Care Quality Commission

B & L Property Investments Limited

Applecroft Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

The inspection was unannounced. The last inspection of Applecroft Care Home took place in November 2013 when it was found to be meeting all the regulatory requirements that we looked at.

Applecroft Residential Care Home has a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

We found that the home needed more robust arrangements to make sure that people had access to the provisions of the Mental Capacity Act. The Mental Capacity Act outlines the arrangements which must be made when someone becomes unable to make some decisions for themselves. The home did not have arrangements in place to implement best interest or Deprivation of Liberty Safeguards (DoLS) arrangements which form part of this. This is a breach of regulation 18 of the relevant regulations. You can see the action we told the provider to take at the back of the full version of this report.

We saw that repairs were required to the building and fittings. This meant that the provider did not comply with the relevant regulation 15 relating to this. You can see the action we told the provider to take at the back of the full version of this report.

We found that care needed to be based more around individual people's needs and preferences and a wider choice of activities offered to the people who lived at the home. We did not see evidence of sufficient engagement by the owner of the home.

People felt that they were safe from harm and staff knew how to safeguard them. Safeguarding means taking steps to make sure that people who use services do not suffer abuse and responding appropriately if there are any allegations or suspicions of abuse. There were sufficient staff and they had access to training. The provider used safe recruitment practices to make sure that staff were suitable to work in the home.

People said they liked the food at the home. We checked that the cook planned menus in a way that ensured that people received adequate food and drink. Staff at the home were kind and caring and the management team involved themselves in the care being provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe because there were sufficient staff to provide care for the people living in the home. Staff had a good understanding of safeguarding and whistleblowing arrangements. There were processes in place to manage risk.

People who lived in the home told us they felt safe and their relatives told us that they had no concerns about safeguarding in the home. Staff were subject to checks before they were employed to make sure that they were suitable.

No-one was subject to Deprivation of Liberty Safeguards (DoLS) in the home. These safeguards help to protect people who are unable to make certain decisions for themselves.

Good

Is the service effective?
The service required improvement because there were not robust and effective arrangements for the assessment of people who might not have mental capacity.

Staff were well-trained. The exception to this was arrangements for mental capacity training. Staff did not fully understand the requirements of mental capacity legislation.

People who used the service felt that there were enough staff and that they knew how to do their job. People received enough to eat and drink at the home and the menu was designed and adjusted to meet their dietary requirements. People's health needs were monitored and they were able to access a range of health care services.

Requires Improvement

Is the service caring?
The service was not caring and required improvement because there were aspects of the building which required immediate attention. This included the back door which had been broken for some time and some electric light bulbs in the main lounge. Some carpet needed replacement.

We saw that the staff at Applecroft Residential Care Home were caring and made positive relationships with the people who lived in the home as well as their relatives. Staff knew and responded to individual preferences and choices based on these relationships.

Requires Improvement

Is the service responsive?
The service required improvement because the methods of planning care were not sufficiently based around the individual needs, preferences, and characteristics of the people who lived in the home. The provider was aware of this and had already started to put in hand arrangements to improve this.

Requires Improvement

Summary of findings

There was insufficient choice around activities in the home. The activities on offer were not reflected accurately in the information made available in the home.	
Is the service well-led? The service was not well-led because there were no records of the owner's visits to the home and therefore no way of progress-checking tasks such as repairs that needed to be completed. Policies and procedures had been marked as updated but the content did not reflect this and some were still out of date. The service required improvement because it did not have a statement of purpose which accurately reflected the current situation in the home and which had been submitted to the Care Quality Commission. The manager and assistant manager of the home involved themselves in direct work with the people who live in the home. It was clear that this helped staff and enabled the managers to keep in touch with what was happening in the home. The manager also used audit systems to check the quality of service being provided in the home.	**Requires Improvement**

Care Quality Commission

Applecroft Residential Care Home

Detailed findings

Background to this inspection

The inspection team consisted of a lead inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case the care of older people.

We carried out the unannounced part of this inspection on 8 July 2014 when both the lead inspector and the expert-by-experience visited the home. The lead inspector returned to the home on 10 July and 15 July 2014 to complete the inspection.

