Regal Care (Liverpool) Ltd

Appleby Court Care Home

Inspection report

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05 January 2022

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18 February 2022

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

About the service
Appleby Court is a care home providing accommodation, personal and nursing care for up to 60 people; some of whom live with dementia. At the time of our inspection 32 people were using the service.

People's experience of using this service and what we found
Risks to people were not always assessed, mitigated or planned for, monitored and reviewed. We found examples where care records were incomplete and lacked information about the care people needed and received to minimise the risk of harm. There was a lack of guidance for staff on how to manage identified risks people faced. Wound assessment and monitoring records were not consistently kept up to date therefore we could not be assured that wounds were safely managed in line with current best practice guidance.

Although incidents and accidents were recorded there was no oversight of the records to look for patterns and trends and whether any lessons could be learnt to prevent or minimise further occurrences.

Some environmental hazards posed a risk to people's safety. This included an unlocked sluice room, storeroom and some vacant bedrooms which contained potential hazardous items and trip hazards. This was addressed after we raised it with staff.

There was a lack of effective systems to monitor the quality and safety of the service. Audits and checks were not consistently used to assess, monitor and improve the care people received. There was a lack of provider oversight of the quality monitoring systems at the service. There was a failure to identify and mitigate risk and bring about improvements to the service people received.

The provider had not always notified The Care Quality Commission (CQC) of incidents which they are required to do by law.

Some people did not always receive person-centred care with good outcomes because their records were not fully completed and kept up to date with their current needs and the care provided to them.

There was evidence of staff working in partnership with other health and social care professionals, however this was not consistent for all people.

There was the right amount of suitably qualified staff deployed across the service to meet people's needs and keep them safe. Recruitment of new staff was safe.

We were assured that safe infection prevention and control (IPC) measures were being followed. Government guidance was adhered to ensure safe admissions and visits to the service. The environment was kept clean and hygienic and staff used and disposed of personal protective equipment (PPE) in a safe

way.

People told us they felt safe and were treated well by staff. Family members told us that they were confident that their relative was safe and well cared for.

Rating at last inspection
The last rating for this service was good (published 15 March 2019).

You can read the report from our last inspection, by selecting the 'all reports' link for 'Appleby Court Nursing Home' on our website at www.cqc.org.uk.

Why we inspected
CQC received information of concern about people's safety. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. Please see full details in the individual sections of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to people's safety and the governance and leadership of the service.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our safe findings below.

Appleby Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Appleby Court is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means they and the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection visit was unannounced.
Inspection activity started on 05 January 2022 and ended on 18 January 2022. We visited the service on 05 January 2022.

What we did before the inspection
We reviewed all the information we held about the service since it registered with the Commission. We also obtained information about the service from the local authority and local safeguarding teams.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection visit
We spoke with six people and two family members about their experience of the care provided. We also spoke with the deputy manager, care, nursing and ancillary staff.

We reviewed a range of records. This included six people's care records and medication records. We looked at recruitment records for three staff members employed since the last inspection.

After the inspection visit
Due to the impact of the COVID-19 pandemic we limited the time we spent on site. Therefore, we requested records and documentation to be sent to us and reviewed these following the inspection visit. We looked at policies and procedures, some people's care records, quality monitoring and staff training records. We continued to seek clarification from the deputy manager and provider to validate evidence.

We spoke over the telephone with four family members about their experiences of the care provided to their relatives.

We referred one person to the local authority safeguarding team during the inspection as we had concerns about their safety.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people's health and safety were not always assessed, monitored and managed in a safe way.
- Records were not kept up to date to reflect some people's needs and the care delivered to them, therefore we could not be assured that people received the care and treatment needed to keep them safe from the risk of harm. This included care and monitoring records for the management of people's wounds, weight, skin integrity and people's food and fluid intake.
- Care plans and assessments for aspects of some people's care were either incomplete or had not been regularly reviewed. For example, an assessment for one person at risk of skin breakdown was last reviewed in August 2021 and they did not have a care plan for skin care. A Malnutrition Universal Screening Tool (MUST) used to assess any risk of malnutrition was not completed for another person with a wound.
- Wound assessment and monitoring records did not always evidence nursing staff had adhered to guidance set out by National institute for Health and Care Excellence (NICE) for the prevention and management of pressure ulcers.
- Risk assessments completed did not always provide sufficient information on how identified risks should be managed to minimise the risk of harm to people. For example, a risk assessment for one person at risk of falls did not assure us that adequate measures were in place to minimise the risk of them falling.
- Environmental hazards placed people at risk of harm. A sluice room, storeroom and some vacant bedrooms containing potential hazardous items and trip hazards were accessible to people posing a risk to their safety. Staff took immediate action to address the environmental hazards after we raised it with them.
- It was difficult for us to assess how and if lessons had been learnt following accidents and incidents as the there was no auditing system in place for monitoring them.
- Records of accidents and incidents such as falls, and pressure wounds were completed however there was no oversight of them to establish any patterns or trends and any lessons which could be learnt to minimise the risk of further occurrences.

