Apex Care Centre Limited

Apex Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Apex Care Centre is situated in the seaside resort of Mablethorpe in Lincolnshire. The home can accommodate up to 40 adults and older people with personal and nursing care needs, some of whom live with memory loss associated with conditions such as dementia. The home also provides day care support although this activity is not regulated by the Care Quality Commission (CQC).

We carried out our previous unannounced comprehensive inspection at Apex Care Centre on 8 and 9 March 2017. The rating for the service at this inspection was Requires Improvement.

We had found that a number of improvements were needed to ensure people received support which was safe, effective and well-led. This was because the security of the building was not consistently safe, medicines had not always been managed safely and records did not clearly reflect people's needs and how these were being met. We also found that the registered provider had not completed robust quality checks. This latter shortfall had led to the persistence of the problems noted above and also had contributed to people not receiving consistent and safe care.

This unannounced, focussed inspection was completed on 17 May 2017 to review two of the questions we ask when we carry out our inspection visits; Is the service 'Safe' and is it 'Well-Led.'

We carried out the inspection because we received information from service commissioners about concerns in relation to the service. The concerns related to the safety and well-being of people and about the leadership of the home.

This report covers our findings in relation to the concerning information. You can see what action we have taken at the end of the full version of this report.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission 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 four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to properly assess and mitigate risks to people, including supporting people to take their medicines safely; staffing levels were insufficient; staff did not always provide people with person-centred care that met their needs and the provider had failed to sustainable establish systems to assess, monitor and keep improving the quality of the service.

We also found one breach of the Care Quality Commission (Registration) Regulations 2009.This was because the provider had failed to notify us of issues relating to the safety and welfare of people living in the home.

Care records were variable in quality and they were not being consistently kept updated to evidence risks identified were being managed and that safe care was always being given.

There were no clear or consistent systems for determining the staffing levels needed based on people's dependency.

We found there were some improvements in the medicine care records. However, we found there were still some gaps in administration and fridge temperature records and no clear PRN protocols were in place.

Arrangements for the security of the building and the maintenance of the homes call-bell system had not been fully addressed.

The provider had failed to notify CQC of issues relating to the safety and welfare of people living in the home.

There was ineffective communication between the provider, registered manager and senior staff and staff were not consistently supported to receive or act upon good practice guidance.

Arrangements for receiving feedback about and responding to the way the service was being run were ineffective and the provider's quality assurance and audit systems were not robustly managed.

A culture based on positive team work approaches had not been formed by the provider and registered manager. There was no evidence of clear operational or strategic management planning in place to reliably identify or resolve shortfalls in the way care was delivered. In addition, staff were not supported to receive or act upon good practice guidance. This reduced the registered provider's ability to ensure that people who lived at the home were kept safe and that people received all of the help they needed.

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 safe.

Risks to people's health, safety and welfare were not robustly managed.

There were not enough staff to ensure people reliably received the care they needed.

The systems in place did not support consistent administration with medicines prescribed as required.

Arrangements for security and maintenance of the building were not being robustly managed.

This meant that the provider was in breach of legal requirements.

Is the service well-led?

Requires Improvement

The service was not well led.

Arrangements for receiving feedback about and responding to the way the service was being run were ineffective.

The provider had failed to notify CQC of issues relating to the safety and welfare of people living in the home.

A culture based on positive team work approaches had not been formed by the provider and registered manager. In addition, staff were not supported to receive or act upon good practice guidance.

The provider's quality assurance and audit systems were not robustly managed and did not reliably identify or resolve shortfalls in the way care was delivered. This reduced the registered provider's ability to ensure that people who lived in the service were kept safe.

This meant that the provider was in breach of legal requirements.

Apex Care Centre

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 home, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection at Apex Care Centre on 17 May 2017 to follow up on concerning information that we had received. We also followed up on some of the issues we identified needed to improve at the last inspection.

There were 35 people living in the home at the time and the inspection team consisted of two inspectors.

We inspected the home against two of the five questions we ask about services: is the service safe and is the service well-led? This was because the concerning information indicated that the registered provider may not have been meeting legal requirements in relation to these areas.

Before the inspection we looked at the information that had been sent to us by service commissioners and the local authority safeguarding team. We also looked at other information we held about the home such as notifications, which are events that happened in the home that the provider is required to tell us about.

During our inspection we spoke with four people who lived at the home and three visiting relatives. We also spoke with two senior care staff and seven care workers, the cook, the registered manager, the office manager and by telephone with the registered provider.

In addition, we reviewed the information available in six care plan records. A care plan provides staff with detailed information and guidance on how to meet a person's assessed social and health care needs. Other information we looked at as part of our inspection included; new care staff recruitment information, staff duty rotas, staff training and supervision arrangements and the process the provider and the registered manager had in place for assessing and monitoring the quality of services provided at the home.

