are great I wouldn't say it if they weren't"; "The staff are very good kind and caring. He's treated as an individual and with dignity that's why he moved out of his previous care home. I'm also made to feel welcome here" and "There's always a family member in every day and we don't just observe how they treat Mum, but the other residents as well. They're all treated as individuals and with dignity and respect" and "The staff are really nice, we like them all.

People using the service and relatives spoken with were generally complimentary of the standard of care provided at Apple Court. However, some negative feedback was received during the inspection and CQC also received negative feedback on the standard of care provided from other sources prior to the inspection. Examples of comments received are included in the responsive section of this report.

We spent time with people and staff on each of the units in the Apple Court over the two days of the inspection. We saw that staff were both polite and respectful and addressed people by their first name in an appropriate manner.

Our use of the Short Observational Framework for Inspection (SOFI) tool found interactions between staff and people using the service were positive, dignified and kind. Staff were observed to communicate and engage with people in an appropriate manner and people using the service were seen to be relaxed and at ease in the company of themselves and the staff supporting them.

We asked staff how they promoted dignity, privacy, choice and independence when providing care to the people who lived at Apple Court. Staff were able to give examples such as knocking on doors and waiting for permission before entering people's rooms; asking people what time they wished to get up or go to bed; offering people the right to choose a meal at each sitting or what they wished to wear for the day. We observed examples of this practice whilst spending time with people around the home and we could see from the expressions and reactions of people that they were comfortable and relaxed.

We also observed people's choices were respected and that visitors attended throughout the day without restriction and were made welcome with drinks.

A number of bedroom doors were noted to be open whilst walking around Apple Court. It was therefore evident to see that people using the service had been supported to personalise their rooms with pictures; photographs; fresh fruit and ornaments and other personal possessions and memorabilia.

We found the regional manager who was managing the home pending the appointment of a new registered manager had a good knowledge of the staff team and the people who lived at Apple Court, for example their personalities, needs and support requirements. We noted that the regional manager had previously been registered as the manager of Apple Court.

Through discussion and observation it was clear that that the regional manager was approachable and friendly towards with the people using the service and staff responsible for the delivery of care.

Information about people who lived at Apple Court was kept securely to ensure privacy and confidentially.

A statement of purpose and a guide for new residents was available for prospective service users and people using the service to view. These documents contained a range of information about Apple Court, the aims and objectives of the service, philosophy of care and how to raise a complaint.

Systems were also in place to regularly gather the views of people who used the service or their representatives via relatives and residents meetings and satisfaction surveys.

Requires improvement

Is the service responsive?

Our findings

We asked people who used the service or their relatives if they found the service provided at Apple Court Care Home to be responsive. Feedback received confirmed people were generally of the view that the service was responsive to individual need.

Comments received included: "They're [staff] very friendly, caring and helpful. They make you feel at home. Family and visitors are made welcome as well"; "I'm an outdoors man. I used to be a farmer. I enjoy going out into the garden"; "We did a bit of gardening the other day, planting hanging baskets"; "She gets the care she needs. We had a meeting last November and they explained her care. We were able to provide input to it. As far as we are aware, her care is going as per plan"; "She's encouraged to take part in activities but not forced to. Which is her choice really"; "The staff are all very approachable. We get regular updates and we're confident they would deal with any issues. One issue we did have was with the laundry and her clothes going missing, even though we said that we would do the laundry ourselves. Anyway we brought it up and it's not happened again"; "We did have issues regarding her eating and staying in bed. She needs constant encouragement to eat and to get up and get dressed. The staff do that now. Something about which I was really impressed was that we noticed that there were bruises on her hand. We mentioned it to the staff and they got the doctors out straight away" and "I made a complaint about a staff member and it was sorted immediately."

We did receive some negative feedback during our visit. For example one relative reported: "I came this morning and he was still in his night clothes. I mentioned it to a carer and they told me that they would dress him when they had a moment. They've only now got him dressed. Another time, he hadn't had a drink all morning." Likewise another relative stated: "I got called by the night staff at seven in the morning to tell me that he'd gone to hospital. They told me that someone had gone with him. When I got to the hospital, I found that nobody was with him, and that he wasn't dressed. He just had a blanket and a pad on." We raised this issue with the regional manager

CQC also received negative feedback on the service from other sources prior to the inspection which were shared with the local authority so that the issues of concern could be monitored externally.

