Apex Prime Care Ltd

Apex Prime Care - Isle of Wight

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Apex Prime Care is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, people living with dementia, people with a mental health condition, physical disabilities, sensory impairments and younger adults.

At the time of the inspection, the service was providing care and support to 35 people. Each person received a variety of care hours, depending on their level of need. The CQC only inspect the services being received by people provided with 'personal care'; such as help with tasks related to personal hygiene and eating. Where this is provided, we also take into account any wider social care provided.

This was the first inspection of the service as it was a new service registered with CQC in September 2017. Inspection activity started on 1 August 2018 and ended 13 August 2018. This inspection was announced. We gave the provider 48 hours' notice of our inspection as we needed to be sure key members of staff would be available.

There was a registered manager in place. 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.

There were quality assurance systems in place based on a range of audits. However, we found these had not been effective in identified concerns raised during the inspection.

Policies and procedures were in place to dealt with safeguarding concerns. During the inspection, we identified a historic safeguarding incident that had not been raised to the relevant authority by the registered manager. We have made a recommendation in this area.

People did not always feel treated with kindness and compassion. We have made a recommendation in this area. Where people had requested not to receive care from a particular staff member, this was not always dealt with promptly.

People were not always confident that staff would be able to respond to a change in their needs. Staff were not always provided with sufficient information about a new person before they started supporting them.

The service had a complaints procedure in place, however concerns raised were not always dealt with in a robust manner.

People did not always feel the service was well-led. Staff did not always speak positively about the culture and vision of the service and told us that staff morale was low amongst their colleagues.

Individual risks to people had been identified within their care plans, including risks to them and staff in their home environment.

Staff had received training in The Mental Capacity Act 2005 and people's rights were protected.

People received care from staff who were trained, skilled and knowledgeable to carry out their role effectively.

Appropriate recruitment procedures were in place and pre-employment checks were completed before staff started working with people.

Where people required support with their medication, this was managed safely. Medication administration records were completed fully and accurately.

The service had a system in place to analyse accidents and incidents that occurred, which included identifying patterns and trends. The service had appropriate procedures in place in the event of an emergency.

People had access to suitable healthcare professionals and were supported by staff with eating and drinking where required.

Staff protected people's privacy and dignity. They encouraged people to remain as independent as possible and involved them in planning the care and support they received.

People's cultural and diversity needs were explored during their initial assessment and developed over time by senior management.

Although no one was receiving end of life care during the inspection, the registered manager was aware of their responsibilities to ensure that people's end of life wishes were respected.

The registered manager felt supported by the provider and was invited to regular meetings with other managers of the provider's locations.

Staff meetings were held for senior management to discuss updates and changes within the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Safeguarding policies and procedures were in place.

Individual risks relating to people's health conditions were identified and risk assessments had been completed.

Recruitment procedures were followed to ensure staff were safe to work with people. Staffing levels were sufficient to meet people's needs.

There were safe medication administration systems in place and people received their medicines when required. People were protected from the risk of infection.

There were processes in place to enable to provider to review accidents and incidents.

A business continuity place was in place to deal with foreseeable emergencies.

Is the service effective?

Good

The service was effective.

People's rights were protected and staff had received training in The Mental Capacity Act 2005.

Staff were supported in their role and were trained to carry out their roles effectively.

People received consistent care from staff they knew.

People were supported to access health professionals and were supported with eating and drinking where required.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always feel that staff were kind and caring.

People told us they did not always get on with certain members of staff.

Staff were aware of how to protect people's privacy and dignity. People were encouraged by staff to maintain their independence where possible.

The registered manager was aware of their how to use advocacy services where required.

People's cultural and diversity needs were explored during pre-admission assessments and developed over time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always confident that staff would recognise and respond to a change in their needs.

Care plans contained detailed information about support people required, however this was not always person-centred.

There was a complaints procedure in place, however people did not always feel that their concerns were dealt with robustly.

The registered manager was aware of their responsibilities to ensure people's end of life wishes were respected where appropriate.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance procedures were in place; however, these had not identified the areas of concern found during the inspection.

People gave mixed views about how the service was led.

Staff did not always speak positively about the management and culture of the service.

The registered manager received regular support from the provider and worked in collaboration with other agencies to ensure joined-up care.