Requires Improvement

Is the service safe?

Our findings

During our inspection we looked at whether care records reflected the risks relating to people's care needs and found that the information and quality was variable. For example, care records included some information about how risks relating to people's care needs should be managed. However, the records did not include enough up to date detail to assure us that people's needs were being met in a consistent way. For example, in the care records we looked at there were no risk assessments in place for needs such as wound care, asthma or mental health needs.

One person who lived at the home required support to change their catheter so that it was safe to use. Before we undertook our inspection we had received a concern from service commissioners that the records for the person did not include information to show when the support they needed to help maintain their catheter care had been given. When we checked the records on this inspection they had still not been updated and no new recording system had been implemented. There were no clear instructions as to how staff should provide the support the person needed to manage the risk related to this part of their care. We also found that there was no clear plan to show when bladder washes had been carried out or when they were due to be given.

In addition, where risk assessments had been carried out and management plans developed they were not always robust or effective in linking with other records related to how people's care needed to be delivered. We saw an example in which nine people who lived at the home needed additional support to help reduce the nutritional risks associated with diabetes. However, nutritional risk records kept for kitchen staff to refer to only included details about how three of the people should be supported. This meant people were unsafe because staff did not have the guidance available for them to follow in order to manage peoples needs safely.

Another person had care needs related to swallowing. Care record guidance stated that this need should be included in the person's care plan. However, no care plan was available to reflect how this specific need was being met and the information had also not been recorded in the person's eating and drinking plan. The person had risk assessments in place for moving and handling and falls and there was also information which indicated the person lacked capacity to make complex decisions. However, there was no information to confirm which specific decisions the person could or could not make. This meant there was a risk decisions may be made for the person which would not be in their best interests.

Although care staff had received a range of training including nationally recognised qualifications in care, the training records held by the provider indicated that staff had not received sufficient specialised training to enable them to safely provide all of the care the person needed. For example some of the people who currently lived at the home had needs associated with catheter care, Parkinson's disease, Huntington's disease and epilepsy. The records did not show care staff training had been completed or planned in these areas. In addition, the registered manager and a registered nurse we spoke with told us how they had asked the provider to set up a structure to support them with their professional learning and competencies in order to re-validate and maintain their nurse registrations. However, at this inspection we could find no

evidence that a structure had been put in place or was being planned.

During our last inspection we found that the support being given to manage and help people take their medicines safely was not consistently in line with good practice and national guidance. For example, although people's care records included their names and showed how and when they were supported to take their prescribed medicines there were no photographs linked to the medicine records. We also saw there were a number of gaps in the medicine records which indicated that the person had not received the medicines they needed. The registered manager showed us the medicines had been administered but that the staff member responsible had not updated the record to confirm this. Temperature checks for the refrigerator used to store medicines which needed to be kept refrigerated had also not been consistently updated. The registered manager assured us that the other areas we had discussed requiring action had been followed up and fully addressed.

During this inspection we found some improvements had been made. For example, we observed the medication round at lunch time. This was undertaken correctly in regard to dispensing and administration. The registered nurse who carried out the administration had a good knowledge about why one person was having their medication administered in their food and followed the person's care plan in respect of this. Another person had a raised blood glucose levels and the nurse followed this up with monitoring and described how they did this including referral to the local doctor if there was any change in need.

We also saw action had been taken to update the medicine administration records (MAR) so they included identity photographs for each person. However, they had not been transferred to the folders that held the current MAR. This meant there was still a risk people would not be identified correctly by new staff and agency staff.

We also found one person was prescribed as needing one or two tablets twice a day but there was no record on the MAR to show if either one or two tablets had been given. The nurse told us the person always asked for two tablets so that's what they gave them. However there was no information to show if the arrangements were being kept under review or if the person's pain levels were being reviewed.

In addition we found there were still some gaps evident in the records which indicated people may not have received the medicines they had been prescribed. We also found fridge temperature records had not been kept updated and that there was a lack of written guidance to enable staff to safely administer medicines which were prescribed to be given only as and when people required them. These are known as known as 'PRN'.

Overall, there was a lack of consistent management oversight with respect to medicines management and no clear or consistent system of audit to drive forward all of the improvements we had previously identified as needed.

Shortfalls in medicines and risk management and the arrangements to support staff in delivering safe care meant that people were at risk of not receiving care and treatment in a safe, timely and consistent manner.

