Apex Community Care Limited

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Inspection report

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05 June 2017
13 June 2017
19 June 2017
27 June 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 5, 13, 19 and 27 June 2017. The inspection was announced to ensure that the registered manager or appropriate person would be available to assist with the inspection visit.

Apex Community Care Limited is a domiciliary care provider registered to provide personal care to people in their own homes. At the start of our inspection information provided from the local authority suggested the service supported two people however the service declared that only one person received personal care. This is the first time the service has been inspected.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

During this inspection we found the service had breached a number of regulations. The service had not undertaken the necessary checks to ensure staff were suitable to work with vulnerable people. Staff did not receive appropriate training to ensure the safe delivery of care and support. Supervisions and appraisals were not up to date. Identified risks were not always assessed and mitigated against. Safeguarding incidents had not always been recognised and referred to the local safeguarding authority. The service failed to maintain suitable records for the management of the service. We also found that the provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support.

Staff were not trained in the safe administration of medicines, competency reviews were not conducted.

Accidents and incidents were not collated appropriately and analysed to ensure actions were taken to reduce future events.

Relatives told us staff treated people with dignity and respect. People who used the service were not proactively enabled to express their views about the care and support that they received.

Staff supported people to access external health appointments when required. People were supported to meet their nutritional needs.

Care plans were not written in a way that identified a person's wishes as to how they wanted their care to be provided.

The service did not have a business continuity plan to ensure people would continue to receive care in the event of an emergency.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

The service had failed to conduct necessary employment checks to ensure staff were of good character and suitable to work with vulnerable people.

Allegations of abuse were not immediately acted upon to ensure people were safe.

Staff had not received training for the management and administration of medication.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive adequate training to support people in a safe manner. Some staff had not received an induction or any form of training.

The service failed to ensure they acted lawfully by lacking to monitor the reviews of people's Court of Protection Orders.

People were promoted and supported in maintaining a healthy diet.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not have the appropriate skills and knowledge and the provider did not have systems in place to enable people to express their views and be actively involved in making decisions about their care, treatment and support.

Staff were knowledgeable about the people they supported. They were aware of their interests and family structure.

Relatives told us people were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service did not store care records in an appropriate manner.

Care plans referred to training which staff members had not received.

The service ensured activities were constantly available and were planned around people's preferences.

Is the service well-led?

Inadequate

The service was not well led.

The service did not have effective quality assurance processes to monitor the quality and safety of the service provided.

The registered manager did not have an understanding of their legal requirements relating to their registration with the Care Quality Commission.

Team meetings were not held regularly and staff did not have a structured forum to share concerns, learning and ideas for developing the service.

Apex Community Care Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 5, 13, 19 and 27 June 2017 was announced. The inspection was announced to ensure that the registered manager or appropriate person would be available to assist with the inspection visit. The inspection team consisted of one adult social care inspector.

On19 June 2017 an adult social care inspector spoke with a relative of a person who used the service.

We reviewed other information we held about the home, including any statutory notifications we had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. Before the inspection, we also contacted the relevant local authority social work teams safeguarding teams to gain their views of the service provided.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at care records for people who used the service. We examined documents relating to recruitment, supervision and training records and various records about how the service was managed.

During the inspection we spoke to the registered manager, an external social health care professional and four support workers.

Inadequate

Is the service safe?

Our findings

The service did not have safe recruitment processes in place. Pre-employment checks were not conducted which meant the service could not give reassurance that the staff employed were suitable to work with vulnerable adults.

The registered manager advised that seven staff were currently employed. We asked to view all recruitment files. The registered manager told us that only three recruitment files were held in the office and the others, they believed, were held within a cabinet in a bedroom in the person's home. Despite requests we did not receive copies of all of the recruitment files.

From the three recruitment files we were able to review we found none met the requirements of Schedule 3 of the Act. Schedule 3 clearly defines what checks and documentation needs to be receipted by a registered provider as part of their recruitment processes. We found two recruitment files only contained an application form. There were no checks on identity, right to work in the UK, employment history, references from past employers, education or training certificates or checks with Disclosure and Barring Service (DBS) had been carried out. One file held a DBS check dated September 2011. We noted the service's DBS policy advised renewals to be conducted every three years. DBS checks help employers make safer recruitment decisions and help to prevent unsuitable people from working with vulnerable adults.

