Regal Care (Liverpool) Ltd

Appleby Court Care Home

Inspection report

173 Roughwood Drive
Northwood
Kirkby
Merseyside
L33 8YR

Tel: 01515486267

Date of inspection visit:
08 September 2022
13 September 2022

Date of publication:
12 October 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Appleby Court is a care home providing accommodation, personal and nursing care for up to 60 people; some of whom live with dementia. At the time of our inspection 32 people were using the service.

People's experience of using this service and what we found
People's safety continued to be placed at risk. Care records continued to lack information and guidance for staff about the care people needed to minimise the risk of harm. Current government guidance for the use of face masks for staff was not being adhered to. Medicines were not always kept safe and secure and handwritten medication administration records (MARs) were not checked to ensure the accuracy of the information recorded. Robust training records were not maintained so we could not be assured staff had the qualifications, competence and skills to meet people's needs and keep them safe. Accident and incident records continued to lack information about action taken and lessons learnt to prevent or minimise further occurrences.

There continued to be a lack of effective systems to assess, monitor and improve the quality and safety of the service. Audits and checks carried out at the service were unreliable and ineffective, they failed to identify risk and bring about improvements. There was a lack of provider and management oversight of the quality and safety of the service. There were significant delays in submitting notifications to The Care Quality Commission (CQC) of incidents and events which occurred at the service. People did not always receive person-centred care with good outcomes because their records were not fully completed and kept up to date with their current needs and the care provided to them. There was a lack of partnership working with other health and social care professionals to improve the quality and safety of the service people received.

There was the right amount of suitably qualified staff deployed across the service to meet people's needs and keep them safe. Recruitment of new staff was safe. People told us they felt safe and were treated well by staff. Family members told us that they were happy with the care their relative received.

Rating at last inspection and update
The last rating for this service was requires improvement (published 18 February 2022).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to people's safety, governance and leadership. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

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

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified continued breaches in relation to people's safety and the governance and leadership of the service.

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

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

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or varying the conditions of the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Appleby Court Care Home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The first day of the inspection was carried out by an inspector and an inspection manager, the second day of inspection was carried out by an inspector.

Service and service type
Appleby Court is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was no registered manager in post. A manager was appointed following the last inspection, but they have not yet applied to CQC to become the registered manager.

There is a nominated individual appointed by the provider. The nominated individual, referred to in the report as the providers representative, is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection
Both days of the inspection were unannounced.

What we did before the inspection
We reviewed all the information we held about the service since it registered with the Commission. We also obtained information about the service from the local authority and local safeguarding teams. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection visit
We spoke with eight people and two family members about their experience of the care provided. We also spoke with the manager, assistant manager, six care staff, three nurses and two ancillary staff.

We reviewed a range of records. This included seven people's care records and a selection of people's medication records. We looked at recruitment records for one staff member employed since the last inspection. A variety of other records relating to the management of the service, including audits and checks were reviewed.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people and systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulations 12.

At our last inspection the provider had failed to ensure accurate and complete records were kept in respect of people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- There was a continuous lack of robust assessment, monitoring and management of risks to people's health and safety.
- Records continued to lack information about people's needs to minimise the risk of harm to them. For example, risk assessments and care plans had not been completed for aspects of people's care which it was known presented risk. This included risks associated with breathing, diabetes and skin integrity.
- Care plans had not been updated to reflect changes in peoples care needs which presented new risks. For example, changes in moving and handling equipment, skin care, weight and continence care.
- Records for one person showed they had lost a significant amount to weight over a seven-month period; however, no action was taken in response to this such as a referral to a dietician.
- Daily records used to monitor aspects of people's care did not provide important information required to enable staff to provide people with safe and effective care. There was a lack of information about people's fluid intake requirements and airflow mattresses settings. Airflow mattress settings for two people at risk of skin breakdown were incorrectly set.
- Personal evacuation plans (PEEPs) were not up to date. A grab file containing each person's PEEP contained plans for six people who were no longer living at the service. Some people's PEEPs had not been updated to reflect changes which impacted on their ability to mobilise.
- The format used to record accident and had improved, however records continued to lack information

about action taken and lessons learnt to minimise further occurrences.

Staffing and recruitment; Systems and processes to safeguard people from the risk of abuse;
● There were sufficient numbers of staff on duty, however we were not assured they had the qualifications, competence and skills to meet people's needs and keep them safe.
●Training records provided to us showed managers and staff had not received up to date training in topics relevant to people's needs and topics of health and safety including; infection control, first aid, diabetes and catheter care.
● Just four staff out of 47 had received up to date safeguarding training. Whilst staff were confident about recognising and reporting safeguarding concerns, they felt they would benefit from up to date training to refresh their knowledge around responding to incidents of a safeguarding nature.

The provider failed to assess the risks relating to the health safety and welfare of people and systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.
The provider failed to maintain accurate and complete records in respect of people. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Agency staff were deployed when needed to maintain safe staffing levels.
● Safe recruitment processes were followed. The required checks were carried out on applicants and agency staff to make sure they were fit and suitable for the role.
● Allegations of abuse were referred to the relevant authorities.
● People told us they felt safe and were treated well by staff. Their comments included, "Oh yes I feel safe here" and "They [staff] all treat me very well indeed." Family members told us they were confident their relative was kept safe.