We made a referral to the Local Authority Safeguarding Team for one person because we had concerns about the ongoing management of their wound care.

The provider failed to robustly assess the risks relating to the health safety and welfare of people and systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accurate and complete records were not kept in respect of people. This was a breach of regulation 17 (Good

governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Allegations of a safeguarding nature were reported to the relevant local safeguarding authority; however, CQC were not notified as required. The information provided in these notifications helps CQC to decide if any action is needed to help ensure people are safe from abuse or the risk of abuse.
● Staff completed safeguarding training and had access to a safeguarding policy and procedure and other information and guidance on how to recognise and report any concerns of a safeguarding nature.
● People told us they felt safe and staff treated them well and family members told us they were confident their relatives were kept safe. Comments included; "Yes I feel very safe and secure" and "[Relative] is safe and comfortable there and relaxed around staff."

Staffing and recruitment
● There were sufficient numbers of suitably qualified staff to meet people's needs and keep them safe.
● Agency staff were called upon in the absence of permanent staff to maintain safe staffing levels.
● Safe recruitment processes were followed. The required checks were carried out on staff including agency staff to make sure they were fit and suitable for the role.

Using medicines safely
● Medicines were generally managed safely. However, improvements were required in relation to 'as and when required' (PRN) records.
● One person was prescribed a PRN medicine however, there was no guidance on their medication administration record (MAR) for staff to follow about why, when and how the medication should be given. This was actioned at the time of the inspection. The required records were completed and made available to staff.
● Staff responsible for the management of medicines had completed the required training and had access to current policies, procedures and codes of practice for the safe management of medicines.
● Daily temperature checks of medicine rooms and fridges were carried out and recorded to make sure they were at safe level for storing medicines.

Preventing and controlling infection
● We were assured that people were fully protected against the risk of the spread of infection including those related to COVID-19.
● The cleanliness and hygiene of the environment was maintained to a good standard. Regular cleaning of high touch areas was taking place.
● There was a good supply of PPE available to staff and they used and disposed of it safely. Staff were provided with regular training and updates in relation to IPC policies and procedures and they were knowledgeable about them.
● COVID-19 testing was carried out in line with government guidance for people, staff and visitors.
● Government guidance was followed for introducing new people to the home and, for visitors.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The registered manager was absent throughout the course of the inspection. The deputy manager had been appointed to manage the service in the absence of the registered manager.
- The deputy manager was very knowledgeable about people and their needs and was helpful in providing information we requested. However, they lacked some understanding about regulatory requirements in relation to effective monitoring and management of risk.
- There was a lack of effective systems and processes operating within the service to monitor the quality and safety of the service, to identify and mitigate risk and bring about improvements.
- Audits and checks had not been completed on aspects of people's care to make sure their needs were being safely met. For example, audits were not completed for wounds, falls and accidents and incidents. Care plan audits had not been effective in identifying concerns we found in relation records used to assess, plan, monitor and review people's care.
- There was a lack of robust oversight and scrutiny by the provider to ensure their systems for assessing and monitoring the quality and safety of the service were fully implemented. We reviewed the last two 'Regulation Management' reports completed by the providers representative in September and December 2021. However, the reports showed no evidence of care records or any other records required by law being reviewed and there was no evidence of seeking the views of people, staff, family members and other stakeholders about the quality and safety of the service provided.
- There had been a deterioration in the quality and safety of the service people received since our last inspection. The providers systems had not been of sufficient quality, had failed to identify concerns and had not promoted learning or a culture of improving the quality and safety of the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

- The provider did not always plan, promote or ensure people received person centred and high-quality care.
- The lack of robust assessment, care planning, monitoring and reviewing of people's care resulted in them not always receiving the care and support they needed to fully meet their needs and keep them safe.
- Staff were knowledgeable about people and were person-centred in their approach, we observed staff treating people with kindness and interacting with them in a friendly manner. It was clear that staff had positive relationships with people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider failed to submit all notifications of incidents to The Care Quality Commission (CQC) which they are required to do by law.

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

● There was evidence that staff had worked in partnership with other health and social care professionals such as district nurse teams and GPs, however this was not consistent for all people. For example, referrals for assessment by a dietician for people at risk had not been made.

● Although records indicated care plan reviews had taken place, they did not always evidence the involvement or agreement of the person and/or their representative.

Systems were either not in place or robust enough to demonstrate effective systems for checking on the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Family members told us staff contacted them to update them about things such as GP appointments. Family members were complementary about staff. Comments included; "The staff are all brilliant" and "They [staff] do a really good job, they have coped really well during COVID."

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to robustly assess the risks relating to the health, safety and welfare of people and systems were either not in place or robust enough to demonstrate safety was effectively managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to maintain accurate and complete records in respect of people and they failed to operate effective systems for checking on the quality and safety of the service.