The provider sought feedback from people and their relatives. Staff meetings were held regularly.

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Detailed findings

Background to this inspection

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

This was the first inspection of the service as it was a new service registered with CQC in September 2017. This inspection was announced; we gave the provider 48 hours' notice of our inspection as it was a domiciliary care service and we needed to be sure key staff members would be available.

Inspection activity started on 1 August 2018 and ended 13 August 2018. It included home visits to people using the service; telephone conversations with people using the service and their relatives; interviews and telephone conversations with staff. We visited the office location on 1 and 2 August 2018 to see the registered manager and to review care records, policies and quality assurance processes.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed the information in the PIR, along with other records we held about the service including notifications. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

During the inspection we spoke with eight people who used the service and three relatives by telephone. We visited and spoke with four people in their homes. We spoke with the registered manager and eight care staff. We looked at care records for eight people. We also reviewed records about how the service was managed, including staff training and recruitment records. Following the inspection, we received feedback from a social care professional about the service.

Good

Is the service safe?

Our findings

People and their family members told us they felt safe. People's comments included, "Yes I feel safe. They come in and do their job well, I am very happy", "Yes, I feel safe. I trust them with my life" and, "I know I am safe when they [staff] are around."

Staff had received training in safeguarding and were aware of how to identify potential signs of abuse. The service had a safeguarding process and policy in place, however during the inspection we identified a potential incident of abuse which the registered manager had not dealt with robustly as a safeguarding concern. We discussed this with the registered manager, who was unable to give a satisfactory response as to why this had not been reported to the local safeguarding team as they did not consider this to be classified as a safeguarding incident. We recommend that the provider and registered manager seek advice and guidance on adopting the latest best practice protocol in respect of reporting safeguarding incidents. Following the inspection, we raised the incident with the local authority safeguarding team.

We looked at people's care files, which showed individual risks to people had been assessed. Assessments were completed by senior staff to identify risks to people using the service or to the staff supporting them, including consideration of environmental risks in people's home. For example, one person had a key safe risk assessment in place for care staff to follow when accessing their property, which was in a busy location. The assessment reminded staff to ensure that the key safe numbers were jumbled after opening the safe and to make sure no one was watching. Another person had a risk assessment in place for bathing and showering which detailed clear guidance to ensure the risk of injury was minimised.

The provider had a process in place to review accidents and incidents and take action to ensure that lessons could be learnt from what had happened. For example, we saw a record where one person was independently transferring from their bed to their wheelchair and on two occasions, had become trapped between the wheelchair footplates and wheelchair seat. As a result of the second incident, the team leader took action to reassess the person's needs when transferring and update the person's care plan with new guidance for staff to follow.

There were sufficient numbers of staff available to keep people safe. Staffing levels were determined by the number of people using the service and the level of care they required. The registered manager told us that where possible, care staff were allocated to a particular person to provide consistency and to ensure that a good rapport could be built between staff and the person.

Appropriate recruitment procedures were in place to help ensure that only suitable staff were employed. Staff recruitment records for three members of staff showed the registered provider had operated a thorough recruitment procedure to keep people safe. Relevant checks were carried out before a new member of staff started working at the service. These included the completion of Disclosure and Barring Service (DBS) checks, which will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

Where the service supported people to take their medicines, this was managed safely by suitably trained staff. One person said, "They get them [medicines] out of the packet for me and I can take them." Another person said, "I can do them myself, I like to, but they will help me if I need it." We saw that records of medicine administrations were completed fully and confirmed that people received their medicines as prescribed.

There were appropriate systems in place to protect people by the prevention and control of infection. Staff had attended infection control training and the registered manager told us infection control was a focus area of regular 'spot check' observations on staff when they were working in the community. Staff told us they had access to stocks of personal protective equipment (PPE), such as disposable aprons, gloves and shoe covers.

The service had a business continuity plan in place to deal with foreseeable emergencies. This concerned events such as extreme weather conditions and disruption to network lines. This was put into practice on the second day of the inspection, when the service experienced a temporary loss of telephone and internet connection. The service responded promptly by sourcing another computer resource and arranging emergency contact numbers via mobile telephones.

Good

Is the service effective?

