Lifeways Community Care Limited

Applewood House & Apartments

Inspection report

Kirklington Road
Bilsthorpe
Newark
Nottinghamshire
NG22 8TT

Tel: 01623343050

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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
Applewood House and Apartments is a residential care home for people with autism and learning difficulties, providing personal and nursing care. The service can support up to 13 people, ten people in one large house and three people in a connected apartment. There were ten people living at the service at the time of the inspection. The building is one of four services on the Bilsthorpe site owned and run by Lifeways.

The service has been developed and designed in line with the values that underpin Registering the Right Support and other best practice guidance. However, the service did not always (consistently) apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.
The outcomes for people did not fully reflect the principles and values of Registering the Right support for the following reasons; there was a lack of choice and control; people had not been supported to undertake social activities of their choice on a regular basis; staff did not always support people in the least restrictive way.

People's experience of using this service and what we found
People living at the service were not always safe, as safeguarding concerns were not effectively reported, monitored or analysed in a timely way. This had resulted in lessons not being learnt following incidents occurring. People and relatives told us they did not think the service was safe.

Risks to people's safety was assessed but staff did not always follow this guidance.

People were not always supported by enough staff, and staff did not always know people well enough. Staff had not always received up to date training to support people in a suitable way.

There was a lack of evidence to show complaints and concerns were managed. The quality monitoring processes had not been undertaken consistently enough to provide effective oversight of the service.

Peoples medicines, nutritional needs and health care needs were managed. People were protected from the risk of infection. Staff supported people to maintain their privacy and dignity.
For more details, please see the full report which is on the CQC website at www.cqc.org.uk
The last rating for this service was Good (published 8 March 2019).

Why we inspected
The inspection was prompted in part due to concerns received about staffing, safe guarding issues, lack of activities and management of the service. A decision was made for us to inspect and examine those risks.

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

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

We have identified breaches in relation to staffing, management of safeguarding issues, safe care, person centred care, and governance 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 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?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not always well led.

Details are in our well led findings below.

Requires Improvement

Applewood House & Apartments

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.

Inspection team
The inspection was carried out by two inspectors and an assistant inspector.

Service and service type
Applewood House and Apartments is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 did not have a manager registered with the Care Quality Commission at the time of the inspection. Both the registered manager 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
Prior to the inspection we sought feedback from local authorities, clinical commissioning groups, agencies and healthcare professionals involved with the service. 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 of this information to plan our inspection.

During the inspection-
During the inspection we spoke with three people living at the service, and two relatives, we spoke to nine members of staff, including support workers, agency staff support workers, team leaders, the acting manager, the regional manager, the area manager, and the quality compliance manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. We also reviewed all agency staff profile records. We viewed a variety of records relating to the management of the service, including policies and procedures, the training records, audits, accidents and incidents, maintenance, behavioural monitoring records and quality audits.

After the inspection
We continued to seek clarification from the service to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People were not always protected from harm, because systems and processes to safeguard people from the risk of abuse were not always effective.
- Staff did not report and record incidents in a consistent way, incident forms were filed in different places or left in drawers, there was a lack of management oversight of this. A number of safeguarding issues had not been reported to the safeguarding team as required when they had occurred.
- One person had suffered a serious choking incident, this had been recorded in their care records, but we could not find an incident report for this. Staff we spoke with, were not aware of the incident and there was no evidence of any investigation into this.
- During our inspection another person experienced a choking incident, an incident form was completed, but it had been placed in a drawer and neither the senior carer or acting manager had been informed. This meant the person was at further risk of harm. The failure to analyse events that occurred, meant the opportunity to learn lessons was missed.
- We discussed our concerns with the senior management team. They told us they were aware of the issues with reporting safeguarding concerns and were working to address this by continually trying to raise staff awareness and retrospectively submitting incidents to both ourselves at CQC and the local safeguarding teams. However, this continuation of inconsistent reporting meant opportunities to learn lessons were still being missed and people were at risk of harm.

