Admire Healthcare Ltd

Apollo House

Inspection report

Argyle House
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Apollo House is a residential care home providing personal and nursing care to 35 older people at the time of the inspection. The service can support up to 61 people.

People's experience of using this service and what we found
Unexplained injuries had not always been investigated to establish the cause and to protect people from abuse. Records of injuries were not always kept up to date with follow up information.

Not all risk assessments had been completed or strategies identified to mitigate risks. Care plans did not always contain the information required to ensure staff knew the person's needs. People's healthcare needs had not always been recorded and managed.

Records of care tasks had gaps in the recording. We found repositioning charts had not been consistently completed, fluid charts had no recommended amount and had not been tallied up, oral care and continence needs were not consistently recorded, and skin integrity checks had not been completed. These failures put people at risk of harm.

Systems and processes in place to ensure oversight of the service were not effective. Not all information had been audited to ensure it was factual and up to date.

Medicine management required improvement. We found staff had not recorded the reason, time and outcome for administering 'as required' medicines as per the provider's policy.

Staffing levels were appropriate during the inspection, however people and staff told us additional staff were needed to complete activities and spend time with people. The service was using high levels of agency staff while they recruited permanent staff into post.

Some staff had not received all of the training required to support the people living at Apollo House. However, people told us most staff were kind and respectful to them.

People were protected against infections. The registered manager completed regular COVID-19 testing on staff and people. Visitors were required to complete a test before entering the service. Staff wore appropriate personal protective equipment (PPE) and received training in infection control.

Staff, people and relatives knew how to complain. Recorded complaints had been responded to within the provider's timeframe.

People were supported to have maximum choice and control of their lives and mental capacity assessments had been completed. Staff supported most people in the least restrictive way possible and in their best

interests; the policies and systems in the service supported this practice.

People's communication needs were documented, and the provider understood the accessible information standard.

The provider was committed to continuous learning and improvement. The registered manager listened to feedback and sent an action plan through to identify what actions they would be taking to improve.

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

Rating at last inspection
This service was registered with us on 17 August 2020 and this is the first comprehensive inspection.

This service had an infection prevention and control (IPC) inspection published on 30 November 2020. This inspection was not rated.

Why we inspected
We received concerns in relation to the level of care people received, limited information within care plans and risk assessments and limited oversight. As a result, we undertook a full comprehensive inspection

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

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 in relation to safe care and treatment, investigation into unexplained bruising and oversight of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we 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 findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Apollo House

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 carried out by two inspectors.

Service and service type
Apollo 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. We sought feedback from the local authority and professionals who work with the service.

During the inspection
We spoke with six people who used the service and three relatives about their experience of the care

provided. We spoke with 15 members of staff including the provider, registered manager, nurses, care workers and the chef.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. 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 quality assurance records. We spoke with two professionals who regularly visit 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.

This is the first inspection for this newly registered service. This key question has been rated 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.

Systems and processes to safeguard people from the risk of abuse

- People were not consistently safeguarded from abuse. We found records and investigations relating to incidents were not always completed appropriately. For example, we found five people had unexplained bruises which had not been recorded and we found no evidence of investigations being completed to identify the cause of these injuries.
- People were at risk of improper treatment as staff did not receive training in physical intervention. We found written documentation regarding three staff being required to support one person with personal care to 'hold [person's] hand'. Staff told us they needed to hold people's hands whilst completing personal care to stop the person hitting them. Restricting a person's movement is defined as a physical intervention. This put people at risk of harm from inappropriate practices being used.

The provider had failed to ensure that people were protected from abuse. This was a breach of Regulation 13(1)(3)(4) (Safeguarding service users from abuse and improper treatment), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong.

- Not all risks to people had been identified or mitigated. For example, we found that people did not always have the required risk assessments completed in behaviours that pose a risk to others and healthcare needs. This meant people were at risk of harm due to a failure to suitably assess and mitigate risks to people.
- People at risk of pressure damage did not always have this need met. We found gaps in the recording of repositioning tasks and the skin integrity checks. One person who had pressure relieving equipment had their pressure mattress set at the wrong weight for them. This placed people at risk of developing pressure damage to their skin.
- Staff did not always follow the strategies in place to reduce risks to people. For example, when people required specific monitoring due to health conditions, this was not always completed in line with their care plan or in line with best practice guidance. This put people at risk of deteriorating health concerns.
- We saw no evidence of lessons learnt. The provider did not have oversight of incidents or accidents. This meant risks could not be identified, trends or patterns identified, or improvements made.
- Medicines were not always managed safely. When people were prescribed 'As required' [PRN] medicines, staff did not consistently record the reason for giving the medicine or the effectiveness of the medicine once administered.