Before our inspection the home provided us with a pre-inspection information pack which allowed us to prepare for the inspection. We contacted the local authority safeguarding and commissioning offices and they provided us with information about their recent contact with the home. We contacted the local Healthwatch as well as some NHS professionals but they did not make any comments.

During our inspection we saw how the people who lived in the home were provided with care. We spoke with eleven people who used the service as well as five relatives who were visiting the home. We also contacted four relatives by telephone although only two were available to speak with us. We spoke with the manager and assistant manager of the home, four members of care and other staff as well as the cook.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked around the home and grounds as well as checking records. We looked at the care plans of all of the people living in the home and used one of these to track the way that these plans were put into practice. We looked at other documents including policies and procedures and audit materials. We talked with two professionals who visited the home during our inspection. We spoke by telephone with another professional who visited a person who lived in the home.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

All the people we spoke with told us that they felt safe at the home. One person told us “I feel very safe. I would know what to do if there was a problem”. One of the relatives of a person who used the service told us “I chose this place because I talked to someone who had a relative here and I wanted my relative to be safe. I have no concerns”. Another relative told us “I do feel the home is safe”. This relative told us that they felt the security of the home offered protection to the person who lived there. Other relatives we talked with said they were “very comfortable” with the home’s safety policy and that they felt they could “rest easy – I do feel (my relative) is being looked after well (at the home)”.

We asked all of the staff we spoke with if they understood the meaning of safeguarding. They were able to explain what this meant and to identify the various forms of abuse which could affect the people living in the home. Some of the staff we spoke with had worked in the home for a number of years and they told us that they felt there had never been any issues relating to safeguarding.

All the staff told us that they would report any concerns that they might have to the manager. We checked the records of staff training and saw that safeguarding training had been undertaken within the last fifteen months. Staff told us that it was due to take place again in the next few weeks. We saw that the home had a policy on elder abuse but that this was dated some years ago and did not include local authority procedures. However a leaflet from the local authority advising the public on these procedures was available in the hall.

Services such as Applecroft Residential Care Home are required to notify the Care Quality Commission of certain incidents or events where there might be an allegation of abuse. We had received three such notifications which we discussed with the manager and checked against other records, We were satisfied that these had been dealt with appropriately.

We looked at how the home managed risks which might affect people who lived in the home. We saw that the home monitored people’s weights on a monthly basis and used the Malnutrition Universal Screening Tool (MUST) to identify whether people were at nutritional risk. We identified one person who had lost weight. When we asked the manager about this we were satisfied that appropriate action had been taken and that the help and advice of an appropriate healthcare professional had been sought. We talked with this person and checked that their relative was satisfied with the way that the home was dealing with this person’s nutritional needs. They told us that the home had tried a number of solutions to try and find one that would work.

We saw that one person was identified on the central computer system as having moving and handling requirements. When we visited this person in their room we found that detailed instructions had been printed out and made available for staff. There were paper records in the room which staff completed recording their actions in relation to responding to nutritional and moving and handling risks.

We were concerned that information was not always accurately reproduced on the printed sheets held in the bedroom. We saw that the risk assessment was incomplete because it did not include some of the personal variables which should be considered in such an assessment. These might include the weight of the person being lifted and their ability to cooperate with the care being provided. The provider agreed to review practice in this area and we saw that printed documentation was already prepared to address this issue.

We looked at four records of staff to see if the provider recruited staff to work in the home so as to check their suitability for this work. We saw that application forms were completed listing the previous employers. References were taken up in order to help verify this. Each file held a photograph of the employee as well as suitable proofs of identity. There was confirmation that the employee had completed a suitable induction programme. A Disclosure and Barring Check had been obtained in each instance so as to make sure that the provider could be aware of any criminal convictions.

We were told that a number of people living in the home did not have the capacity to make informed decisions. The manager told us that the home relied on the local authorities who placed people there to provide an assessment of mental capacity. The manager did not consider that staff in the home could undertake this assessment. However since a number of people living in the home were not placed by a local authority this meant that there were no arrangements for those people to be assessed if required. It is important that where required this

Good

Is the service safe?

assessment is in place because this means that decisions can be made in a person's best interests. We asked the manager to review these arrangements urgently. We saw that there was a policy and procedure relating to mental capacity and Deprivation of Liberty Safeguards (DoLS) but we did not see any evidence of recent training in this subject. Because of these factors the home is not ready to meet the requirements of the Deprivation of Liberty Safeguards.