Using medicines safely
● Medicines were not safely stored and recorded.
● The medication room on the ground floor was unlocked and the cabinet containing controlled drugs (CDs) within the room was also unlocked. A controlled drug is tightly controlled by the government because it may be abused or cause addiction.
● Handwritten medication records (MARs) had not been signed by the scriber or a second member of staff to check the accuracy of the information recorded.
● Records of checks carried out on the temperature of the medication room on the first floor were inconsistent. There were no recordings entered onto the records for three days out of eight for the month of September 2022.

The provider failed to ensure the proper and safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were not assured that people were fully protected against the risk of the spread of infection including those related to COVID-19
● Current government guidance states, 'Face masks should be worn by all care workers and encouraged for

visitors in care settings irrespective of whether the person being cared for is known or suspected to have COVID-19 or not'. On the first day of inspection staff were not wearing face masks and we were advised they had not worn them for two days prior to our inspection. When we queried this with the manager, they told us they had received an email from the Local Authority advising that staff no longer have to wear face masks. The manager had misread the information and advised all staff they no longer had to wear face masks. Staff were immediately instructed to put face masks on after we raised this with the manager.

The provider failed to assess the risk of the spread of, infections. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Immediate action was taken to mitigate risks to people.

- The cleanliness and hygiene of the environment was maintained to a good standard. Regular cleaning of high touch areas was taking place.
- COVID-19 testing was carried out in line with government guidance.
- Government guidance was followed for introducing new people to the service.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection systems were either not in place or robust enough to demonstrate effective systems for checking on the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● There continued to be was a lack of effective systems and processes operating within the service to monitor the quality and safety of the service, to identify and mitigate risk and bring about improvements.
● There had been very little progress made to improve the quality and safety of the service since our last inspection. Breaches of regulations found at the last inspection in January 2022 remained outstanding and we found other concerns in relation to people's safety and governance and leadership of the service.
● There was no registered manager in post. The providers representative advised us on 3 February 2022 that the previous registered manager had resigned. They also advised us the current deputy manager had been appointed as manager and would be applying to The Care Quality Commission (CQC) to become the registered manager. To date no registered manager application has been received by CQC. We were also advised of the appointment of a new deputy manager.
● The manager was not provided with any opportunities to improve their knowledge and understanding required for their role. The manager knew people well and had formed positive relationships with them, their family members and staff. However, they continued to lack knowledge and understanding about their role and responsibilities and regulatory requirements. The manager told us they felt supported by the providers representative through daily telephone calls. Despite this they were unable to provide us with any documentary evidence detailing any support or training they had received from the providers representative since the last inspection.
● Audits and checks carried out by managers and senior staff were unreliable and ineffective. For example, care plan audits and monthly care plan reviews had taken place, however, they consistently recorded statements such as 'care plan ongoing, no problems identified,' and 'no changes care plan remains effective.' This was despite our findings which showed a lack of robust care planning, monitoring of people's needs and risk management.
● There was a lack of accountability within the service. Managers had not maintained oversight of tasks they

delegated to senior staff such as reviewing and updating care plans, supplementary care records and the completion of other required records.
● There continued to be a lack of robust oversight and scrutiny by the providers representative to ensure improvements were made to the providers systems for assessing and monitoring the quality and safety of the service.
● The manager told us the providers representative had visited the service on just one occasion since the last inspection. There was no documentary evidence detailing checks carried out during that visit on the quality and safety of the service, such as a review of records and seeking the views of people and staff.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
● The provider did not always plan, promote or ensure people received person centred and high-quality care.
● The lack of robust care planning, monitoring and reviewing of people's care placed them at risk of not receiving person-centred care and support they needed to fully meet their needs and keep them safe.
● Staff knew people well and attended to their requests for assistance in a timely way.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● There were significant delays in the provider notifying CQC of incidents and events that occurred at the service since the last inspection. Providers are required by law to submit the required notifications to CQC without delay. The information provided in notifications helps CQC to decide if further action is needed to ensure people's safety.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There was a lack of consistent working in partnership with other health and social care professionals.
● Since our last inspection health and social care professionals have provided continuous support to managers to help bring about the required improvements. This included assistance to develop an improvement plan and ongoing monitoring of progress. Feedback from those professionals involved showed a lack of action taken in response to their advice and guidance.
● There was no documentary evidence of formal staff meetings having taken place to share updates and information. The manager confirmed staff 'huddles' take place daily but are not recorded.

Systems were either not in place or robust enough to demonstrate effective systems for checking on the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to robustly assess the risks relating to the health, safety and welfare of people and systems were either not in place or robust enough to demonstrate safety was effectively managed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to assess, monitor and improve the quality and safety of the service and mitigate the risks relating to the health, safety and welfare of service users and others.

The enforcement action we took:

Serve warning notice.