Appletree House Care Home

Appletree House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Appletree House is a residential 'care home' registered to provide personal care for up to 15 older people in one adapted building. At the time of the inspection there were 15 people living in the care home. Some people were living with dementia or frailty and other associated health conditions.

People's experience of using this service and what we found
There was a failure to assess, monitor and mitigate risks relating to the health, safety and welfare of people. People's care plans and risk assessments lacked important detail to guide staff on how to make people safe. There were unsafe practices in the way medicines were stored and recorded.

Leadership and governance of the service were not effective in identifying some service shortfalls. There was not an adequate process for assessing and monitoring the quality of the services provided and that records were accurate and complete.

Some infection control practices did not mitigate the risk of contracting and spreading COVID-19 within the care home. Processes were not in place to support safe visiting inside and away from the care home. Infection control processes had failed to identify some risk of cross contamination and transmission of COVID-19.

Systems were in place to protect people from the risk of abuse and improper treatment and staff knew how to identify potential harm and report concerns. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staffing levels were enough to meet people's individual needs. Positive and caring relationships had been developed between staff and people. People were treated with kindness and compassion and staff were friendly and respectful. People and their relatives told us they were happy with the service they received.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 30 April 2019) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating.

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.

We carried out an unannounced comprehensive inspection of this service on 4 March 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve. We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to gaining people's consent and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

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

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

We have identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment , infection control and good governance.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The 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.

Details are in our safe section below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led section below.

Appletree House Residential 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 inspection was undertaken by one inspector.

Service and service type
Appletree House 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.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not

asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with seven people who used the service about their experience of the care provided. We spoke with six members of staff including the provider, registered manager, assistant manager and care workers.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and monitoring records. We spoke with two relatives about their experience of the care provided. We sought feedback from healthcare professionals about the service.

Requires Improvement

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. Staff were not always recruited safely and risks to people were not always identified. At this inspection staff were recruited safely however there was a continued failure to identify risks to people. At this inspection this key question has remained requires improvement.This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

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

- Processes were not robust to ensure risks to people were identified and mitigated. For example, a person who had a history of seizures prior to admission did not have a seizure risk assessment or care plan in place. Staff knew the person had seizures however guidance was not available to ensure staff provided the person with consistent safe and appropriate seizure care and management. We asked the provider to take urgent action to address the concerns we had raised.
- Information in people's care records was not always sufficient to ensure safe care. For example, there was no care plan in place for a person with type 2 diabetes. Information was not available to ensure the person's diabetes was managed and monitored safely. There was a failure to provide guidance to staff to recognise changes in the person's blood sugar levels or the action to take. There was risk that staff could miss the signs that the person needed immediate assistance to prevent a rapid deterioration in their health. Following the inspection, the registered manager sought medical advice about the person's diabetes.
- Where care plans identified a potential risk, appropriate action was not always taken. For example, the care plans for two people had identified a potential risk of choking whilst they were eating. These risks had not been explored or assessed. A person's care plan reflected they required food that was softer to manage due to a lack of teeth and difficulties eating. Speech and language therapy (SaLT) assessments and advice had not been sought to ensure the person was receiving the correct consistency and texture of food to mitigate their risk of choking. We made the registered manager aware of our findings. We have reported further on modified diets in the well-led section of this report.
- There was a lack of effective oversight of head injuries. Records did not evidence that a robust and regular period of enhanced monitoring had been implemented following a head injury or bang to the head causing redness. We reviewed accident and incidents records for two people who had sustained head injuries. Both had received professional medical treatment at the time their injuries occurred. Processes were not in place to accurately record details of enhanced and regular observations over a 24 hour period following their injury. There was a failure to ensure staff were provided with guidance on how to effectively record and monitor people following a head injury. Consideration had not been given to complications arising from head injuries such as the increased risk of excessive bleeding for people who have medicines to thin their blood. The potential risk of head injuries being life threatening had not been effectively mitigated.
- The provider had not always learnt from previous inspections. The monthly audits failed to evidence a robust process for exploring factors that may have contributed to an incident occurring such as underlying health conditions, medicines or environmental factors. There was a failure to evidence the outcome of these audits had been used to drive improvements and mitigate further risks to people.