Poor systems and processes to manage and learn from safeguarding issues placed people at risk of harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Two relatives we spoke with told us they did not feel their family members were safely supported. During the inspection we observed six occasions where staff who were meant to be providing one to one support, were not observing people closely and people were left without adequate support. On one occasion a person was left alone in the kitchen where they could have burnt themselves from a kettle of boiling water, and we needed to alert staff to the fact they were alone.
- Relatives also told us their family members were at risk because the front door and gate were unlocked and not monitored sufficiently. This meant people who had been assessed as requiring one to one support in the community to support their safety could access the busy road at the end of the driveway. This lack of supervision put people at risk of harm.
- One person told us they did not feel safe, because they did not always know the staff who were supporting them, due to use of agency staff.

Assessing risk, safety monitoring and management

● Risks to people were not always managed effectively. There were detailed risk assessments in place, however these were not always followed by staff. We observed one incident where triggers to a person's changing behaviour identified in their care plan were not picked up by staff and the person's behaviour escalated putting them in a dangerous situation. Staff did not deal with the behaviour in a safe and appropriate way, putting them at further risk. Staff's actions showed they did not know the person well and had not followed their behavioural plan.

This failure to follow risk assessments and support plans, placed people at risk of harm. This was a breach of Regulation 12 (Safe care) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014

● People had personal evacuation plans in their records to identify how staff needed to support them if they needed to leave the building.

Staffing and recruitment

● People were not always supported by appropriate numbers of suitably trained staff. The service was reliant on the use of agency staff. The acting manager told us staffing had improved and agency use had reduced, however on the first day of the inspection, agency staff comprised 50% of the staffing levels. One agency staff member we spoke with during the inspection told us they did not know much about the person they were supporting.

● One member of staff told us, "We could do with more staff to give people more time and attention".

● On both days of the inspection, the team leader was supporting two people whilst overseeing finances, medication rounds, staffing and a number of other roles. This meant they were often based in an office and not able to provide the support these people required.

● Staff recruitment was safe. Pre-employment checks were undertaken on people to ensure staff were safe to support people. All agency staff had profiles, however these were not always available in the location staff were working, as staff moved across the four different services.

Using medicines safely

● Although there were safe systems and processes in place to order and store medicines staff did not always follow safe practices when administering people's medicines. Medicines charts had gaps where signatures to show medicines had been administered were missing, so we could not be sure people had received the medicines prescribed. Two people did not have photographs or allergies recorded on their medicine's charts.

● There was a lack of oversight by managers to monitor staff practice as audits performed did not pick up the issues we identified.

Preventing and controlling infection

● People were protected from the risk of infection. There were infection control policies and procedures in place, and handwashing signs at sinks, staff had training in preventing the spread of infection. There was personal protective equipment available for staff to use when supporting people with personal care and when undertaking cleaning duties at the service

● There were cleaning schedules in place to ensure the service was cleaned.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People were supported by staff who did not always have up to date training for their roles. Staff (and agency staff) received training on induction. However, we looked at one member of staff's training records and we could see they hadn't completed any training since they finished their induction nine months previously.
- We reviewed the staff training records and found there was a significant amount of staff who had training that was overdue or not completed across the four services. For example, fire, manual handling, infection control. Staff across all services may be allocated work at Applewood, therefore we could not be assured that staff at the location had sufficient training to support people's needs.
- Staff told us that supervision and yearly appraisals were inconsistent. Staff told us they were unsure who would undertake their supervision and appraisals due to constant changes in the management team.

Due to the lack of sufficiently trained and skilled staff. This is a breach of Regulation 18(2) of the Health and Social Care Ac 2008 (regulated activities) Regulations 2014

Adapting service, design, decoration to meet people's

- The environment was not always maintained. Some areas needed repair and maintenance. There had been recent improvements to the bathroom and kitchen areas which were very clean and spacious. However, an oven had been broken for over five months. Some flooring had been replaced and areas had been decorated. The decoration in some communal areas was very clinical and not very warm and homely.
- People were able to personalise their bedrooms to reflect their interests, and people told us they liked their bedrooms.
- People were able to access a garden with a seated area, however some of the outside space was untidy and had rubbish lying around. The building and grounds were not secure, one door was alarmed but unlocked and staff did not always respond to this. This meant people could access a busy road at the end of the drive.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's physical, mental and social needs were assessed on admission to the service, and regularly reviewed, however support plans were not always followed by staff to ensure safe care was provided.
- Staff were supported by other healthcare professionals to provide support and care in line with national guidance and best practice guidance.