The provider had failed to assess the risks to the health and safety of people using the service or take action to mitigate risks, and to ensure the safe administration of medicines had been completed. This was a breach of Regulation 12(1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Not all staff files had evidence of all the safe recruitment checks required as per the providers policy. For example, we found two agency files which did not contain their full name or Disclosure and Barring Service (DBS) check date. We also found two staff files which did not contain the relevant risk assessments to ensure safe recruitment. The registered manager agreed to ensure this information was documented.

● We found no concerns with the staffing levels at Apollo House. However, there were high levels of agency staff used. One person said, "Staff do respond but staff keep changing." A staff member told us, "There are enough staff on duty, but the issue has been agency staff, as there is a lot of them. We have enough staff to get our duties done." Another staff member told us, "There is enough [staff] for personal care, but not enough for activities."

Preventing and controlling infection

● We were not assured that the provider effectively prevented or managed the risk of outbreaks. We found gaps within the records of cleaning.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- Staff did not always have the information or equipment they required to safely manage the diabetes care for people. Where people had a diabetic care plan, this was not followed by staff. For example, records showed high sugar foods being given to people with diabetes and blood sugar monitoring was not always taken before meals or at the prescribed time. Therefore, staff are unable to provide accurate or reliable records to the Diabetes Care Team to make clinical decisions about people's diabetes management. This put people at risk of complications associated with unstable diabetes.
- Staff did not always have the information they required to support people with epilepsy. One person did not have an epilepsy care plan in place to inform staff of the type of seizure, any precursors or what action to take in the event of an epileptic seizure. Staff also did not record the type or time of seizure they witnessed. This information would assist doctors or specialists in recognising patterns and changes in the person's condition and inform ongoing management and treatment. This put people at risk of not receiving the correct support or healthcare.
- People were at risk of deteriorating health conditions. For example, when people were unwell, staff did not consistently record all of the observations required. The information provided to the GP and any other medical professional would not be complete, making a clinical judgement difficult.
- People were at risk of dehydration. Not all people who were at risk, had their recommended amount of fluid recorded and their fluid charts had not been tallied to review how much they had drunk. Where people had reduced fluid intake, we found no evidence of actions being completed.

The provider had failed to assess the risks to the health and safety of people using the service or take action to mitigate risks. This was a breach of Regulation 12(1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We received mixed feedback from people regarding the food offered. Two people told us the food was "nice", but two other people stated the food was "terrible". The registered manager was in the process of changing the menus.
- We found no evidence that people were supported to attend healthcare appointments such as dentist, doctors and opticians. However, the registered manager was in the process of arranging for people to have all health checks completed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Staff did not always have the required information to support people in line with their individual needs. Not all care plans held up to date relevant information in them. For example, one person whose daily notes evidenced they displayed behaviours that could put others at risk, had nothing regarding behaviour documented within their care plan.
● People and relatives told us they were not always involved in people's care plans or reviews. One relative said, "I have been asking for a review, but still nothing has happened."
● People's oral care was not consistently completed. We found gaps in records of support with teeth or denture cleaning. One relative told us, "Staff were not cleaning [person's] teeth as they told me they didn't have time."
● People's care needs were assessed before they moved into the service. The registered manager had implemented new admission paperwork, to ensure that effective care could be delivered to people.

Staff support: induction, training, skills and experience
● Staff completed online training, covering subjects such as manual handling, mental health, medicines, fire and infection control as well as practical training sessions for equipment, manual handling, medicines and first aid. However, we found not all staff had received training on people's specific needs such as epilepsy, diabetes and dementia. This had a negative impact upon their practice.
● When staff started their employment at Apollo House, they received an induction which included training and shadow shifts. One staff told us, "It was a good induction. I had an induction pack and the training I needed to complete before working on the floor. The clinical lead showed me where everything was and talked me through each person."
● Staff received supervisions and annual appraisals in line with the providers policies. Staff told us, they did not all feel confident that any issues raised would be dealt with. The registered manager was in the process of reassuring staff and discussing any concerns they may have.

Adapting service, design, decoration to meet people's needs
● People had free access to communal areas and outside space.
● Dementia friendly signs were in place within the service.

Ensuring consent to care and treatment in line with law and guidance
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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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 had the appropriate legal authority and were being met.

● Where people lacked capacity, decision specific mental capacity assessments had been completed and best interest decisions had been made with all the relevant people being involved.
● The registered manager had appropriately submitted Deprivation of Liberty Safeguards (DoLS) applications to the local authority.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
- Care plans did not always contain up to date information. Three people's care plans did not fully detail their health condition and how it impacted their day to day life.
- People told us most staff were kind and respectful. However, due to the level of agency staff used they did not always know them.
- Relatives felt their loved ones were well looked after. However, one relative told us, "[Person] is often in other people's clothes." Another relative said, "Staff don't actually tell me how [person] is, I just get 'they are fine' which does not tell me anything."

