APC Care Limited

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Inspection report

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Date of inspection visit:
26 September 2018
28 September 2018

Date of publication:
06 November 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 26 and 28 September 2018 and was announced.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, people who may be living with dementia and younger adults. At the time of this inspection the agency provided personal care to 16 people.

Not everyone using APC Care Limited receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

At the time of this inspection there was no registered manager in post. 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. A manager had recently joined the agency and had applied to us to become the registered manager for the agency. We had received their application to register with us.

We did not find any breaches of regulations at this inspection but have rated the 'Well-led' key question as 'Requires improvement' due to the historic and current lack of continuity in the management of the service which had resulted in some people experiencing an inconsistent service.

People were safeguarded by a staff team with awareness and understanding of how to report concerns of abuse to appropriate professionals. People were given medicines safely and records were held of the care provided to people. The provider engaged with healthcare professionals as appropriate.

People were involved in the planning of their care and independence was promoted where possible. Consent was sought from people before services were provided to them. Risks to people were assessed and action taken to mitigate risk. The risks of infection were reduced with infection control measures which included the appropriate use of protective equipment such as gloves and aprons. There were enough staff to provide support to people. The care manager was recruiting additional staff to ensure that people received a consistent service from regular staff.

Care staff received training and support from the management team to support them in their roles. Care staff were observed to provide care safely and appropriately to people. Privacy and dignity was maintained by caring and dedicated staff.

People and care staff views were sought regarding the service provided and people were confident to use the complaints process when this may be required. Complaints were investigated and responded to appropriately.

Improvements had been made to the quality and safety of the service following the termination of the former franchise contract.

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 remained Safe.

People were safeguarded from abuse by staff who understood how to report concerns appropriately.

Risks were assessed for people and mitigating actions taken to reduce risks.

People were protected from the risks of infection.

Medicines were managed safely for people when care staff supported this.

Lessons were learned when things went wrong.

Is the service effective?

Good

The service remained Effective.

People's needs and choices were assessed and people received support to eat and drink enough.

Care staff had the right skills to support people appropriately.

The provider supported people to access healthcare services as they needed it.

The basic principles of the Mental Capacity Act 2005 were understood.

Is the service caring?

Good

The service remained Caring.

People received a service from kind, compassionate care staff.

People were supported and encouraged to maintain their independence when they were able.

Privacy and dignity were maintained. Records were held securely.

Is the service responsive?

Good

The service remained Responsive.

People were involved in decisions about their care.

People felt able to raise complaints when they needed to and complaints were responded to appropriately.

End of life care needs were understood although people did not receive end of life care at the time of this inspection.

Is the service well-led?

Requires Improvement

The service was not always Well-led.

There had not been a registered manager in post for over 24 months which did not provide assurances about the consistency and day to day running of the service.

People's views were considered in the day to day running of the service.

The provider had improved the quality of the service from lessons learned.

APC Care Limited

Detailed findings

Background to this inspection

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

We previously inspected the service in December 2016 at which time we rated the provider as 'Good' in all five key question areas. In line with our methodology we would not be required to inspect the service again until a period of 30 months had passed. However, at the time of the last inspection this provider was part of a franchise organisation. We had received concerns from the franchise organisation regarding the provider and the franchise contract was terminated. We require registered providers to have a registered manager. This provider had not had a registered manager in post since 2016. We inspected the service sooner than we were required to do so to seek assurances of the quality and safety of the service people received.

This inspection took place on 26 and 28 September 2018 and was announced.

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 26 September 2018 and ended on 28 September 2018. It included shadowing care staff when they visited people in their homes. We visited the office location on 28 September 2018 to see the care manager and office staff; and to review care records and policies and procedures.

The inspection was conducted by one 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.

Due to technical problems, the provider was not able to complete a Provider Information Return (PIR). This is information we require providers to send us at least once annually 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 spoke with seven people and two of their relatives. We also observed staff practice of two care staff with three people in their homes. We reviewed the care records for three people. Three staff records were reviewed which included, staff supervisions, 'spot checks' and training records. Organisational policies and procedures and systems for monitoring the quality and safety of the service were also viewed.

We spoke with the registered provider, the care manager, assistant care manager and three care staff. We also received information about the service provided from the East Sussex County Council social services brokerage manager and market support manager who commission services with the provider.

Good

Is the service safe?

Our findings

The service remained Safe. People were safeguarded from abuse by care staff and a management team who understood how to raise concerns appropriately, when required, to external organisations which included social services. The provider had notified us when safeguarding concerns were raised by them.

Systems and processes protected people from the risks of abuse. The care manager described a recent example of when they and the staff had safeguarded a person from abuse regarding the use of medicines. Care staff had been vigilant and identified that a person may have received medication which was no longer required for them. They reported this to the management team who acted appropriately. Effective communication ensured the person was safeguarded. Electronic records held by the service also detailed concerns that had been raised by the person's relative regarding an allegation that care staff had not given medicines as prescribed following concerns they had received from the person's neighbour. A clear log of actions taken by the service were maintained. The care manager knew the person well and was aware that medicines had been stopped following a recent admission to hospital. They contacted the person's GP to request a medication review. The GP reviewed the person's medication with the care manager present and confirmed that they did not require medicines to be given to them. Care staff acted appropriately and proactively to safeguard the person and managed risks to avoid possible mismanagement of medication. The care manager said that the person's relative was, "over the moon" as they did not want their loved one to be given medication they did not require. This demonstrated that people were safeguarded by robust systems.