Supporting people to eat and drink enough to maintain a balanced diet

● The majority of people's nutritional needs were met, and there were systems to monitor people's weight and food and fluid intake were in place as necessary.

● Peoples care plans identified how staff should support them, including, risk assessments for choking and information on how to reduce the risk, but we could not be assured that staff were following these plans.

● People told us they had meetings to discuss what food was going on the menu. Staff told us one person liked a cooked breakfast, so on Saturday they had an all-day breakfast menu, so this person could have breakfast at any time they preferred.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● The service worked with other agencies to ensure people received timely care and support.

● People had health support and wellbeing plans in their records and we could see the support people were accessing from other agencies. People had detailed hospital action plans, which provided ambulance and hospital staff important information on how to support people in an emergency admission to hospital.

● People had detailed health plans that identified triggers in health conditions with step by step protocols if they occurred. There was a lack of detailed evidence to show how peoples oral health was maintained.

● People had missing persons information sheets to help emergency service identify them in the event they left the premises.

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.

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. 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.

● Everyone at the service required a DoLS, however staff were not able to express a detailed understanding of MCA, or best interest decisions. Staff told us that the management dealt with MCA assessments, and were unsure where DoLS information was kept

● We saw people had mental capacity assessments and best interest decisions and DoLS in place and we could see families had been involved.

● People had access to easy read information available on MCA, and DoLS.

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to 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

- People were not always treated with respect by staff who supported them, and we observed poor interactions between some people and agency staff looking after them. There was a lack of conversation and we observed staff watching and following people rather than engaging with them. We observed one person wearing trousers that were very creased and had not been ironed. A relative told us they had complained about their family member coming home in clothes that had not been ironed which they felt showed a lack of personal care.
- We observed staff walking around eating and drinking. Staff stood in corridors and talked loudly. One person told us it did not feel like their home due to the way staff behaved.
- We received mixed reviews from people. One person told us, "I love it here, everyone is lovely." Another person told us they, "Were not happy living at Applewood".
- We observed some staff talking to people in a way they understood, and interactions were warm and friendly. One member of staff told us they really enjoyed their job supporting people. Another member of staff told us they enjoyed making a difference to people and if they could make someone feel relaxed and have a laugh, it was a good feeling.

Respecting and promoting people's privacy, dignity and independence

- People's independence was not fully promoted, it was not always possible for people to leave the building when they wanted to. We observed agency staff restricting people's movement and guiding them to a certain area rather than letting people wander around freely, this was addressed by the acting manager.
- People's privacy and dignity was maintained during the inspection. Staff knocked on doors and kept doors closed when necessary. People were able to make hot drinks and prepare their own food, one person told us he had made himself a lovely omelette for lunch. Some people were able to do their own laundry and help to clean their rooms. Staff encouraged people to do things for themselves if they wanted to.
- One person showed us they had a key to their room and locked it when they went out.

Supporting people to express their views and be involved in making decisions about their care

- Some people's views were incorporated into their care plans, and we could see relatives were involved in their care planning.
- People who did not have close family were supported to make decisions about finances and other matters by advocacy services. Advocates speak up for people when they are unable to speak up for people on their behalf. Where appropriate some people had support from independent mental capacity advocates (IMCA). Independent Mental Capacity Advocacy was introduced as part of the Mental Capacity Act 2005. This gives

people who have an impairment, injury or a disability which results in them being unable to make a specific decision for themselves, the right to receive independent support and representation

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to 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; 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 had detailed care plans with information to show how staff should provide personalised care, this included their choices for social activities. However, people did not always receive this.
- The service's approach to providing social activities for people was not always about identifying meaningful pursuits for people, but about how many people staff could "get out" on a daily basis, the majority of trips out involved going to the local shop.
- One person told us that there was not enough activity in the home and they wanted to go out more. We observed another person asking to go out, but there were insufficient staff to allow this until later in the day.
- A relative told us they felt their family members mood was affected by the lack of social activity and this led to a low mood and behavioural issues. They told us that their family member would like to go out but there were not enough staff to take them alone, so they had to go along on group activities which was not personalised to them. They gave an example of a recent trip and the activity their relative was unable to do because the group chose a different activity. This meant they did not engage in activities that were meaningful to them.