The provider had failed to ensure care and treatment was provided in a safe way or that risks to people had been mitigated. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not stored in line with safety guidance. Guidance produced by the National Institute for Clinical Excellence (NICE) requires all medicines in care homes to be stored safely. We found medicines waiting to be returned to the pharmacy on an open shelf in the registered managers office. This included eight bottles of liquid paracetamol. In total there were 16 separate boxes or bottles of medicine dated between November 2020 and May 2021. There was a medicines fridge in the managers office which was not locked and contained prescribed medicine for one person. The registered managers office was a wooden cabin in the garden, and we observed when the manager left the office the door was not locked, and windows remained open. This meant that medicines were not stored in a way that was safe and in line with guidance.

● Medicines were not disposed of safely. The providers policy for the safe disposal of medicines was not being followed. Medicines waiting to be disposed of were not stored safely. Processes to record returned stock were not followed and this had led to uncertainty during the inspection as to whether the medicines listed in the returned medicines book on 29 April 2021 had been collected or were unaccounted for. During the inspection a manager sought clarity from the pharmacy who confirmed the medicines had been collected at the beginning of May. The failure to follow the correct process meant the provider could not be assured that all medicines were accounted for and stored safely.

● Accurate records were not maintained for controlled medicines. The Misuse of Drugs Act 1971 places controls on certain medicines. These are known as 'controlled medicines'. It is recommended that care homes keep a running balance of the stock levels of controlled medicines. We viewed the stock levels of two people's controlled medicines and found multiple discrepancies with recorded stock levels. We have reported on this in more detail in the well-led section of this report.

● As and when required (PRN) medicine records were not always completed correctly. There were duplicate signing records for each PRN medicine and staff were required to check and sign both before and after administering PRN medicine. We viewed three people's PRN signing sheets and found discrepancies in all three. There was a potential risk of people receiving a second dose of the same medicines if staff failed to record information simultaneously on both records.

There was a failure 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 the provider was preventing visitors from catching and spreading infections. Government guidelines on care home visiting (updated 14 May 2021) require care homes to have a nominated testing area which allows for social distancing before during and after the test including a waiting area and a one way system.

● On arrival at the service visitors were required to undertake a lateral flow devise test (LFD). Test results took thirty minutes and a negative result was required to enable the visit to go ahead. We observed staff and a service user spending time in the same room as a visitor who was waiting for the results of their LFD test. People and staff entering and using the room were not made aware a test was in progress. The room led off the main hallway used to access bedrooms and communal areas. The door to the room was open and we observed the hallway to be busy with people and staff. The failure to follow government guidelines for safe visiting increased the risk of people, staff and visitors catching and spreading COVID-19. We signposted the

manager to government guideline on safe visiting in care homes.
● We were not assured that the provider was promoting safety through the layout, and hygiene practices, of the premises. The premises did not support good hygiene and cleanliness to prevent the spread of infection. Cleaning schedules were not robust to ensure an enhanced level of sanitation and disinfecting. Ventilation of communal areas and some people's bedrooms on the ground floor was not easily facilitated. At inspection the registered manager informed us they would undertake a review of cleaning schedules and implement a monitoring system to ensure the required level of cleaning was undertaken.
● We were somewhat assured that the provider's infection prevention and control policy was up to date. The provider had a COVID-19 policy and had implemented practices to protect people from acquiring COVID-19. For example, in order to prevent cross contamination a separate area had been created for staff to change their clothing on arrival at work. However, this area was on the second floor and was accessed by staff walking through the care home. This increased the risk of virus transmission within the care home. We made the registered manager aware of our concerns.
● We were somewhat assured that the provider was meeting shielding and social distancing rules. All 15 people were living as one household. This is because people shared communal areas and facilities which made socially distancing from one another difficult to implement. Government guidelines on visits out of care homes (updated 27 May 2021) requires care home residents to self-isolate for 14 days on return from overnight stays. Records held within the service did not provide assurance that government guidelines for visits out of care homes were being robustly and consistently implemented. We have sign posted the registered manager to government guidelines on visits out of care homes.

