Apex Prime Care Ltd

Apex Prime Care – Highcliffe

Inspection report

413a Lymington Road
Highcliffe
Christchurch
Dorset
BH23 5EN

Tel: 03302020200
Website: www.apexcare.org

Date of inspection visit:
23 August 2017
29 August 2017

Date of publication:
06 October 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 23 August and 29 August 2017 and was announced. When we last inspected in July 2016 we found breaches in regulation. People were not always having risk assessments and care plans in place that protected them from avoidable harm. We found that actions taken had led to the improvements required. We had also found that systems and processes had not been in place to assess, monitor and improve the quality and safety of services provided to people. We found that actions had not been taken to make the improvements required.

The service provides personal care to older people living in their own homes. At the time of our inspection there were 46 people receiving a service from the agency.

The service has a registered manager. 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.

The service had sent us an action plan following our inspection in July 2016 detailing the systems and processes they would be putting in place to assess, monitor and improve the quality and safety of services provided to people. This had included monthly audits of care plans and medicine records. Audits had not been completed in June, July or August 2017. The action plan had stated that a full service audit would be carried out. A process had been introduced by the provider whereby a manager from another service would complete the full audit. This had not been implemented. We were shown a process introduced in June 2017 which had been designed to capture an oversight for registered managers of people living with an assessed high risk of harm. This had not been implemented. Support and monitoring visits had been made at least weekly by the regional manager but no records were available to demonstrate how they had monitored service delivery. Their monitoring visits had not captured that processes and systems introduced to monitor and oversee that people received safe care and that regulations were being met had not been implemented.

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 provided care in people's best interests but this had not always been recorded within the framework of the MCA. This meant that people were at risk of not having their rights upheld. We discussed this with the registered manager and on the second day of our inspection senior staff were completing MCA training.

A quality assurance survey had captured the views of people using the service and any feedback had been explored by the registered manager and actions taken where appropriate. People, their families and staff

spoke positively about the management of the service and told us the registered manager was accessible, helpful and well organised. Staff understood their roles and responsibilities and felt appreciated by the service. The registered manager had shared information with CQC and other statutory organisations appropriately and in a timely way.

Assessments had been completed that identified risks to people and were regularly reviewed. People had been involved in how risks were managed. Staff understood the actions needed to minimise the risk of harm to people. Medicines had been administered safely and staff understood the process for reporting and dealing with any errors. People had been supported to access healthcare when needed. Staff had been trained to recognise signs of abuse and knew how to report concerns. People were supported by enough staff to meet their assessed care needs. Staff had been recruited safely and received an induction, ongoing training and support to carry out their roles safely and effectively.

People and their families found the staff kind, caring and patient. We observed relaxed, friendly relationships between people and the care staff. Staff had a good understanding of peoples care needs and respected peoples dignity, privacy and need for independence. People felt involved in decisions about their care and told us that staff listened. A complaints process was in place and people told us they felt able to use it if 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?

Good

The service was safe.

People were supported by staff who were able to recognise signs of abuse and understood the actions they needed to take if they suspected abuse or poor practice had taken place.

Peoples risks had been assessed and actions needed to reduce risk had been implemented and were understood by the care team.

People were supported by enough staff to meet their needs. Staff had been recruited safely which included employment and criminal record checks.

People had their medicines administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Records had not been completed to demonstrate that the principles of the Mental Capacity Act 2005 had been followed which meant people may not have had their rights upheld.

Staff received an induction and on-going training and support to enable them to carry out their roles effectively.

People had their eating and drinking needs met.

People were supported with accessing healthcare.

Is the service caring?

Good

The service was caring.

People and their families describe staff as kind, caring and patient.

People felt involved in decisions about their care.

People had their dignity, privacy and independence respected.

Is the service responsive?

Good

The service was responsive.

Care and support plans described how people liked to be supported and were reviewed regularly.

A complaints process was in place which people were aware of and felt if they needed to use it would be listened to and appropriate actions taken.

Is the service well-led?

Requires Improvement

The service was not always well led.

Processes and systems had been developed but not implemented to monitor and review the quality and safety of the service provided to people.

The service had an open and positive culture which enabled people, their families and staff to access the management of the service freely.

Communication was effective which meant that staff understood their roles and responsibilities and had a clear understanding of the boundaries of their decision making.

Apex Prime Care – Highcliffe

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.

The inspection took place on the 23 and 29 August 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection was carried out by one inspector. Before the inspection we looked at notifications we had received about the service and we spoke with a social care commissioner to get information on their experience of the service.