Medicines were given safely. People's needs regarding their medicines were recorded in their records and staff completed the medication administration records (MAR) when medicines were given to people as prescribed. People received their medication on time. One person said, "They [staff] put out my tablets and watch me take them. I get my medication on time." Care staff confirmed they received training to give medicines safely and that there were no medicines errors. A member of staff said, "No medication errors. It's common sense" [safe medicines practice].

Risks to people were assessed and the safety of people was positively supported by the provider. This included managing the needs of people who may display some challenging behaviours. A social services brokerage manager told us that the provider had "picked up some challenging clients" and that the staff were, "good at managing these packages of care." They also told us that this was important as people were able to have continuity of care with a provider who was willing to work with them instead of handing the package of care to a different provider. Other risks to people which included moving and handling were assessed. The care manager was reviewing the assessment form for this at the time of this inspection. We observed care staff used moving and handling equipment safely with people. Two care staff were seen to use a 'stand aid' to help a person to mobilise. Staff spoke calmly and gently encouraged the person. Clear verbal instructions were given which enabled the person to stand. One person said that care staff, "watch that I am walking correctly with my 'Zimmer' [walking frame]." The management team reviewed staff competence to move people safely during 'spot check' unannounced observations of their practice.

There were sufficient numbers of staff. Care staff were recruited safely with appropriate checks completed which included Disclosure and Barring Service (DBS) checks and references from previous employers which showed staff were of good character. The registered provider said that if care staff were, "running late" that they or the care manager would "go out to cover calls" for people. This ensured that people did not miss their visits. People confirmed that the office contacted them to let them know if staff were running late. One person said, "If one of them [staff] is running late, they phone up to let me know." Another person told us that, "Carers are on time and turn up when they should." They also confirmed that they receive a weekly leaflet with the name of the carer and time of their visit.

The service operated an electronic call log system which the care staff used to log the times they arrived and left people's homes. This showed that people had received their calls. The registered provider was reviewing this system to ensure that the duration of visits to people could be more clearly reviewed. The care manager and registered provider also told us they were advertising to increase the number of care staff.

People were protected from the risks of infection. Care staff used 'protective equipment' such as gloves and aprons appropriately when they provided personal care support to people. The registered provider also gave care staff 'face shields' to use if a person needed to be resuscitated. Staff completed infection control training as part of the providers 'mandatory' training. The provider gave staff enough gloves and aprons to do their job safely and people confirmed that care staff used their gloves and aprons. We also observed care staff used protective equipment safely.

Lessons were learned when things went wrong. The provider operated systems to update care staff about important issues. This included sending text messages and regular emails to staff via their work mobile phones. This ensured that information was regularly shared to improve and maintain safety for people. An electronic system maintained records of actions taken following incidents and changes that had been made to keep people safe.

Accidents and incidents were recorded. The management team were developing systems to analyse these more effectively for any trends or themes so that appropriate preventative actions could be taken. We found that appropriate actions had been taken to minimise risks to people when these had been identified.

Good

Is the service effective?

Our findings

The service remained Effective. People were involved with the assessment of their care needs and choices. A person told us that they were, "involved in setting up my care plan." The provider used an electronic system to monitor the service provided to people. Management staff used the system to log changes to people's care needs and any concerns that care staff raised with the office, which enabled these to be reviewed and monitored centrally. This demonstrated that systems were used to enhance the delivery of effective care for people.

People had choice and control about the care they received which achieved positive outcomes for them. One person told us, "I feel my care is as individual and 'free-range' as I like." For example, they said they do not always want to have personal care and stated that care staff understood and respected this. The person had a long-term condition and told us that staff accommodated their individual needs and preferences.

Care staff had the right skills and experience to deliver effective care. One person said that care staff were, "very good. They do all I need. They shower me and dress me. They're careful. Very good." Another person said, "Carers are willing and capable and they answer any questions I have. They cheer me up and make me smile." A further person told us that care staff were, "Very smart and very professional," and "They are quality." Care staff training records were being reviewed at the time of this inspection by the new management team. Care staff completed training that the provider stated was mandatory. Training was delivered using a 'blended' approach with 'on-line' and classroom based practical sessions.

People were supported to eat and drink enough. We observed that care staff provided meal support and encouragement to people in their own homes when they required this. People and their relatives confirmed that staff supported them appropriately with food and drink. Care staff and the management team had awareness of people's different dietary needs and the external professionals who would be able to effectively support people with this. The assistant care manager knew about dieticians and speech and language therapy therapist (SaLT) team roles for people who needed this additional input and support. They were able to describe how specialist advice and recommendations were carried out by the care staff to ensure people received the outcome they required. This demonstrated that there was understanding about how people would receive a consistent service when they were referred to use different services. The assistant care manager described a person who needed care staff encouragement to eat. Meal care plans were followed by care staff and choices of meals were offered to people.