The registered manager confirmed that DBS checks had not been carried out as staff did not have suitable forms of identification and were reluctant to complete the required paperwork. A staff member responsible for recruitment told us they had made repeated requests to staff to complete the paperwork but staff were not compliant. The provider had taken no further action to address this shortfall in ensuring safe recruitment practices.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a safeguarding policy and procedure in place, which detailed what action to take if a safeguarding incident had been identified. This included alerting the local safeguarding team and notifying the CQC. We saw a safeguarding incident had only been investigated following the request of the local safeguarding team and had not been notified to the CQC. The concern had been raised to the local safeguarding authority anonymously. We noted safeguarding training was out of date with no refresher training completed and new staff had not received any training on the subject. This meant the service did not have effective systems and processes in place to identify, investigate and act upon any allegation of abuse.

We saw meeting minutes from a meeting held in February 2017 with a person's social worker. It stated 'without training, staff should not be undertaking physical intervention.' We noted that new staff had not received physical intervention training and training was a year out of date for other staff. A staff member told us physical intervention training had been booked but had had to be cancelled due to other commitments

and further training had now been booked.

One person's Behaviour Support Plan directed support workers to follow 'Apex's company guidelines' in order to maintain [person]'s and others safety, in the use of physical restraint.

This meant staff did not have the appropriate training to ensure people's safety in the event of the use of restrictive practices, placing people at risk of harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager what processes were in place to monitor the safe administration of medicines. They told us medicine administration records ('MARs') were checked daily and any discrepancies were discussed with the member of staff. MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. We asked to see these reviews, the registered manager advised the checks were conducted but didn't have a written record. There were no records available for inspectors to review to confirm that staff competency had been checked. We noted no staff had received training in the safe management of medicines. The National Institute for Health and Care Excellence (NICE) guidelines relating to managing medicines for adults receiving social care in the community state, 'When social care providers are responsible for medicines support, they should have robust processes for medicines related training and competency assessment for care workers, to ensure that they: receive appropriate training and support, have the necessary knowledge and skills, are assessed as competent to give the medicines support being asked of them, including assessment through direct observation and have an annual review of their knowledge, skills and competencies.'

Identified risks were not always assessed and managed appropriately. We saw the service had generic risk assessments in place covering areas such as safety and security of premises, service user finances risk assessment and service user outing. These were a yes/no tick box answer and did not describe how to minimise the associated risks. Risk assessments did not provide specific guidance about how to keep people safe and referred to another document or guidance. This meant support workers did not have up to date guidance on how to manage these risks safely.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us staffing levels were set by the needs of the people using the service. They said, "I ensure staff are available to support [person], if we are down I will always go. [Person] is our priority." A relative told us, "Staffing can be a problem but they always get cover. I have said staff need days off as they could be burnt out and it could impact on [Person]. [The registered manager] will do shifts they wouldn't let us down." We did not visit the service due to the distress this would cause the person so could not verify the presence of staffing but staff told us enough staff were deployed to meet the needs of the person. The person's relative also confirmed that enough staff were readily available to support the person as described within care records. However following the inspection we received concerns that in fact that was not the case and staffing levels were not as detailed on rotas viewed. We raised a safeguarding alert with the local authority about this matter.

We found accidents and incidents were recorded but these were not collated. For example we found information relating to one accident within a staff member's recruitment file. It described an accident which involved a visit to the hospital to receive emergency treatment. We asked the registered manager if the

incident had been notified to the CQC. They stated they did not know they had to submit a notification about that type of incident.

The service did not have a business continuity plan for example if there was a loss of an office base, or the computer system. The registered manager said, "Staff would contact me and we would always ensure [Person] was cared for."

Inadequate

Is the service effective?

Our findings

Staff had not received appropriate training to ensure they were able to care and support people in a safe manner. The service did not conduct competency reviews to confirm staff had the necessary skills to provide care in line with people's wishes.