Before the inspection we did not request 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 improvements they plan to make. We gathered this information from the provider during the inspection.

During our inspection we spoke with the regional manager, registered manager, care co-ordinator, administrator, four care staff, four people who use the service and two relatives. We visited two people in their own homes and observed interactions between them and the staff.

We reviewed seven peoples care files and discussed with care workers their accuracy. We checked three staff files, health and safety records, medicine records, management audits, staff meeting records, and records of feedback from families and others.

Good

Is the service safe?

Our findings

When we last inspected in July 2016 we found a breach in regulation. Risk assessments and plans relating to health, safety and welfare of people were not always carried out. The provider told us they would make improvements by 26 November 2016. We found at this inspection that improvements had been made and people's risks had been assessed and plans in place to reduce risk of harm.

Assessments had been completed that identified risks people experienced and had been regularly reviewed. When a risk had been identified actions had been put in place to minimise the risk. People were involved in decisions about how risks they lived with were managed. One person was at risk of falling and measures in place to reduce risk had included using a walking aid and wearing an alarm to call for help. Another person had risks associated with their moving and transferring and a referral had been made to an occupational therapist. We spoke with staff who had a good knowledge of the risks people lived with and their role in reducing risk. A care worker told us "We get a lot of information about risk and it's all written down in people's care and support plans". One person was at risk due to behaviours associated with their dementia. We read an entry in the communication log where care staff had recognised deterioration in the person's behaviour and contacted a GP. They diagnosed and treated a health condition that had contributed to the behaviour. This demonstrated that people were at a reduced risk of harm as care staff recognised and responded to people's changing needs.

Environmental risks had been assessed and actions put in place to reduce risk. One person's home had a frayed carpet and tape had been applied to avoid a tripping hazard. Another person had no fire alarm fitted and had agreed for the fire service to carry out a safety visit.

People and their families told us they felt safe. One person told us "I feel safe when they hoist me. I feel the care is safe and I feel better at home". Another said "I definitely feel safe". We spoke with a relative who said "I feel (relative) is safe in their hands when they are here". Staff had completed safeguarding training and understood their role in recognising any possible abuse and the actions they needed to take if abuse was suspected. Staff were able to explain their role in reporting poor practice and felt confident to do this if needed.

People were supported by enough staff to meet their care and support needs. People told us that staff were reliable, usually on time and known to them. A relative told us "They (care workers) have time to do what is needed". Staffing levels had been considered in relation to both the number of people and level of support they needed. We spoke with a care worker who told us "Staffing levels are not great at weekends. We are trying to recruit staff at the moment. Staff are doing additional hours to cover. We're currently not taking any additional numbers of people until were fully staffed". Staff had been recruited safely which included employment and criminal record checks to ensure staff were suitable to work with vulnerable people. Procedures were in place to manage unsafe practice and had been used effectively.

People had their medicines administered safely. A care worker told us "We get medicine training and we also get checks regularly to make sure we're doing it properly". When people needed topical creams

applying a body map had been completed which showed which creams needed applying to which part of the body. We saw records of a reported medicine error. Appropriate actions had been taken which included contacting GP, investigating how it had occurred, supervision with staff involved and feedback to the staff team to share lessons learnt.

Requires Improvement

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.

The service was not always effective. Care practices for some people were restricted, however assessments were not always completed to ensure that the care was provided in the least restrictive way to maximise people's freedom while protecting them from harm. One person had been assessed as not having the capacity to make decisions about eating and drinking, managing medicines and walking and leaving their home. Care plans were in place that detailed the actions care workers needed to take to minimise risks associated with these activities. However, there was no assessment or plan to demonstrate that there had been a full consideration of whether these actions were in the person's best interest. Another person's assessment had recorded they lacked capacity to make decisions about their medicines and leaving the building. When we spoke with staff they told us the form had not been completed correctly. The person had full mental capacity and could make their own decisions but that it was physical health restrictions that prevented the person managing medicines or leaving the building. Another person's assessment had recorded they had no mental capacity impairment but also stated they were unable to make decisions. We discussed our findings with the registered manager who agreed that staff had not completed the assessments correctly and required MCA training. This meant that people were at risk of receiving care that was restrictive and not in their best interests. On the second day of our inspection senior care staff were attending a MCA training workshop.

People who had capacity told us they felt in control of their care. One person said "I feel the (care workers) are good listeners and will always do as I ask them". A care worker explained how they supported a person make choices who had limited capacity for making decisions. "I give options to them so that they can make up their own minds. When somebody doesn't have full capacity I find it helps with decisions".