We saw that a best interest meeting was taking place in the home during our inspection. This had been convened by the local authority social worker who had also undertaken the mental capacity assessment of the person concerned. This is a meeting in which people who know a person well meet to make a decision that is in that person's best interests when they cannot make the decision for themselves. The manager of the home attended this meeting. We talked to the local authority social worker who said they felt that this meeting had allowed decisions to be made which eliminated risks to the person who used the service. We talked to the family members who had attended the meeting. They told us that they felt they had been involved in this and the wider decisions taken by the home in relation to their relative's care.

Some of the staff we spoke with were unclear about mental capacity legislation but were clearer about the meaning of best interests and Deprivation of Liberty Safeguards (DoLS). However the manager told us that there was no one subject to DoLS in the home at the time of our inspection. DoLS are safeguards that help to protect people who do not have mental capacity.

We checked that there were sufficient staff to provide safe care for the people living in the home. At the time of our inspection there were three members of care staff on duty together with one member of senior staff. The manager and assistant manager were in addition to these numbers. We checked the rotas for the home and saw that this pattern of staffing was consistent throughout the week but that at weekends it reduced by one member of care staff. We saw that staff were allocated to each of the two floors which made up the home with more staff working on the ground floor where there were people with the greatest needs. One relative told us "There are always staff on hand" and "I can't fault the staff at all" and another said "When we were looking around (for a placement) Applecroft Care Home seemed to be the only place where there seemed to be sufficient staff around".

Staff told us that daytime staffing had improved over the last year and the manager told us that this had been achieved by organising the rotas differently. We saw from the Provider Information Return that the provider proposed to increase the number of waking night staff from two to three. The manager told us that this was in response to the increased needs of the people who lived at Applecroft Residential Care Home and in particular to those who tended to be active at night.

Requires Improvement

Is the service effective?

Our findings

The rating for this question was changed as a result of the ratings validation exercise described in the 'Background to this inspection' section of this report.

The service was not effective because there were not adequate arrangements for assessing the capacity of some people under the provisions of the Mental Capacity Act 2005. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Our findings are included in the "safe" findings of this report.

Staff told us that they received "lots" of training at the home. We checked a sample of training records and saw that staff had undertaken a range of training relevant to their role. This included moving and handling training, administration of medicines, the care of people living with dementia, and food hygiene. One member of staff said "I think we are very well trained". People we spoke with said that they felt that the staff were properly trained and one person said "They know how to do their job. If they didn't I'd tell them". All the people we spoke with as well as their relatives told us that "There are enough staff".

Staff told us that they received support, induction, supervision and appraisal. We checked records and confirmed that these had been recorded for each member of staff although we noticed that the computer entries were very brief. We saw that staff had either supervision or appraisal meetings three times a year. The staff we spoke with told us that recent training had included dementia, moving and handling, medication, first aid, and equality and diversity. We checked a sample of staff training records and confirmed this.

Training in health and safety was taking place during the afternoon of the first day of our inspection. This was the second day of this training which was provided face-to-face by a trainer commissioned from a local college. We saw that the training was well attended.

We sat and talked with three people who had been served breakfast. This was toast and cereals together with choice of a hot drink or a glass of milk. People told us that they could choose what they had for breakfast and the time at which they wanted it. Other people told us that the food at the home was "OK". We saw that one resident had asked for a message to be passed to the cook by care staff which read "(Person) has asked tell you (the cook) she loved her tea tonight". We saw that the standard of food scored consistently highly on the family feedback questionnaire.

We sampled a lunchtime meal. The dining room could accommodate all of the people who lived in the home at one sitting. The tables were basic and there were no tablecloths or napkins.

We talked with the cook who told us that people's preferences were sought by the staff and the kitchen would respond to these. During our inspection we saw staff asking people about their preferences and saw that there were records of these kept in the kitchen for the cook to refer to. One relative told us "My relative eats very well there. Although there is a set menu I have sometimes asked for something extra (for my relative)". We saw that the quality of meals scored consistently highly in relatives' feedback to the home.