The provider had developed a complaints policy to provide guidance to people using the service, their representatives and staff on how to raise and / or manage a complaint.

We reviewed the complaints file. There was no tracking form in place to provide an overview of complaints received and there only two complaint records in the file. Brief details of the complaints had been recorded however there were no details of the action taken, findings or how the outcomes had been communicated to the complainant.

The regional manager attempted to find out where the other complaint records had been stored together with details of the missing records relating to the two incidents recorded on file. The records could not be located during our visit.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to demonstrate that the service was acting on complaints because records were not being appropriately maintained.

We received assurances from the regional manager that the outcomes of all future complaints would be recorded and followed up in writing to ensure best practice and a clear audit trail.

Apple Court was divided into four units. The 'Daresbury'; 'Grosvenor' and Rylands units provided nursing care and support for a combined total of up to 50 people living with dementia who required general nursing care. Likewise, the 'Crossfield' unit provided residential care for up to 17 people living with dementia. Dementia can cause memory loss, confusion, mood changes and difficulty in functioning and coping with day-to-day tasks.

Apple Court had one full time activity coordinator employed to develop and provide a programme of activities for people living within the home. Records of activities provided and participants were also available for reference.

We saw that a copy of the programme of activities was displayed on a notice board in the reception area of the home and other areas for people to view. The programme had been developed using pictures and a summary was included in the home's newsletter.

Discussion with staff, people using the service and examination of records confirmed that people had access

Requires improvement

Is the service responsive?

to a range of activities including: use of a sensory room; hairdressing; bingo; reminiscence sessions; dancing; singing; craft work; quizzes; newspaper discussions; movie afternoons and group games such as hoopla and parachute ball. Other activities such as theme days, local outings and visits from local entertainers had also been coordinated. On the first day of our visit we noted that the activity coordinator was spending 1:1 time with a person in the sensory room.

Feedback received indicated that an additional activity coordinator would be advantageous to help expand the range of activities available to people living at Apple Court and to help keep people occupied in the evening. This feedback was shared with the regional manager who agreed to look into the issues raised.

Staff spoken with demonstrated a good understanding of people's individual needs and told us that they spent time with new residents discussing their needs.

We looked at six care files and found copies of corporate documentation that had been developed by the provider (Leyton Healthcare).

Care plan records viewed contained assessments of need; care plans and risk assessments together with a range of supporting documentation such as daily care notes, incident records and observation charts.

We noted differences in formats and the detail of information recorded. Care plans were found to be standardised and there was scope for the development of a more personalised approach to care planning within the home. Furthermore, although there was evidence that care plans had been kept under monthly review we noted gaps in some information. We received assurances from the regional manager that these matters would be addressed as a matter of priority.

Staff told us that they were given time to read people's care plans and risk assessments to help them understand the needs and support requirements of people using the service. Care files we looked at included a staff signature list which confirmed that staff had read care plans and other supporting documentation.

Staff told us that updates on people's needs were discussed at the handover during shift changes, via the daily reports and informally with senior carers.

Key information on Apple Court was available in the reception area and documents such as the home's statement of purpose, service user guide and complaints procedure was available for reference.

We recommend that the care planning system is updated and reviewed to ensure it is more person-centred.

Requires improvement

Is the service well-led?

Our findings

We asked people who used the service or their relatives if they found the service provided at Apple Court Care Home to be well led.

Comments received included: "The manager left last week, so I don't know who the manager is"; "All things considered, I'd say the place is favourable"; "I've never had to make complaints. Everything is fine"; "We're happy that she's here, I'd say she was 90% better looked after than where she was before"; "I've no complaints" and "I haven't needed to make a complaint, but I'd know how to go about it."

Upon commencing our inspection we were notified by the regional manager that the registered manager had resigned from post the week prior to our visit and that the deputy manager had also stepped down from her role during February 2015. The regional manager informed us that she had taken over the management of Apple Court pending the appointment of a new registered manager.