Our findings

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. Staff had received training in The Mental Capacity Act as part of the provider's annual training refresher requirement. Although people using the service had the capacity to make their own decisions regarding the personal care and support they received, we identified that the registered manager had a shortcoming in knowledge of The Mental Capacity Act from a management prospective. The registered manager told us they had requested further training from the provider in order to clarify their own understanding and support staff further in their awareness and application of the MCA.

New staff completed an effective induction into their role. This included classroom-based and online training, followed by 'shadowing', where they worked alongside experienced care staff until they felt confident and competent to work unsupervised. One staff member commented on their experience of shadowing, they said, "I felt so confident afterwards, they supported me well." The induction also included time for staff to read the provider's policies and procedures, review care plans, risk assessments and complete training. The registered manager told us that the length of the induction period would depend on the staff member's competence and abilities.

Staff had received relevant training to carry out their role effectively. Staff told us they found the training offered by Apex Prime Care was "good" and were able to recall their most recent training session. On reviewing the system used by the registered manager to monitor staff training, we saw that training had not always been updated in a timely way. For example, the training matrix showed seven staff members who had not completed all essential training as required by the provider, such as Safeguarding, MCA, and Manual Handling. However, we found this did not pose a risk to people as staff spoken with were knowledgeable of key topics and could demonstrate how this was relevant to their role. We discussed the gaps in some staff member's training records with the registered manager, who acknowledged this and informed us that training had been booked for these staff members. People felt that staff were trained to deliver appropriate and effective care. One person said, "Yes, I think they [staff] are trained well", another person said, "They are wonderful, they do anything I ask. They make sure everything is done as it should be."

Staff were supported to carry out their role effectively. Staff confirmed that they received one-to-one sessions of supervision with the registered manager or the team leader, which alternated between face to face meetings and observed practice in a person's home called a 'spot check.' A staff member commented, "Spot checks are really good and very helpful."

People told us staff always stayed for the amount of time allocated, so as to ensure care tasks had been completed and to meet the person's needs. People also commented that staff were mostly always on time, however if a member of staff was running late, the office contacted the person to let them know or make other arrangements. Office staff produced weekly rotas for each person's care calls, which they could receive

a copy of in advance. This allowed people to know which staff member was due to complete a particular care call. One person told us, "I am very satisfied, I always get a rota through so that I know who is coming."

People were supported to maintain good health and to access appropriate healthcare services when required. Where concerns were noted, we saw that healthcare professionals including GPs and nurses were consulted appropriately and in a timely manner. For example, one person told us how the office had arranged emergency cover for a staff member so that a person could be accompanied to their medical appointment. A relative told us, "Oh yes, they can get [family member] a doctor's appointment straight away and I know they will."

Most people's meals were planned and prepared by themselves or their family members. Where care staff were responsible for preparing meals, they encouraged people to maintain a healthy, balanced diet based on their individual needs and preferences. People confirmed care staff made sure they had snacks available and enough to drink before they left.

Requires Improvement

Is the service caring?

Our findings

People's choices were not always respected and they were not always supported to be involved in decisions about which staff would support them. We received mixed feedback from people in regard to the compassion and kindness of staff. Most people spoke positively about staff and told us they were treated in a caring way. Their comments included, "They are always cheerful and helpful, they are great", "My [family member] looks forward to seeing them, they have a chat, they are great. [Family member] has got to know them and they know him well" and, "They are very friendly and caring. I can't fault them." Some people told us they received care and support from a team of staff with whom they had built positive relationships and which suited their preferences. One person told us, "The majority of them [staff] I get on well with, they talk about things with me, but there are some I get on better with than others." A relative said, "[My family member] has a mix of care staff of different ages, it's great and it works for her."

However, other people told us they were not always treated with respect. For example, one person told us how they received support from two carers, who often spoke loudly between themselves over the top of the person whilst delivering personal care. Other people's comments included, "Sometimes I get the feeling they want to leave" and, "I sometimes feel like they don't want to give any me information [about their care arrangements], like it's none of my business and that hurts." People we spoke with told us they were going to raise these concerns with the registered manager as part of a monthly care review process. Staff also expressed mixed views regarding the compatibility of people and some staff members, which they felt was not always addressed appropriately by senior staff responsible. One staff member said, "Some people don't gel. I know a few clients who don't get on well with some carers." Another staff member said, "They [the provider] don't care, they will put people with staff that they do not like. It's like they think 'let's put a square peg in a round hole'."