We asked the cook to show us how the menu provided a balanced diet to the people who lived in the home. We used the "Eatwell" plate which illustrates the five food groups which should be included. Examples of the way in which some of the groups were encompassed included the use only of fresh vegetables, the substitution of biscuits with fresh fruit, and the provision of milky drinks such as hot chocolate. We saw that fresh fruit was sometimes also included on the menu. Staff told us that fresh fruit was not made readily available in bowls because of concerns about hygiene if multiple people handled items. The manager assured us that fresh fruit was sometimes served to people in the communal lounge.

We saw that drinks were not made available in jugs in communal areas. This meant that people could not help themselves to drinks. The manager told us that they had tried this but that few people had taken advantage of it. The cook explained that drinks were routinely made available with each meal as well as in the middle of the morning, afternoon, and at bedtime. We saw staff offer people drinks between these times and saw that they were alert to individual people's preferences and choices in this respect. We saw that where there was felt to be a risk of dehydration a record was kept of fluid intake in people's rooms. One relative told us "They (the staff) come round with cups of tea. If they (the people living in the home) ask for anything they give it to them immediately".

Requires Improvement

Is the service effective?

We saw that the people who lived at the home received health and care services from a range of agencies. Lists of contacts and a log of their actions were recorded on each person's computerised file. We saw that community occupational therapy advice had been provided by the local authority and that some social workers maintained contact with people who they had placed at the home. We met a district nurse who was visiting people in the home and they told us that they were satisfied with the care provided to the people they had seen that day.

We saw records of visits from district nursing and other staff from the local NHS. During our inspection a chiropody service visited the home. People told us how much they valued this service. We noticed that this treatment was carried out in the communal lounge which did not promote people's dignity and restricted any other activities that might be carried on in the same room. On another day of our inspection opticians visited the home to provide people with eye tests which were conducted in a private room.

We saw that the people who lived at Applecroft Residential Care Home were registered with a number of different local general practitioners (GPs). Contact with each GP was logged in each person's care record. A list of the contact numbers for all these GPs was kept separately for ease of reference in an emergency. During our visit we heard the manager arranging dental care with a local practice for a person who had recently been admitted to the home.

We saw from records that the home had kept in contact with the local hospital during a person's admission there for treatment. We saw during our inspection that when this person's relative contacted the home for information about them a member of staff responded to them in a way that was informative, professional, and friendly. When the resident returned to the home we saw that they were welcomed back warmly by the staff. Another relative told us that they had seen how the home had responded to a fall and had felt this was efficient, prompt and appropriate. They told us that the home kept in touch with them about important matters relating to their relative's care.

Requires Improvement

Is the service caring?

Our findings

The service was not caring because repairs were needed to the building. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that they thought the staff at the home were “very very good” whilst another person said “they are excellent”. Another person told us “The staff are very good, I can’t fault them. If you think you want to be left alone they leave you alone. But they would look after you if you needed it”. One relative told us “I think (the home) is really good. The people (staff) are fantastic. When we looked around other homes (Applecroft Residential Care Home) was the only place where there always seemed to be staff around. They’ve been really wonderful”. Another relative said “The quality of care is excellent. Staff are always on hand. It’s a good care home”.

We saw that staff treated the people who lived in the home with dignity. People were spoken to with respect and personal care tasks were undertaken in private. Staff offered support to people when required but also took care to match this to the needs and abilities of the person. For example we saw that staff knew the best way to help someone with their mobility requirements. In another instance we saw one person was helped to the toilet but that the care staff waited outside because the person was able to undertake their personal care tasks on their own. This meant that the staff promoted people’s independence and promoted dignity. People told us that they valued this and one person said “I am allowed to do things for myself because I can – which I like”.

People told us that they felt able to express their opinion about the care provided at the home. One person told us that they had asked if they could change the location of their bedroom and that this had been arranged. However one person told us that although they were asked about the care at the home they did not feel that their requests and comments were always acted on.

About half of the people who lived at Applecroft Residential Care Home had first been admitted some time ago whilst other people had been admitted in the last year. This meant that people had quite widely differing needs. We saw that Applecroft Residential Care Home responded to these needs on an individual basis. Some of the people living in the home liked to stay in their room or combined this with trips out to the local town or to see their family and we saw that this was encouraged by the staff.