At the time of the inspection the registered manager and the provider were unable to access current staff employment and training details. No information was held centrally. We were shown three staff training files and saw the last training took place in June 2015. One of the directors, who was responsible for overseeing the administration of the service, advised all mandatory training was yearly and confirmed new staff had not completed an induction or any form of training. They also confirmed supervisions and appraisals were not being conducted in line with the service's policy.

The registered manager advised that it had been a struggle recruiting and retaining staff. They said they were currently providing support to a person to ensure the person received appropriate levels of support.

This meant the service did not ensure staff received the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties they were employed to perform.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A support worker told us, "We encourage [person] to help us make tea, have a go." The registered manager described how all the support workers on shift have their meal together with the person they are supporting. The care plan reported, 'Staff not to leave [person] alone at table and to show good example by using manners at the table.' A staff member told us, "Staff encourage [person] to make healthy choices but it can be difficult but we try to balance out the day." We saw staff monitored and recorded people's daily food and fluid intake. However there was no written analysis of this information.

The registered manager told us they recorded and monitored appointments with health care professionals, including GP, chiropodist and dentist. We saw people were supported in attending their appointments.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We were told by the registered manager and director that a relative had legal authority to act on behalf of a person to promote their best interests. This was not documented within the care records provided. We were shown a court of protection documentation in respect of this person however this had expired on 27 April 2017. The registered manager advised that a meeting regarding the continuation of the court of protection order had been held but they did not have a copy of the document to confirm the outcome of that meeting. We were not assured that the service was acting in accordance with decisions of the Court of Protection or that they were regularly monitoring these decisions and reviews.

Staff had not received training in relation to the Mental Capacity Act 2005 (MCA).Whilst staff were not clear on the principles of MCA they were able to describe situations where they supported people in making decisions.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

The provider failed to ensure that people who used the service were appropriately represented or engaged in decisions around their care and support. People who used the service were not proactively enabled to express their views about the care and support that they received. Staff did not have the appropriate skills and knowledge and the provider did not have systems in place to enable people to express their views and be actively involved in making decisions about their care, treatment and support.

Relatives we spoke with told us the service was caring. One relative said, "I think they have the caring ability, they need training in other aspects for fully supporting and understanding [person]. I have told [the registered manager] just because someone is trained doesn't make them right, they have to be right for [person] and click with [person]." "[Person] is happy; I can tell when he isn't." Whilst we were told staff were caring, the provider failed to ensure suitably recruited and trained staff were deployed to ensure people's needs were met.

Relatives we spoke with told us they were happy with the staff who supported their relative. One relative said, "[Staff member] is one of the nicest ones. [Staff member] takes time to sit down and listen to [person]. [Person] enjoys their company. [Staff member] is affectionate when [person] wants to be, he knows when it's not genuine. [Staff member] is not frightened to place an arm around [person] when he needs it." [Person] can be hard to look after, he has complex needs. [The registered manager] is dedicated to look after him."

An external social care professional told us, "[Person] seems happy and [the registered manager] has known and worked with the family for years."

Staff spoke of the significance of maintaining independence for people who used the service. One Staff member told us, "I make sure [person] does what they want to do. I support them to do as much as they can for themselves. Another staff member said, "I just remind [person] what to do and encourage them." One relative told us how their relative enjoyed helping prepare their own meals and took pride when everyone sat together and ate the meal.

Staff members spoke about people they supported with fondness. A staff member described how one person loved treasure hunts so the registered manager drew maps of different areas and hid present for the person to find. Staff members we spoke with had knowledge of people's likes and dislikes and family structure.

Relatives told us people were treated with dignity and respect. One relative said, "Staff follow [person] routine and are always respectful to [person]. I'm at hand, I pull up the staff if I see something that not right, I speak to them 1:1. I try to educate them to how I know [person] likes things I have a high standard and won't stand for second best."

Requires Improvement

Is the service responsive?

Our findings

One relative told us, "If I needed to complain I would say something to the staff myself but would speak to [The registered manager]." The registered manager told us no complaints had been received.