This was breach of Regulation 12 (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

During March and April 2017 the provider had informed us that they had experienced a number of staff changes at the home and that they had needed to undertake an on-going recruitment programme in order to fill the existing vacancies. The provider told us they had recently undertaken a review regarding

recruitment and that robust processes had been put in place when recruiting new staff. This was because they had recently identified one staff member had started to work at the home before all of the necessary checks had been completed. We looked at the systems in place for those staff members most recently recruited to work at the home. We saw background checks had been carried out. This included Disclosure and Barring Service (DBS) checks to ensure that prospective staff would be suitable to work with people who lived in the home. They had also checked areas such as employment history and obtained references from previous employers. However, the checks had not always been carried out in line with the registered provider's recruitment policy. The registered provider said they would obtain two references for prospective staff members regarding their previous employment, conduct and character. However, in one of the files we looked at one reference had been obtained. We discussed this with the registered manager who said that they had only been able to obtain one written reference but that they had received a verbal reference. However, a record to confirm when this reference had been obtained and who from was not available. This meant that the registered provider had not obtained all of the necessary assurances they said they needed to establish a person's previous good conduct.

During our last inspection the registered manager told us how they used a dependency tool scoring system to identify the needs for each person and how many staff they needed to ensure safe care was given. They also told us risks related to maintaining the care staff levels needed were escalated to them and senior staff and that action would always be taken to communicate any changes and identify if additional staff were needed. They told us this helped ensure safe staffing levels were being maintained.

On the day of this inspection the staff duty rota indicated that the registered manager had the number of staff they had identified as required to meet people's needs. However, we could see that the rota was constantly being updated with changes to ensure there was appropriate cover. When we looked at the planning for the rotas for the next two weeks there were inconsistencies in staffing levels the provider had identified as being needed.

The registered manager had identified they needed nine staff in total for each shift every day. However, for the next two weekends the rotas showed staffing levels were not scheduled to be sustained at these levels. The registered manager told us they could use the support of agency staff if needed and that they had access to a small number of bank staff but even with access to these options they were finding it difficult to maintain consistent numbers of staff. Care staff we spoke with told us that they covered as a team wherever possible but that extra care staff, including bank and agency staff were not always available at short notice, particularly at night and during weekends.

When we looked at how the staff dependency tool was being applied to work out the staffing ratios needed we could not see how the scoring system was being used to calculate the staffing numbers needed. For example, one person's record included a dependency score of 30 but there was no information to confirm what the score meant in regard to the staff time or number of staff needed to care for the person.

In addition we found communication about staffing levels and any staff changes was not consistent with the registered manager's description of how she managed changes at our previous inspection. For example, when we were speaking with the registered manager we saw they identified a care staff member was unwell. They undertook action to support the staff member and advised them that they should stop working and go home. The registered manager acknowledged to us that the staff member had just taken part in a staff handover meeting which had not identified the staff member's condition. We saw another staff member took the staff member home. However the changes in staffing and actions taken were not communicated by the registered manager to the senior staff member who was responsible for supervising the care staff team for the shift. We informed the senior staff member of the change and they told us, "I will need to check and

get things organised with the staff who are here."

This change meant the home was being run with staffing levels below those identified by the provider as required. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that the registered provider had not consistently protected people's personal safety. This was because there was still an on-going security issue relating to managing and maintaining the systems which allow safe access to and from the home.

The registered manager showed us that they had reviewed the security arrangements in place and some improvements had been made. For example, they showed us the front door was now secure. Two emergency exit doors we previously identified as not being safely locked had been fitted with magnetic locks at the top of each door. However, the bottom of both doors had movement to them and we were concerned they could still be opened if heavy pressure was applied. We were therefore still not assured that the security systems in place were fully secure.

Furthermore the call bell system people used to call for assistance with their care was still not fully working or for one person's room so that it clearly showed the when person was calling for help. Although staff were aware of the fault and which room it related to so they could respond to calls there was a risk the person would be calling for help which they were at risk of not receiving. In addition, the registered manager told us that for some of the time the call bell system people used to call for support had needed to be linked to the front door bell because staff couldn't hear the main doorbell ring. This meant there was an on-going risk staff would be called away and diverted from giving care by thinking people who were calling at the door were calling for assistance.

This was a breach of Regulation 15 (1) (b) (c) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post at the home who was the registered manager during our previous inspection.

At our last inspection we had identified shortfalls in staff communication between the provider, registered manager, office manager and staff. It was not always clear about who was responsible for the management tasks each manager was leading on so that staff would know who to report any specific issues they had to. The provider and registered manager told us they were in the process of establishing clear definitions and delegation of lead responsibilities for themselves and the management team. They also told us they had meetings planned to discuss and agree how they would be leading the team.