During our inspection we talked with relatives who were visiting people who lived in the home. They told us that they had seen a “big” improvement in their relative’s wellbeing since they came to the home and that they were able to visit at any time – “The home fits me in”. Another relative said “We can go up to visit in the home whenever we want”.

We were concerned about some of the physical aspects of the building because this can affect the dignity of the people who live in it. We noted that the back door needed replacement and that the glass in it was broken. We were told that this had been reported by a relative more than six months ago. We were told that the whole door and frame had been due for replacement for some time but that this had not been attended to. We checked and found that the door still locked securely. The manager confirmed that this work was outstanding and that quotations for repair work had been obtained but the work had not been authorised and actioned.

We saw that where the lock had been removed from a bathroom door the wood had not been restored so that a hole was left in it. We saw entries in the most recent survey from staff and relatives of people who used the service, commenting that the décor of the home needed improvement. We were told that some months ago one relative had offered to pay for the redecoration of the bedroom in which their family member lived but that they were still waiting for a decision on this. Whilst emphasising the positive aspects of care to us some relatives mentioned negative aspects of the environment. They said “It’s outdated. The décor is not brilliant” and “The building needs attention”.

We looked in three people’s bedrooms with their permission. We saw that they were clean and comfortably furnished. We saw that in some rooms new carpets had been installed but that in the communal lounge downstairs the floor covering was showing signs of wear and was stained. The walls in this lounge also showed signs of wear and tear. Because the lounge was narrow in design with the main window at one end, the room had a tendency to darkness. However we found that two of the light fittings

Is the service caring?

did not have working light bulbs fitted and so the room was darker than necessary. The manager told us they were waiting for supplies of the appropriate bulbs with the correct fitting.

We were told that the home had a number of systems for heating water and central heating. Two of the people who used the service told us that sometimes the water was cold. We tested the water temperature on the first day of our inspection and found that there was no hot water. The manager investigated this and found that the pilot light on the boiler had failed and corrected this. We checked the temperature of the hot water on the second day of our inspection and found that it was satisfactory.

Staff told us that some of the radiators could not be controlled. As it was a warm day we checked the radiators and found that one set was continuing to heat some people's bedrooms and the communal lounge. We found the inability to easily control the temperatures in these rooms was a concern. We raised this with the manager at the time of our inspection who told us that the people who lived in the home preferred this temperature.

The manager told us that the home had been without a handyperson for some time. We saw that a new member of staff had been appointed to this role and saw that they were working to improve the grounds and that the gardens which had been untidy had already been attended to. We spoke with the handyperson who told us about the work that was planned to improve the home. The handyperson told us that they received a list of tasks to complete each week but also made suggestions for other improvements. We asked the handyman to check that the means of controlling the heating systems in the home was operating correctly. We saw that the need to attend to the decoration of the home featured consistently in the family questionnaires.

Requires Improvement

Is the service responsive?

Our findings

We saw that whilst the computerised care records system met many of the functions required to provide care in the home they did not contain information which would allow the care to be personalised to each individual person. Person-centred care ensures that services are planned firstly around individual needs and not the requirements of the service. Providing person-centred care to people living in care and particularly to those living with dementia is an important way of maintaining familiarity for them and making sure that a service responds to their individual needs.

The manager told us that the home was responding to this by introducing a "This is me" paper file developed by the Royal College of Nursing and the Alzheimer's Society. Once completed these would be placed in each person's room and be available to anyone providing care to people including visiting professionals. We saw that these files were being prepared and already included a photograph of each person with space to write details of people's life histories, hobbies and interests, preferences and anxieties. A recent paper profile produced from the computerised system was also included. The manager told us that some people's families had already taken the files away so as to complete them.

We also saw that there was a key worker system in place at the home. Each person living there was allocated a designated member of staff responsible for taking an individual interest in that person. The key worker was required to complete a paper folder in which they could monitor changes in health or mood, identify any changes that night be required to care plans, and make sure that clothes and toiletries were properly looked after. Each of the staff we spoke with was able to tell us who they were acting as key worker for and correctly described the role to us. Relatives we spoke with confirmed to us that they were aware of the key worker system but that "it does not get in the way. Everyone knows (my relative) and is prepared to discuss them with me".