Supporting people to express their views and be involved in making decisions about their care
- People's communication needs were documented in their care records; this supported staff to understand and communicate effectively with each individual person.
- Care records had consent forms regarding who could look at people's personal information as well as sharing information with others.

Respecting and promoting people's privacy, dignity and independence
- Staff told us how they would protect people's privacy and gave examples such as closing doors when assisting with personal care, knocking before entering a bedroom and discussing any personal tasks sensitively. A person told us, "Staff check me at night, this is what I wanted. If I changed my mind, they would stop. Staff will gently knock then close my door after." A staff member said, "I always give privacy when helping with personal hygiene. I treat them like family."
- Information was kept securely; staff were aware of the person's right to privacy.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People were at risk of not receiving person centred care due to care plans not being up to date or factual. Not all care plans contained the relevant information required to support staff to understand the person's needs.
- We saw limited information recorded regarding people's personal choices and preferences. For example, we did not find evidence of people being asked if they had a preferred gender of staff.
- We found limited information regarding people's cultural and religious needs, which meant there was a risk their needs in this area may not be met.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were documented within their care plans. We saw staff communicating with people in their preferred method.
- The registered manager understood their responsibility to follow AIS and told us they could access information in different formats to meet individual needs. For example, easy read, large print or another language.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People and staff told us there were not enough activities offered. Two people told us, "We used to do quizzes and things, not anymore, it can be boring." One staff member stated, "No activities, the only one is watching films." Another staff told us, "The activities person is helping with visitors from 11-2 so there is not much time left to do any activities."
- People were supported to see their relatives and friends in line with government guidelines on COVID-19. Visitors were tested before entry and provided with PPE.

Improving care quality in response to complaints or concerns

- Staff, people and relatives knew how to complain. However, we received mixed responses regarding whether they felt they would be listened to. Staff felt more confident that they could raise concerns with the new manager, however, some people and relatives did not feel they would have their complaint resolved.
- The complaints seen had been responded to appropriately and in a timely manner.

End of life care and support

● At the time of our inspection no one using the service required end of life support. However, when appropriate, people had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) order in place.

● Care plans were in place for end of life care and included funeral arrangements. However, not all plans identified people's individual preferences at the time of death. For example, who would be there, if they wanted any music or sounds playing or if they wanted a priest or minister to deliver their last rites.

● Not all staff had received training on supporting people at the end of their life.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Systems and processes were not in place to monitor, assess and evaluate people's risk assessments and care plans. This put people at risk of receiving care that did not meet their current needs as care plans and risk assessments did not contain the information required.
- Systems and processes to monitor people's health needs were not in place. This put people at risk of deteriorating health and not accessing healthcare support in a timely manner.
- Systems and processes to assess, monitor and improve the service were not in place. We found no evidence of audits being completed to ensure records were kept up to date and factual. For example, the gaps found in repositioning checks, oral healthcare support, fluid charts and toileting records had not been identified or actioned prior to the inspection. Audits would also support the management team to understand and identify any risks that required mitigation.
- Systems and processes to ensure risks to people's health and safety was not effective. For example, we found water temperature records that evidenced some outlets were above the recommended temperature to protect people from scalding and descaling of water outlets had not been completed. This had not been identified prior to the inspection.

The provider had failed to implement a robust system of quality assurance or to identify and address the shortfalls in the service. This was a breach of Regulation 17 (1) (good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider was in the process of requesting feedback from people, relatives, staff and professionals. However, these had not been returned so we saw no evidence of people's feedback on the service.
- We found limited evidence of people being involved in their care planning. People's care documents did not contain information of people's consent or involvement.
- Staff told us they felt supported and the registered manager was accessible and available to staff, people and relatives.

Continuous learning and improving care. Working in partnership with others

- The registered manager was working closely with the funding authority to make improvements and

changes required.
● The provider was committed to continuous learning and improvement. The registered manager listened to feedback and sent an action plan through to identify what actions they would be taking to improve.

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
● The registered manager had responded to previous complaints appropriately. We found no evidence of the duty of candour being required; however, the registered manager understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information.
● Staff knew how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns acted upon.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to the health and safety of people using the service or take action to mitigate risks. The provider had failed to ensure the safe administration of medicines had been completed.

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that people were protected from abuse

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems and processes were in place to assess, monitor and improve the quality and safety of the care provided.

The enforcement action we took:

Warning notice