Staff had completed an induction and received ongoing training that enabled them to carry out their roles effectively. The induction included completing the Care Certificate. The Care Certificate is a national induction for people working in health and social care who had not already had relevant training. People described the staff as well trained and felt they had the skills to do their jobs. Training had been completed that was specific to people's needs. Staff explained to us how training in dementia had made a difference. A care worker told us "It made me relook at things 100% differently. It helps you understand that some things that happen, it's not the person it's the dementia. I'm ok with that as I understand".

Staff told us they felt supported. One care worker told us "Spot checks are carried out by (senior care worker) who is very good. They are helpful; they check our work but also help with any problems". Staff files contained supervision agreements that were signed and for three monthly supervisions. This did not reflect

current practice. Individual supervisions took place three monthly initially, then six months and then once yearly. The regional manager told us staff supervision contracts would be reviewed. Staff had opportunities for professional development which included level two and three in health and social care diplomas.

People had their eating and drinking requirements met. Staff were knowledgeable about people's likes and dislikes and explained how they offered choices when preparing breakfasts or snacks. One relative explained how their relative was unable to mobilise independently and that care workers made and left snacks and drinks that were within their reach.

Records and conversations with people demonstrated that staff responded appropriately to both on going healthcare needs and health emergencies. We read of one person who had a swollen eye and staff had contacted their GP.

Good

Is the service caring?

Our findings

People described the staff as kind and caring. One person said "They (care workers) give me time and are patient. I'm a slow walker but they give me time to get to the shower". People were supported by care workers who knew them and told us they mainly got the same care workers. One person told us "It's so much nicer having the same (care workers) coming back". A relative told us "We get a core of four carers. That's really good. (Relative) has dementia and they know her routine; that really makes a difference".

We observed a relaxed and friendly relationship between people and the care staff. Conversations with people were about things that were of interest to them such as pending family visits. A relative described how a care worker communicated with their relative "(Name) gets down to (relatives) level and makes eye contact; it makes the difference". We observed care staff giving people time to answer questions and supporting the person at their own pace. One person told us "They do understand me and are helpful. They give me time; very patient".

Staff spoke positively about the people they supported. A senior carer told us of how some care workers go the extra mile. "A couple of carers will stay and do washing or pick up a little something to spoil people with. One is sewing hems on a person's trousers".

People felt involved in decisions about their care. One person said "They (care workers) listen. After the first time you don't really need to tell them; they know the routine I like". A relative told us "I get involved. I feel able to say what I think". We observed staff asking people what they would like them to do before supporting with care. An example included making a person comfortable in their chair and other organising drinks before they left. People had been signposted to advocacy services when they needed independent support with decision making.

People and their families told us that care staff respected their privacy, dignity and independence. One relative explained "Staff go out of their way to communicate, to make (relative) aware of what they are doing, recognising it may be embarrassing but explaining that it needs to be done. That really helps with (relatives) reactions when being supported". Another told us "Carers never have talked about other clients or staff whilst visiting here; they're quite respectful". We spoke with a person who explained how care staff supported with their independence. "I'm mobile but a slow walker and they encourage me to walk, they give me time to get to the shower myself".

Good

Is the service responsive?

Our findings

Assessments had been completed prior to receiving support and this information had been used to form people's care and support plans. The plans contained clear information about people's assessed needs and the actions staff needed to take to support people. Care and support plans were reviewed regularly. A senior care worker told us "When we take on a new client we review after one month, then three months and then six months. We then will review a minimum of yearly. If somebody comes out of hospital we go straight out and check things are the same and review the care needed". People and when appropriate their families were involved in reviews of care. One relative told us "I get involved in reviews; I feel able to say what I think". Another told us "I'm involved in reviews and feel I have a voice. If I said (relative) didn't relate well to one of the carers they would just change it".

Care staff demonstrated a good understanding of people's care needs and told us they were kept up to date with any changes. One care worker said "Communication is very good. They (office) answer every call and let me know of any changes; never been a problem". The staff kept records which included some references to personal care people had received, medicines administered and people's eating and drinking. These records linked clearly to people's care plans and demonstrated the correct support had been provided.

Care and support files contained no information about people past history and experiences, hobbies and interests. The care co-ordinator told us "We are looking into putting more information together about people's lives. It would help with people with dementia. It would also help us avoid certain subjects that perhaps would be upsetting".