There was a failure to ensure robust infection prevention and control practices to ensure people's safety and protect people and staff from the risk of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was admitting people safely to the service. The registered manager provided verbal assurances regarding the current approach to admissions. This included a negative COVID-19 test prior to a person being admitted to the home and a 14-day isolation period, even if the test result was negative.
● We were assured that the provider was using PPE effectively and safely. Staff were observed to be wearing and changing PPE in line with requirements and disposing of it correctly.
● We were assured that the provider was accessing testing for people using the service and staff. Regular testing was in place for people and staff and this was in line with government guidelines for testing within care homes.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Contingency planning enabled infection outbreaks to be managed effectively. Staff did not work across services and agency staff were not used. Staff received training in infection control.

We were not assured the provider was facilitating visits for people living in the home in accordance with the current guidance. We have sign posted the registered manager to resources and government guidance on care home visiting (updated 14 May 2021) and visiting out of care homes (updated 27 May 2021 to develop their approach.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes protected people from the risk of abuse. Staff understood how to report any concerns they had to relevant professionals and worked in line with the local authority safeguarding policy and procedures.
● People were supported to keep themselves and their belongings safe. Relatives told us they had

confidence in the providers processes to protect their loved ones from abuse. People told us they felt safe and were treated well by staff who were kind and caring.

● Safeguarding training was completed by new staff during induction and there was a system to ensure staff undertook refresher training. Staff knowledge of safeguarding reflected up to date information and guidance.

Staffing and recruitment

● There were safe systems and processes for the recruitment of staff. The service followed safe recruitment processes to ensure people were suitable for their roles. This included undertaking appropriate checks with the Disclosure and Baring Service (DBS) and obtaining suitable references.

● Our observations were there were enough staff on duty to meet people's personal care needs. Staff were observed to be busy with the majority of time spent meeting people's personal care needs.

● Visitors to the service provided positive feedback about staffing. Visitors told us there was a low turnover off staff which was reassuring and provided continuity and familiarity. Staff were described by relatives as welcoming and friendly and showed care and compassion to their loved ones. Comments included, "I am very happy with the staffing" and "I sleep at night knowing (name) is looked after with 100% care and commitment."

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 now 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.

At the last inspection on 4 March 2019 there was a breach of regulations. There was a continued lack of robust quality assurance processes which placed people at risk of receiving poor quality care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider remained in breach of Regulation 17. This is the fourth consecutive inspection where the provider has been in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- There was a lack of effective oversight and monitoring of the service. Strategic governance and quality monitoring processes had failed to ensure compliance with regulations. There had been a failure to ensure organisational risks had reduced or embed changes to drive service improvement. The provider lived abroad and visited on an annual basis. Travel restriction due to the global pandemic has meant the provider has been unable to visit the service since April 2019. There was a failure by the provider to ensure adequate monitoring and support to the registered manager in their absence. This had impaired the registered managers ability to make necessary improvements.
- Systems and processes failed to identify and assess risks to the health safety and welfare of people. There had been a failure to address continued concerns with processes to support people's health care needs including diabetes and epilepsy. There was a failure to provide staff with epilepsy training and management oversight of the rota had failed to ensure there were always first aid trained staff on duty. Where people had health conditions that required specific dietary requirements guidance was not provided within care plans to ensure this was known or their dietary needs were met. For example, the dietary intake for a person who required a low sugar, carbohydrate and fat diet recorded in one day they eaten cake, cream, biscuits and potatoes. The provider had failed to assess, monitor and mitigate risks relating to the health, safety and welfare people.
- Quality monitoring systems had failed to identify that care plans did not provide accurate and up to date information. We found examples across multiple people's care plans where information was missing or not up to date. For example, one person who was living with a significant terminal health condition did not have this information reflected within their care and risk plans. Where a person's continence care plan stated they had no continence needs, this had not been updated to reflect they had a catheter and required staff support. A person's mobility care plan said they were independently mobile, although since April 2021 they

