APT Care Limited

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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

During our inspection in December 2015, we found that records relating to medicine administration were not accurately maintained. We found MAR sheets that did not contain information such as dosage, route or time for medications to be given. We found Medication Administration Sheets (MAR) were often illegible and contained information that was not clear. We also found information within daily notes that indicated that topical medication was being administered to an individual, but found that no MAR sheet had been created to properly record this information.

We found that the audit systems in place were not effective as they were not identifying the faults within the MAR.

We found that care plans and risk assessments were not being regularly updated and that staff were giving care to an individual, that was not recorded within the care plan as it was out of date.

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

This report only covers our findings in relation to the outstanding breaches of regulation. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for APT Care Limited on our website at www.cqc.org.uk.

This inspection was unannounced and took place on 27 April 2015.

During this inspection, we found that improvements had been made to the systems in place within the service, to ensure that MAR sheets were filled out and audited correctly. All staff found to have made errors were given a supervision to discuss the errors, and were placed on a monitoring plan to make sure their practice would improve. Care plans and risk assessments were now updated and reviewed, and the care documented within daily notes matched what was in the care plans.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for safe at the next comprehensive inspection.

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

We found that action had been taken to improve the safety of the service.

MAR sheets had been improved and the correct information was being recorded.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for safe at the next comprehensive inspection.

Is the service well-led?

Requires Improvement

We found that action had been taken to improve the management of the service.

We found that monitoring of quality assurance and audit systems had improved since our last inspection but required further time to become embedded.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for well- led at the next comprehensive inspection.

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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.

We undertook a focused inspection of APT Care Limited on 27 April 2016. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 14 December 2015 had been made. We inspected the service against two of the five questions we ask about services: is the service safe and is the service well- led. This is because the service was not previously meeting legal requirements in relation to these domains.

The inspection was announced and the inspection team consisted of two inspectors.

Before our inspection we checked the information we held about the service and the provider and made contact with the local authority to obtain additional information.

During our inspection we looked at records relating to medicine administration, audits, care plans and risk assessments to ensure that improvements had been made to the systems in place.

We spoke with the care coordinator, a member of administration staff, and the provider. The registered manager was not available during our inspection.

Requires Improvement

Is the service safe?

Our findings

During our inspection in December 2015, we found that records relating to medicine administration were not accurately maintained. Medication Administration Records (MAR) sheets that did not contain information such as dosage, route or time for medications to be given. Incorrect codes were being used. We found MAR sheets were often illegible and contained information that was not clear. We also found information within daily notes that topical medication was being administered to an individual, but no MAR sheet had been created to properly record this information. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the service had improved their MAR sheet format and recording. For example, the care coordinator was able to show us MAR sheets that were being used contained full dosage, route and time of medication to be given. A list of staff signatures had been created by the service to make sure that all signatures were identifiable on the MAR. A new system was in place that regularly audited the MAR sheets as they came in to the office. We saw that the correct codes were being used within the MAR sheets. This meant that people were kept safe by staff using complete, accurate and up to date recording methods.

Requires Improvement

Is the service well-led?

Our findings

During our inspection in December 2015, we found that some of the care records we looked at contained information that was no longer relevant to people's care. Care plans and risk assessments were often out of date; some had not been updated since 2012/ 2013. Care records were not always fully completed, contained old information that was no longer relevant to people's care and assessments and consent forms had not always been dated or signed. Medication Administration Records (MAR) charts had not always been completed fully or legibly. Staff told us that they recorded up to date information within a person's daily notes, but the daily care records we saw were sometimes illegible. This meant that any up to date information about a person receiving care was not always accessible for other staff to access. This was a breach of regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, the care coordinator and provider showed us that a new format of care plan that was being implemented for all service users, and that every care plan and risk assessment was being reviewed and updated regularly. The care plans we saw were completed fully and signed by a person or a relative where possible. Information from the daily notes showed us that the care being delivered matched the content of the care plans in place. The provider showed us that he had purchased an electronic care planning system that was in the process of being commenced. This meant that the process of auditing and reviewing care plans and risk assessments would be more efficient and easier for staff to keep track of.

We saw that the care coordinator had implemented a system to keep track of any mistakes made by staff when recording information on MAR sheets. We also saw that staff that had made mistakes were given a supervision where these errors were discussed and an improvement plan was put together. The accuracy of recording information and any trends that were developing were being identified with this system, which meant that peoples records were being kept up to date and accurate.