This meant people did not receive person centred care, this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- People were supported to maintain contact with family and we observed a number of people going on home visits during the inspection.
- Care plans were updated regularly. We could see in some people's records families had been involved in writing the support plan, but one relative told us they had not been invited back to review meetings as promised, another told us they attended annual reviews.

Improving care quality in response to complaints or concerns

- There was a complaints system available, and staff could tell us how they would deal with a complaint, however there was a lack of evidence to show when concerns and complaints had been received or if they had been managed effectively. There were no complaints available to review at the Applewood location. There was a central log of complaints held by a senior manager which only identified one complaint since our last inspection. From this we could not be confident that complaints were being dealt with effectively.

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.

● Staff had identified ways to ensure people's communication needs were met. There was accessible information available to people, such as easy read documents and Makaton. Makaton is a language program that uses signs and symbols to communicate with individuals who cannot communicate by speaking. For people who were non-verbal, care plans identified how people expressed themselves through gestures to communicate their needs.

End of life care and support

● There was no one receiving end of life care at the time of the inspection.

● People had detailed end of life support plans in place, so their wishes could be respected.

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.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. 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; Continuous learning and improving care

- There was no registered manager at the service and the lack of clear leadership had a negative effect on the quality of care people received. At the time of the inspection the acting manager was covering Applewood and three other services at the location and unable therefore to provide consistent oversight at Applewood. The provider had brought in a senior management team to support staff at the service, this team had changed a number of times, resulting in a lack of continuity and consistent oversight of the service.
- Systems and processes to monitor and improve the quality of the service were not effective. Audits in place were ineffective. An environmental audit identified that a cooker was not working, this was consistently noted on five months of audits but there was no clear process to show who was responsible for addressing issues raised from the audit and it had still not been repaired.
- The management team had a lack of oversight of health and safety. Some maintenance records were not up to date such as carbon monoxide monitoring. When we spoke to the maintenance person who supported all four services on the site, they were able to produce up to date records, this showed us that records were held centrally rather than Applewood staff having full oversight of the service.
- The management team lack of oversight of complaints and the inconsistent analysis of accidents and incidents and safeguarding issues, meant that the service had not notified CQC of significant events in a timely way. This had led to a lack of earning from events at the service.
- The management team lacked oversight of staff training and staff did not always have the right skills or training to support people.

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

- People and staff were not always involved in the running of the service. There was a lack of meetings for people and staff to express their views and gain feedback from management. We saw the last staff meeting was July 2019 and the last meeting for people using the service was June 2019. One relative we spoke with said important issues about the service were not communicated well.
- Staff told us supervision was inconsistent and informal conversations occurred instead, but we could not see where these were documented.
- We saw the results of an annual survey to gather views of people and their family but could not see any changes as a result of the survey.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is the legal responsibility to be open and honest with people when something goes wrong.

- Staff did not always demonstrate a positive culture that was person-centred, and a lack of meaningful activities impacted on people's quality of life.
- The acting manager understood duty of candour and told us they informed families and people if mistakes occurred. However due to the inconsistent recording of incidents, we could not be sure that families were always informed. One relative told us that they thought they were kept informed of events that occurred but couldn't be sure.

The lack of systems and processes to monitor and improve the quality of the service and the lack of management oversight to assess, monitor and mitigate risk relating to health, safety and welfare of service users, is a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person-centred care due to a lack of meaningful activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to follow risk assessments and support plans placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There were poor systems and processes to manage and learn from safeguarding issues which placed people at risk of harm

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a lack of sufficiently trained and skilled staff.