had been unable to weight bear following a significant bone fracture. The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each service users care and treatment.
● The provider's processes for quality checking of records and quality assurance audits had failed to identify medicines concerns. There had been a failure in the provider oversight of medicines to recognise procedures were not in line with legislation and guidance. The provider had failed to implement management competencies to ensure the safe ordering, storage, administration and disposal of medicines. There had been a failure to investigate recorded discrepancies in controlled medicine stock and monthly audits had failed to identify medicine records were not being completed accurately. The provider had failed to ensure the safe management of medicines.
● Systems and process for quality monitoring had failed to identify the service was not following the most recent NICE and NHS guidance in relation to patient safety for modified textured diets. In July 2018, NHS England issued a Patient Safety Alert to support safer modification of food and drink. The alert was issued to eliminate use of the imprecise term 'soft diet' and transition to using the International Dysphagia Diet Standardisation Initiative (IDDSI) framework. The IDDSI framework consists of a continuum of 8 levels (0-7) each giving clear definitions to describe texture modified foods and thickened fluids for example, '5-minced and moist' or '6-soft and bite-sized'. Care records in the service did not follow IDDSI guidance. For example, a person's care plan referred to them being on a 'soft diet'. This meant the provider could not be assured correct consistency food was being served to people to reduce the risk of significant harm.
● The provider had not always ensured the premises were safe for people to use and free of potential hazards. People were exposed to hazards caused by environmental factors. Carpets on the stairs were threadbare making this a slip hazard. Garden furniture and cushions were heavily soiled and stained with bird droppings. At inspection we observed a seagull tapping on the patio door of a person's bedroom. The patio door was the only source of ventilation in the bedroom and had to remain closed. People told us they were unable to open patio doors to aid ventilation due to seagulls who frequented the garden. During inspection we observed a penknife with an open blade on a shelf in the registered manager's office. The registered manager was unable to provide information as to why it was there and took immediate action to remove it.

The provider had failed to take the necessary steps to improve. There was a continued failure to ensure adequate systems to assess, monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people and others. Accurate and contemporaneous records were not always maintained regarding people's care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the previous inspection on 4 March 2019 the provider had in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2018. The provider had not always ensured the principles of the Mental Capacity Act were followed. At this inspection enough improvement had been made and the provider was no longer in breach of Regulation 11.
● Processes had been implemented to ensure people's capacity was assessed. Appropriate restrictions on people's liberty were applied for and monitored. There was evidence of multi disciplinary best interest meetings for decision making. When relatives had made decisions on behalf of their loved one they had the appropriate legal power to so.

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
● Services that provide health and social care to people are required to inform CQC of important events that happen in the service in line with regulatory requirements. The provider had informed CQC of significant events in timely way. This meant we could check that appropriate action had been taken.

● Relatives told us that when they have had cause to raise things with the registered manager they were listened to and received good outcomes. People and relatives experienced positive communication with the registered manager and staff and felt able to speak to them openly. Relatives told us the manager kept them up to date with matters arising with their loved one and were always contacted immediately when there was a concern.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Feedback and ideas were regularly sought from the people who used the service. People had the opportunity to complete surveys and participate in meetings. The information from feedback was used to make changes within the service. For example, where people had suggestions for meals these were added to the menu. Relatives told us that their loved ones were respected and listened to and treated as equal partners in their care.

● Relatives were provided with the opportunity to provide feedback on the service being provided. Relatives told us they were pleased with the service their loved ones were receiving. The environment was described as tired but homely. We received positive feedback about the registered manager and staff team. The registered manager was described as a person who always listened, acted and managed the service in a professional, helpful and meaningful way.

● Staff told us they felt supported and had the opportunity to develop their skills and knowledge. Staff felt able to report concerns and share ideas to the management team. They said they felt listened to and valued.

● One person told us that whilst they were not happy about living in the care home, the care they received was good and the staff were kind and caring. The menu was varied, and people told us they enjoyed the food which was described as tasty and plentiful.

● Relatives told us they felt fully involved in their loved one's care and were kept up to date. Records showed that when incidents had happened, families had been communicated with in a timely way. We received positive feedback from relatives who were able to access the electronic daily logs for their loved one. They told us this provided them reassurance and peace of mind. A relative describe their loved one's experience of the transition into care as a pleasurable one adding, "It is the most caring home from home place with continuity of staff with decent home cooked food and the best possible care we could ask for."

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 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to ensure robust infection prevention and control practices to ensure people's safety and protect people and staff from the risk of infection. There was a failure to ensure the proper and safe management of medicines. The provider had failed to ensure care and treatment was provided in a safe way or that risks to people had been mitigated.

The enforcement action we took:

NOP to impose conditions on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to take the necessary steps to improve. There was a continued failure to ensure adequate systems to assess, monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people and others. Accurate and contemporaneous records were not always maintained regarding people's care.

The enforcement action we took:

NOP to impose conditions