We asked people who lived in the home and their relatives if they were involved in making decisions about the care provided there. Relatives said "Yes we could have been involved with decisions but we were happy to leave it to the home management". Reviews of people's care were carried out by the local authorities which had placed people in the home but since about half of the people there were self-funding they were not supported in this way. This meant that there was no formal system of periodic review of some people's care. Whilst we saw that the manager kept individual care plans under day to day review we suggested that in addition the home might introduce a system offering more detailed reviews from time to time and to which people living in the home, relatives and key workers and professionals might be able to contribute.

We saw from surveys that the people who lived in the home were less satisfied with the provision of activities provided there than many of the other features. Instead we were told that staff took it in turns to organise activities. We saw that there was a schedule of activities on the wall at the entrance hall. The activities chart had clearly been in place for some years without change or revision. This listed hairdressing and manicure for the first day of our inspection and a "test your knowledge" quiz for the second. However we did not see any evidence that these activities took place. Two people expressed disappointment that a hairdressing session had been cancelled.

We spent time with people in both lounges during our inspection. On our first visit to the ground floor lounge a member of staff was organising a game of carpet bowling but this was difficult because the chiropodist was treating people in the same room and the television remained on throughout.

Because some of the people who live at the home could not communicate easily we undertook a SOFI. Although there was no organised activity in progress during this period of observation we saw that most of the people were enjoying positive interaction either with each other or with visitors to the home. On the second day of our inspection we saw that a game of bingo was organised. However we could not see how people could express a choice over activities except by going to their bedroom. One person told us that they would not welcome any organised activities.

The main entrance to the home led directly into the ground floor communal lounge and so people had the opportunity to greet visitors as they passed through. However we noticed that the television had been switched on after lunch and turned to a channel selected by a member of staff without asking people if they wished this. During our period of observation we saw that none of the people were

Requires Improvement

Is the service responsive?

actually watching the television. The introduction of more personalised information through the use of the "This is me" files might enable the manager to tailor activities more closely to people's life experiences.

We asked people if they knew how to complain about anything that they did not like at Applecroft Residential Care Home. They told us that they had made no current complaints but that "I wouldn't have a problem speaking to a care assistant or a senior". A relative told us "I've got no complaints but if I had I would just ring up the manager or assistant manager".

We saw that there was a complaints policy at Applecroft Residential Care Home and that this was publicised at the front door. The manager told us that here had been no complaints in the last year.

We saw that the staff were very familiar with the likes and preferences of the people who lived in the home and this meant that they could respond to these as required. Staff also used a computerised care records system and we were able to use this to look at the care records of all of the people who lived at the home. Because the system was updated by staff at the end of each day, evening, and night shifts we found that it was easy to obtain a quick pen picture of the current wellbeing of each person who lived in the home. Entries varied from short reports where a person had had a quiet night to more extensive entries where there had been an incident or an accident. These entries described what had happened and the action taken by staff. The system could display information either on an individual basis or for the whole group of people who lived in the home.

Although the system could only be accessed in one place in the home we saw that entries were made by a variety of staff. One member of staff told us that it was also possible to access the system through the internet and that they would sometimes use this method to brief themself on what had been happening before they came back on shift after a holiday period. The Manager assured us that staff only had access to limited parts of the system and that access to the system was controlled by adequate security.

We asked staff about how they used this system and they told us that information from the system would be passed to them at handover meetings and they would make notes of matters particularly relevant for their shift. The system would then be updated for the next shift. Other information retained on the system included the details of significant others such as next-of-kin and professionals as well as a full list of medicines and a medical history.

Paper printouts of these records could be produced and we saw that the most recent and updated versions were available to be supplied quickly as profiles in certain situations such as when a person was admitted to hospital. In a few cases a brief pen picture of the person was included but these were out of date.

We saw that personal information about people who lived at Applecroft Residential Care Home was stored securely either on a computer system or in a locked office. This meant that people could be sure that information about them was kept confidentially.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who had worked at the home for eight years of which they had been the manager for four years. The assistant manager had worked in the home for nearly five years of which they had been in a managerial role for eighteen months. The manager held the Leadership and Management Award qualification whilst the assistant manager held a level 3 National Vocational Qualification. Both of these qualifications are recognised as relevant to care home management.