We spoke with the registered manager who told us that all people should received a person centred service and be put first in making choices around their care, however feedback we received from people demonstrated this did not always happen. We recommend that the provider seeks advice and guidance on adopting the latest best practice guidance in respect of providing compassionate and dignified care.

People told us they felt their privacy was protected. One person said, "Oh yes definitely, they do a good job of that." Staff were sensitive to the fact that they were working in people's homes, and understood the importance of maintaining people's privacy and dignity when providing personal care. They described how they would close curtains or doors and ensure people were covered when having a wash. One staff member said, "Lying there can be awfully exposing, I would make sure I cover them so they feel comfortable."

People were encouraged to be as independent as possible within their abilities and staff expressed a commitment to promoting independence. One person told us, "They know where [aspects of care] I like to keep my independence, they know me and what I like." A staff member told us how they supported a person to wash independently by putting shower gel on a flannel for them and helping them to take the lid off of a deodorant bottle, so they could apply this themselves. The staff member said, "It's about letting [people] do as much as they can for themselves and not taking over. I only do the things for them that they can't."

The registered manager was aware of how to request the services of independent advocates if needed. Advocates can be used when people have been assessed to lack capacity under The Mental Capacity Act 2005 for a specific decision and have no-one else to act on their behalf. They are independent people who spend time getting to know the people they are supporting to help make decisions that they believe the person would want. Care records confirmed that advocates had previously been used to support people and the registered manager knew where and when to contact them.

The registered manager explored people's cultural and diversity needs during pre-admission assessments and included people's individual needs in their care plans. The registered manager described instances where the service had been flexible and understanding of people's individual preferences to ensure the risk of discrimination was reduced.

Confidential information, such as care records, was kept securely within the office and only accessed by staff authorised to view it. Daily records were collected from people's homes regularly and stored in a relevant file.

Requires Improvement

Is the service responsive?

Our findings

People told us they received personalised care from staff who understood their needs well. One person said of the staff, "I'd be lost without them, I find them very good. If I was stuck, they would unstick me." Another told us, "They would know if I feel ill, they have all gotten to know me well." A relative said, "They do listen, they understand [my family member] as a person." However, people were not always confident in the people that supported them. Some people and their families expressed they did not feel assured that all care staff would be able to identify changes in their or their relative's symptoms or condition. One person told us, "I don't know, some would [recognise a change]. But I think some staff might say 'OK, I've got to go now.' There are [some staff] that I don't think would register if something was wrong."

Staff told us they often did not have any information about a new person to the service before turning up at their home to carry out personal care and support. Staff comments included, "Sometimes you turn up by yourself knowing nothing about that person" and, "I don't know as much as I want to know when there is someone new." Some staff told us they would call the office to get further information about a person and their needs before they supported them, but acknowledged this was not done consistently by all staff. One staff member said, "If I see a name I don't recognise, I will ring the office and ask for more information, but I wouldn't know anything [about the person] otherwise." Staff told us they did not always receive information in an effective or timely manner. One staff member said, "They won't always tell us. I only found out about a change from another carer." We raised this with the registered manager who advised us that if there were any changes to people's needs, this was updated in people's care plans and communicated to staff by various methods such as one to one conversations, group discussions and group emails. However feedback from people and staff showed that this was not routinely the case and we have identified this as an areas of practice that needs improvement.

Initial assessments of people's care needs were completed by a senior member of staff, who then developed a suitable plan of care. They included clear directions for staff about how the person preferred to be supported in all aspects of their care. For example, one person's care plan stated, "I like to sit at the table to eat my breakfast. I would like a hot coffee." Another said, "I am able to wash my own face, front and private areas. The carer will not need to wash my back, legs and feet." However, we found that care plans were not person-centered and had a lack of information regarding people's likes, dislikes, interests and past histories. Staff also confirmed that they felt people's care plans were not person-centred and did not contain enough information for staff to know about people. One staff member said of the care plans, "They are quite brief, just their name, age and allergies, there's no background." We discussed the lack of person-centred information in people's care plans with the registered manager who agreed that the format of the current care plans did not allow for a person-centred approach. They advised that action was being taken to complete more personalised care plans to identify important aspects of people's lives such as their preferences and past histories.