Following our last inspection and subsequent concerns raised by the local authority and health commissioners the provider told us they had appointed a new full time area manager who would be working at the home to support the registered manager so that all of the concerns raised with them could be fully addressed. The new role was due to commence on 11 June 2017. In advance of this the provider told us that there were arrangements in place to support the registered manager through telephone support. They told us this was being provided by the manager of another home owned by the provider.

However, we found at this inspection the provider had not been able to demonstrate or provide evidence that there had been clear and sustainable support available to assist the registered manager or that there was any operational and strategic service planning or meetings in place.

The provider had also not followed up issues raised at our last inspection for example a relative had requested a meeting with the provider and this had still not taken place.

We also found the issues related to staff availability we highlighted earlier in our report had meant the registered manager still needed to work as part of the staffing rota. The registered manager told us they had therefore been unable to dedicate all of their time to the manager role and that they had been unable to focus on developing a positive staff team culture based on clear structures and systems.

At our last inspection we were informed that the provider's new electronic care record system was in the process of being rolled out. During this inspection we spoke with a staff member who had returned from a training session they had attended to enable them to support this process. They said the session had been positive and that they were ready to share their learning with other staff members. However when we spoke with the staff member and then with the registered manager about the how the training would be shared we found there was no clear strategy in place for this.

This meant there were continued shortfalls in communication and a lack of clear leadership with staff still not fully understanding who to report to or how they would be supported to improve the service.

We saw a further example of this when, following our last inspection the registered manager confirmed that

staff had been assigned lead roles so that they could research and provide feedback to the care team and share good practice. These included; promoting healthy skin, supporting people with their personal continence needs or nutrition. However, at this inspection, the registered manager could not demonstrate that steps had been taken to communicate how these roles would be developed and they were unable to tell what resources staff could access to guide them with up to date and best practice methods.

In addition, we could not establish that staff had been provided with the leadership necessary to enable them to engage with other key national initiatives such as the 'Social Care Commitment'. Shortfalls in the systems for developing a team approach and structure for improving the quality of care had reduced the registered provider's ability to ensure people received safe and well-led care.

The registered manager also told us how all of the people who lived at the home had been assigned a key worker. However, there was no information available to show how and when care staff would be supported to undertake any good practice research or how this would be shared with the team. Also, although key worker roles had been assigned to care staff not all of the staff were aware who they had been asked to support and what the key worker role actually involved.

We also saw that although the registered manager had introduced a process as part of the care reviews being completed called 'resident of the week.' This involved care staff having a focus on the person, checking their records and updating them, this work had not been sustained. Following our last inspection we saw review records were still brief and had not been further updated and records related to people's capacity gave only a broad indication of the person's capacity. They also did not fully reflect the type or range of decisions each person could or could not make for themselves. This meant that people, or those who lawfully acted on their behalf could not always be assured that their capacity to make decisions had been suitably assessed and taken into account when care was planned and reviewed. In addition as we highlighted earlier in this report audits had not identified the gaps in care and medicine records that we found during this inspection.

Taken together, the provider had failed to develop and maintain systems and processes to assess, monitor and improve the quality of the service. provided was a breach of Regulation 17(2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that the provider had maintained records relating to incidents which had occurred in the home. However, we noted that in the previous 12 months there had been several cases involving people using the service that had been considered by the local authority under its adult safeguarding procedures but which the provider had delayed notifying CQC about as required by the law. We discussed this with the provider who told recognised notifications needed to be submitted more quickly and told us they would ensure the registered manager and staff would receive additional training and reporting would improve.

At this inspection although the provider had produced information to guide staff about when notifications should be sent to us there was no information to confirm any training sessions with the registered manager and staff had been completed or arranged.

Furthermore a relative we spoke with told us how they had recently reported a concern about a staff member's behaviour to the registered manager. They said the registered manager had assured them the matter they raised would be addressed. With the relatives permission we spoke with the registered manager about the concern. They described the action they had taken in speaking with the staff member and agreed the action they would take. However, at the time of this inspection there was no record of the meeting held

with the staff member and no clear information to confirm what actions had been agreed, taken or planned in response to the concern. We had also not been notified of the concern.

This was a breach of Regulation 18(e) of the Care Quality Commission (Registration) Regulations 2009.

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 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The registered persons had failed to notify CQC of issues relating to the safety and welfare of people living in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered persons had not ensured that people received their medicines in a safe, timely and consistent manner. In addition the registered persons had not maintained effective risk management systems.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	The registered persons had not ensured that all of their security systems such as emergency exit doors and call bell systems were working in a safe and effective manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered persons had failed to maintain effective systems and processes to assess, monitor and improve the quality of the service.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered provider had not ensured that sufficient numbers of suitably skilled and experienced staff were employed to meet people's needs in a safe and consistent manner. In addition, systems for determining the level of people's dependency was not effective.