We were told that the home had a revised statement of purpose but that this had not been registered with the Care Quality Commission (CQC). Providers are required to provide a statement of purpose to the CQC within 28 days of any revision. We were handed a copy of the revised statement but saw that it contained information that was out of date. This included a reference to regulations which had been superseded. The document made reference to future events to occur in a year that had passed. We did not feel that parts of this statement accurately represented the care provided in the home. We have asked the provider to review this document and make sure that any revised statement of purpose is submitted to the CQC at their Newcastle Office.

We found that information about the home was provided for visitors and relatives in the entrance hall and that this included the latest Care Quality Commission inspection report together with a service user guide.

In the provider information return sent to us before the inspection the provider stated that the owner had continued their practice of visiting the home weekly. At a previous inspection we had suggested that the home might record these visits in writing but we saw that whilst this had started it had been discontinued after a short period. Consequently although we were assured that some of the repair items in respect of the environment had been reported to there was no system in place to allow progress to be monitored.

Staff told us that they found both of the management staff to be accessible. We saw that they were on hand to give advice as well as to provide direct care to the people who lived in the home. We saw that the manager took personal responsibility for managing the computer records and ensuring that assessments and other information were up to date and that access to the system was properly controlled. The manager showed us how the computer system could provide them with information to assist with their management of the home.

When we talked with staff they each identified that the small size of the home meant that there was a small staff group who knew each other and worked together well and could get to know the individual likes and dislikes of the people who used the service. We could see that this was the case in the way that staff responded to the needs of the people who lived in the home. When we asked staff what they did not like about the home they identified that the delays in getting some things attended to such as repairs was a frustration.

We looked at the minutes of staff meetings and saw that these were held every two to three months. Topics covered recently had included a reminder about whistleblowing arrangements and a discussion about the need to treat people equally. Staff told us that they received regular supervision and appraisal and we saw that records of this were retained on the computer system in the office. When we checked these records we saw that staff received formal supervision or appraisal three times each year. The records of these meetings were very short however and did not provide the detail of any discussion which might have taken place. It would therefore be difficult to review the discussion or any actions agreed at a later date.

We saw that there were records of meetings with the families of people who lived at Applecroft Residential Care Home and that the most recent of these had been held in the last month. The manager told us that this had been well-attended. A relative confirmed that they had attended this meeting and that the matters discussed had been relevant to the current care provided by the home. Another relative confirmed that they had been invited but were unable to attend. However there were no similar meetings for people who lived in the home. The manager told us that these had been tried but had not been well-attended and they had been discontinued.

The manager told us that one of the ways they sought feedback on the quality of care provided in the home was by the use of feedback questionnaires. We looked at a selection of these which had been completed by people who used the service and their families as well as staff. One had been completed by a professional who visited the home. We looked at the most recent of these

Requires Improvement

Is the service well-led?

questionnaires and saw that the standard of care provided together with the standard of meals was scored consistently highly. The range of activities available for people in the home scored less well and there were a number of negative comments about the physical appearance of the home and relating to the need for some parts of the home to be redecorated.

We saw that the manager had a number of systems in place to monitor other aspects of the service. Medicines audits had been carried out. Risk assessments were in place for a number of the physical aspects of the home such as bathrooms, bedrooms, and the kitchen. In the dining room emergency plans were available for staff to follow.

We saw that the home had a whistleblowing policy and that this was displayed in the staff room. There was a master file of other policies kept in the main office. This included policies on supervision and appraisal. Although there was a sheet identifying that all polices had been reviewed in the last year we could not see that this review had resulted in all the changes which might have been required. For example the whistleblowing policy still directed staff towards a former regulator rather than the Care Quality Commission. Safeguarding is now considered to be a wider concern than elder abuse alone. Although there was a sheet identifying that all policies including this one had been reviewed in the last year we could not see that this review had resulted in any changes to this policy such as revising it in the light of local authority procedures.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises How the regulation was not being met: Parts of the building required repair and maintenance. Regulation 15

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The provider did not have arrangements for some people who lived in the home so they could be assessed for under the Mental Capacity Act 2005. Regulation 18