The service had a policy in place to deal with complaints, which detailed information on the action people could take if they were not satisfied with the service being provided. The registered manager had also implemented a 'monthly care needs review form' which invited people to identify and raise any

improvements that could be made. Despite there being a complaints procedure in place, we received feedback from people stating they did not feel their concerns were responded to appropriately. For example, one person had raised the fact that they preferred not to receive care from a staff member to senior management in a monthly care review format on three occasions. However, when we spoke with the person, it was clear that they still did not feel the matter had been resolved.

Staff completed daily 'log' sheets as a record of the care and support people received. These were kept in people's homes and returned to the office on a regular basis to be audited by a senior member of staff. We looked at examples of the 'log sheets' and found them to be fully completed by staff, with a box for people to sign against each record made. People confirmed that the comments made by staff on the log sheets were accurate and reflective of the care they received. One person said, "I know what is on them, yes. I get the chance to have a look at it and sign it if I am happy."

Although no one using the service was receiving end of life care at the time of the inspection, the registered manager provided an assurance that people would be supported to receive end of life care and support, to help ensure a comfortable, dignified and pain-free death. Furthermore, they told us that they would work closely with relevant healthcare professionals, provide support to people's families and ensure staff were appropriately trained.

Requires Improvement

Is the service well-led?

Our findings

People and staff expressed mixed views about their experience of the service and how it was led. People's comments included, "I'm happy with what I receive. I can't complain", "[The office staff] are amazing. They do a brilliant job and go out of their way to help" and "The staff in the office are fantastic. I only have to pick up the phone and explain what I need. I know they will help me." Staff comments included, "I love working for Apex, I love the professionalism", "I do it for the love of it" and, "I am quite happy with how things are." However other people felt the service was not always well-led and thought the visibility of management could be improved. Their comments included, "I've never had any major hassle. They could be a bit better when things are changing and letting me know" and "I think [management] could do a lot more out on 'the road'."

Although staff spoke positively about their roles, we found that staff expressed uncertainty about how the service was led. One staff member said, "It's all a 'business', they [the provider] forget it's about people's lives", whilst another staff member said, "It's important to empower people, but I don't think Apex understand that side of things at times."

There was a clear management structure in place consisting of the registered manager, team leader and a support desk co-ordinator. Some staff commented that they did not feel senior staff were always approachable and therefore they were not confident in raising concerns. One staff member felt the effectiveness of concerns being dealt with was "debateable" and "would take a long time". Another staff member said, "[The support] depends on the mood of the office."
Staff also described that team morale as 'low' amongst their colleagues. Their comments included, "It's not as good as it was. The office is much more stressed", "[Morale] is low. We are all tired" and, "It's not great, but it is getting better." We discussed this with the registered manager, who acknowledged the sense of low morale amongst staff. They said, "I try to listen to them. At the moment staff morale is quite low. We are working with staff and speaking with them to find out why they feel that way. Some people have said they don't feel like it's a team anymore."

The registered manager told us the service held regular staff meetings to discuss general updates and changes and staff confirmed that minutes of what had been discussed were available if they were not able to attend. The registered manager expressed they had an 'open door' policy for all staff and aimed to interact with all staff members as much as possible. They said, "Staff can talk to me when they want to, I will always make time for them."

The provider had quality assurance systems in place to assess, monitor and improve the service, including audits for daily records and medication administration sheets. We reviewed these records, which showed that where issues were identified, action was taken as soon as possible. However, quality audits had not identified the issues raised during the inspection relating to; gaps in staff training, lack of person-centred care planning, responding to people's changing needs and acting on complaints received. The provider sought feedback from people through monthly care need reviews and a quality care survey twice a year. People confirmed that they were able to give feedback to the service at any time, however it was clear from

the issues that we identified during the inspection that concerns raised had not always been acted on in a timely or robust manner.

The registered manager told us they received regular support from the provider and were invited to regular manager meetings. They said, "The provider arranges it so we get to stay overnight and have a meal with each other. This means we can share ideas amongst managers, bounce ideas around and share positive working. We can also contact each other and use each other's experience at other times when needed."

The service worked in collaboration with other agencies to help ensure there was joined-up care provision. They stayed up to date with changes in the care sector through relevant subscriptions to trade organisations and participating in a local domiciliary care forum. The registered manager had also started to develop links with the local community and used a private social media page to share what was going on within the service.