The local authority had identified a number of concerns regarding the management of the home prior to our inspection. For example, failure by the registered manager to make appropriate safeguarding referrals and commencing internal investigations without consulting the local authority; maintenance of adequate staffing levels and availability of staff; management of accidents and incidents within the service; recruitment processes; care plan, medication and incident audits and moving and handling techniques and equipment used by staff.

As a result of the concerns raised, the local authority undertook a contract monitoring visit in November 2014 and coordinated a meeting with the manager of the service in December 2014 to investigate the issues. The previous registered manager was asked to produce an action plan in response to the issues raised which was being monitored by the local authority.

At the time of our inspection, the action plan was ongoing. Actions recorded as being met included: recruitment records; medication audits; staffing and moving and handling training. There was a system of audits in place. These included: monthly monitoring visits undertaken by the regional manager; 'ad-hoc' audits completed by other regional managers within Leyton Healthcare and infection control; food hygiene; medication; care plan and domestic audits. We noted that although concerns had been raised by the local authority with the provider about how accidents and incidents within the service had been managed, the management audits did not detail action taken in response to accidents and safeguarding incidents to minimise the potential for incidents to reoccur.

CQC also received negative feedback on the service from several sources prior to the inspection. The concerns were regarding people being left unsupervised; care plans not being acted upon; staff failing to respond to the personal care needs of people and their calls for help; inappropriate support of people at mealtimes and staffing levels. These concerns were shared with the local authority and reviewed during this inspection. We found no evidence of the concerns relating to staffing during the inspection but did identify inappropriate support of people with swallowing difficulties at mealtimes. Although some staff told us they had received training in this area, we had concerns that the provider had no systems in place to check and monitor their competency.

Furthermore, CQC was also contacted by a relative who raised concerns regarding an incident in the home where staff had allegedly failed to respond an accident correctly. The matter was referred to the coroner who identified a number of recommendations to improve practice. The recommendations included a review of staff training including CPR; a review of the home's policy and procedures regarding the reporting of emergencies and investigation training for senior managers of Leyton Healthcare.

We noted that systems were in place to seek feedback from people using the service, their representatives and staff on an annual basis. This process had last been completed during February 2015 and the results had been displayed in a chart in the reception area of the home for people to view. However, there was no written summary of the findings of the survey to accompany the chart, comments from people using the service or an action plan to demonstrate how the service would respond to constructive feedback. This feedback was shared with the regional manager who agreed to address the issues.

All of the above information highlighted concerns regarding the management of the service and the need to take prompt action to safeguard the health and welfare of people using the service.

Requires improvement

Is the service well-led?

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to demonstrate that the service was assessing, monitoring and mitigating the risks relating to the health safety and welfare of service users.

We noted that a business continuity plan had been developed to ensure an appropriate response in the event of a major incident. Additionally we were informed that the organisation's estates manager was responsible for co-ordinating maintenance and service checks and a refurbishment action plan had been developed.

We checked a number of test records relating to the fire alarm, fire doors, emergency lighting, fire drills and nurse call system and found that checks had been undertaken at regular intervals. Likewise, We sampled a number of service certificates for the fire alarm system, fire extinguishers; hoisting equipment; passenger lifts, gas installation and electrical wiring and found all records to be in order.

Information on Apple Court had been produced in the form of a 'Statement of Purpose' and a 'Service User Guide'. This provided people using the service and their representatives with key information on the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had failed to ensure that the people using the service were protected against the risks of unsafe or inappropriate care because appropriate action had not been taken in response to incidents.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person had failed to demonstrate that the service was assessing, monitoring and mitigating the risks relating to the health safety and welfare of service users.

Regulated activity	Regulation
	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The registered person had failed to ensure that the people using the service were protected against the risks of unsafe or inappropriate care because staff lacked awareness of how to correctly support people with swallowing difficulties to eat safely.

Regulated activity	Regulation
	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Action we have told the provider to take

The registered person had failed to demonstrate that the service was acting on complaints because records were not being appropriately maintained.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had failed to ensure that the people using the service were protected against the risks of unsafe or inappropriate care because staff lacked competence, appropriate supervision or training in key areas related to their roles and responsibilities. Regulation 18 (2) (a)

The enforcement action we took:
We have issued the provider with a Warning Notice