On the second day of our inspection, when we visited the service's office, the registered manager did not have copies of care records and was unable to retrieve copies from their computer system. The registered manager told us the care records were written with the support of the local behaviour support team and said copies of all care records were available in people's homes. We were given a managing violence and aggression (MVA) plans which detailed how to support people through certain situations. We asked for copies of all care records to be sent to us. The next day the service provided a copy of a Behaviour Support Plan which gave a brief outline of a person's needs, description of types of behaviours, reactive strategies and what action to take if the person became distressed.

The registered manager spoke about the verbal encouragement the person received for personal care, medication and at meals. We received the care plans seven days after our visit to the service's office. Care plans had a brief background, which described an activity or situation, reason for strategy and what to do and not do. We found some care plans were not written in a person centred way and came across as a direction for example, 'Be aware that [person] gets dressed downstairs.' Most were clear and concise but some referred to other care plans or training that staff members had not completed. The person's relative told us they were involved in all discussions relating to the planning of the care received.

Relatives told us they were involved in the discussions about how to support their relative and were happy in approaching the registered manager if they thought a review was required. A staff member told us they consulted care records as a way of getting to know the person they were supporting.

One staff member told us, "Once [person] is up and had their breakfast we sit and chat about what they would like to do that day. It's about what they would like to do, sometimes they change their mind but it's their choice." The registered manager told us they encourage people to take part in a range of activities and to explore the community. Staff members were able to describe people's interests and chosen activities. Records showed people were routinely supported on trips to the pub, restaurants, disco and cinema. The registered manager told us about how a team of staff are put together to support people on holiday.

The registered manager told us about how one person was supported to gain employment locally working with birds of prey. They advised that the person enjoyed visiting the birds of prey centre and the management had offered the opportunity for them to work there. They said, "[Person] helps out, feeds the birds, painted the sheds, takes the owner's dog for a walk and catches fish for the pelicans."

Inadequate

Is the service well-led?

Our findings

The registered manager did not have an understanding of their legal requirements relating to their registration with the Care Quality Commission. The service did not initially engage with the inspector who was conducting the inspection. The service did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support.

We found inadequate record keeping in all areas including staff employment details, recruitment, accidents and incidents, safeguarding and the management of the service. The provider and the registered manager did not complete any audits or carry out any observations to ensure people received care in accordance with their assessment of need or that staff had the required competence to provide care and support to people.

We asked the registered manager how they monitored the quality of the service. The director responsible for the administration of the service told us they had purchased a computer system to assist the management of the service but due to a difficult period of time for staffing, both the registered manager and the director were supporting people and this had taken them away from the paperwork side of the business. The director said, "It was our intention for me to concentrate on the business side but due to staff leaving I'm needed to support."

They confirmed that currently no formal audits were documented. The registered manager explained that checks were carried out on daily records and medicine administration record (MAR) charts but these were not recorded.

On the second day of the inspection the registered manager and the staff member were unable to access their computer systems to obtain requested information. Staff employment information was not held appropriately, care records were not readily available and no systems were in place for the archiving and secure storage of care records. The registered manager stated that the majority of the paperwork was held in people's homes.

This meant the provider did not have effective quality assurance processes to monitor the quality and safety of the service provided, and to ensure that people received appropriate care and support.

Whilst staff we spoke to told us they felt they could approach the registered manager about any concerns they had, they did not have structured opportunities to share information and give their views about people's care. One relative told us, "Communication is a problem. There are no team meetings to pass on messages." We saw the last team meeting took place in March 2017. The registered manager expressed a difficulty in gathering staff together for meetings due to current staffing levels.

We found that in order to meet the staffing levels required to deliver safe care and support the registered manager was also delivering care and support to people who used the service on a day to day basis. They

were regularly included on the rosters and this meant that no supernumerary time was dedicated to their oversight and governance of the service.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we found two incidents which required statutory notifications to be made to us. We asked the registered manager for confirmation that the relevant statutory notifications had been completed and sent to us in accordance with regulatory requirements. They stated they were not aware of the requirement to inform the Commission of incidents. The submission of notifications is important to meet the requirements of the law and enable us to monitor any trends or concerns and respond appropriately.

We are taking action outside of this inspection process in response to this failure to notify.