People had been involved in a community charity event. We saw photographs of people enjoying cupcakes in aid of 'Alzheimer's Dementia Week'. The registered manager told us "We organised a cupcake day. Clients came along to the office and people who couldn't we took a cake in a box to their home and they made donations".

People and their families told us they felt listened to when they gave feedback on the service. One person told us "I would feel able to make a complaint if I felt something was serious". A relative explained "I would feel quite happy to make a complaint if it was needed". People had a copy of the complaints procedure in their homes. We checked the complaints log and records showed us that complaints had been investigated, responded to and outcomes explained. Information had been given to complainants on who to go to if they felt their complaint had not been dealt with appropriately.

Requires Improvement

Is the service well-led?

Our findings

When we last inspected the service in July 2016 we found a breach in regulation as systems and processes were not in place to assess, monitor and improve the quality and safety of the services provided to people. The provider sent us an action plan which detailed how they would meet the regulation. They told us that actions would be completed by 26 November 2016. We found at this inspection that though some progress had been made further improvements were required in order to meet the regulation.

The action plan stated that medicine and care records would be audited monthly. Care records were being audited using guidance that had been produced by the provider. It looked at information that related to the staff teams performance such as when staff arrived, signed in and that daily notes had been completed correctly. A summary had been produced from the audit which captured anything significant such as a missed call not being reported by a care worker or no record of care being provided. These issues had then been investigated to find out the reasons why. Audits had not been completed in June or July 2017 and we were told this was due to workload.

Medicine Administration Records (MAR) had been audited using a guide produced by the company. The audit had checked the MAR had been completed correctly and actions taken if an error had been highlighted. One audit had found a code being recorded on the MAR which needed a narrative and this had not happened. A multi-text had been sent to staff to remind them of the correct procedure. The medicine audit had not been completed for June and July 2017 and we were told this was due to workload.

The action plan stated that full service audits would be carried out by another branch manager by the 26 November 2016. We were shown the peer review audit tool by the regional manager that had been created to support a full audit but this had not been implemented at the service. This meant that areas that required improvement identified at this inspection had not been captured in order that actions could be put in place to drive improvements. The regional manager shared with us details of a process introduced in June 2017 to capture details of people with high risks. The process included a form being completed detailing the risk, cause, preventative measures to reduce risk and the outcome of the prevention. They explained that the registered manager had the responsibility of overseeing the risks. One person had been assessed as having a high risk due to their agitation and associated behaviour. We raised this with the regional manager who agreed this should have been captured within the new process. We discussed this with the registered manager who told us to date they hadn't implemented the new process.

The regional manager visited the service at least once a week to provide support and monitor performance. The visits had not been recorded and action and improvement plans had not been completed to demonstrate how the service was monitoring and reviewing the quality and safety of service delivery. The support and monitoring visits had not highlighted that some quality monitoring processes and systems that had been introduced to ensure people were receiving safe care and that regulations had been met had not been implemented. We discussed our findings with the regional manager who agreed that the current processes and systems were not robust enough to ensure regulations were being met. They told us they would work with the registered manager in ensuring new systems and processes were implemented,

monitored and reviewed.

A quality assurance process was in place that captured feedback from people using the service. The last survey had been completed in April 2017 and 44 questionnaires had been returned. The registered manager told us "The questionnaires get returned to HQ. Then HQ email with the responses and will give me any actions". Actions had been completed and examples included discussing with people about having a more regular care worker and with another increasing the time allocated for visits. The quality assurance process had not included staff. The registered manager told us "In the past we have sent them out but they haven't been returned. We gather feedback at supervision and meetings. The company plan is to try again".

People, their families and the staff team all described the service as well led and spoke positively about how accessible the registered manager was whenever needed. One person told us "The office are helpful and I think well organised". A relative said "The office keep in touch; they are very approachable". One care worker told us "You can talk to (registered manager) any time of the day. Always get an answer; you don't feel your intruding". Another said "I love the office; if you have a problem they're straight onto it".

Staff described communication as good and felt they were kept informed through text messages and staff meetings. We read staff meeting minutes dated 24 November 2016 and guidance had been given to staff on correctly completing medicine and care records. Minutes of a staff meeting on 6 June 2017 read that improvements in recording had been noted. Staff understood their roles and responsibilities and the scope of their decision making and had a clear understanding of the different roles within the team. The registered manager told us about a 'Carer of the Month' scheme that had received positive feedback from staff. Carers who received the reward were given vouchers and a thank you card.

The Manager had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner. The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.