Care staff and the management team supported people to access healthcare services. The care manager told us they had accompanied a person to a mental health appointment. We observed the management team provided compassionate support to people when they needed to access healthcare services. The care manager contacted a person from the office to check how they were feeling as they had been unwell. They were very reassuring and patient with the person. They said, "Do you want me to send someone over to you?" and, "Do you need some help from us?" The care manager stayed on the phone until the person's friend arrived to be with them. The care manager sought consent from them to contact the doctor. The assistant manager went to visit the person to be with them while healthcare support was arranged. This

demonstrated that people were appropriately supported to access health services when they needed them.

People received a personalised service from staff who sought their consent. Care staff had completed relevant training about the Mental Capacity Act 2005 and had basic knowledge of the principles of the Act. The registered provider told us that they had not needed to use mental capacity assessments yet because people who currently used the service did not lack the mental capacity to make day to day decisions regarding the care and support provided to them by APC Care Limited. Some people had the support from others who had appropriate legal decision-making powers, such as lasting power of attorney (LPA) for more complex decisions that they may have difficulty with. The care manager and assistant manager understood the roles of people who held these powers in the lives of those who received a service from the provider. The management team told us that they were working to improve the documentation required to assess people's mental capacity.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack 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. The MCA Code of Practice states that a person's capacity must be presumed unless proven otherwise and that assessments are time limited and decision specific. When a person may lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The Court of Protection can authorise a deprivation of liberty when people live in community settings. We checked whether the service was working within the principles of the MCA. At the time of this inspection people did not require deprivations of their liberty in community settings.

Good

Is the service caring?

Our findings

The service remained Caring and we found that people received a caring service from kind care and management staff. People were happy with the care they received. One person said, "The carers are wonderful" and "I don't know what I'd do without them." Another person told us, "The carers are very caring. Really lovely women. They help me and look after me and do anything I need." A further person said, "I feel like I know them all. We're all one big happy family. I feel relaxed and comfortable with the carers. They're genuine people who are in it because they care."

People were treated fairly and with compassion regardless of their age, gender or disability. People said that the service was run by a caring leadership team. One person told us, "The person who runs the service [registered provider name] is nice, kind and understanding. She's very sensitive. She treats me and my daughter, who's also disabled, as one package." The registered provider told us that they would only want staff to provide care to people in their homes if they were, "good enough to go to my mother and fathers house." They spoke passionately and with empathy about providing a service that was caring for the people who received it. A further person said, "[care manager name] is kind."

Care staff and the management team treated people with respect and dignity. A person confirmed that care staff asked for their consent before they provided support with personal care and that they were "very respectful" of the person's dignity when doing so. They said, "They [care staff] don't do anything without my permission."

Care staff showed good awareness of upholding dignity for people. We observed care staff treated people with the utmost respect and dignity when they provided personal care and support for them. One person's curtains were closed by care staff before they were hoisted from their lounge chair which ensured that passers-by were not able to see in through the ground floor window. Care staff also ensured that a blanket was placed over the person to cover their lower half when they were lifted in the hoist sling to be repositioned in their chair. This demonstrated that care staff were aware of the need to protect people's dignity and privacy.

People were supported to be involved in making decisions about their care, support and treatment. Care staff were attentive to people's needs during visits to them and evidently knew people and their personal preferences very well. One person was encouraged to recall past fishing trips and employment when they had been a skilled worker. A member of care staff shared mutual interests with them and were able to talk at length about the person's past hobbies with them. Care staff were seen to continually check with people for their views and choices while support was provided for them.

At the time of this inspection no advocacy support services were being used. The registered provider stated that no-one who used the service was without support from family or friends when unable or unwilling to speak out for themselves. The care manager agreed to continue to review this to ensure that people who may require additional advocacy support are offered this. Advocates provide independent support and advice to people.

The provider ensured that care staff had enough time to care for people. Visits to people were no shorter than 30 minutes long. This was in line with national best practice guidance. The national institute for clinical excellence [NICE] says that, "Home care visits to elderly people should last for at least half an hour and be centred around personalised care rather than a 'one-size fits all' service."

People were supported to live as independently as they were able. The new care manager described to us about "companionship" visits provided to a person who lived with dementia and how they had supported them to attend a mental health appointment. The care manager told us about the person's individual needs and how they had worked with them closely by, "Opening the conversation and giving options, she still feels in control which I feel is important." This demonstrated how the service worked with people's strengths while positively encouraging independence when possible.

Good

Is the service responsive?

Our findings

The service remained Responsive to people's individual needs. People and their relatives told us that the management of the service was responsive and met the needs of those who needed support. One person said, "The other night, the carer was held up, so I phoned [care manager name]. She came out even though she had only just got home after a long day. She came and helped me. Then the carer came."

People were involved as much as they could or wanted to be with the planning of their care. Care was reviewed with people and their representatives, as appropriate. A person told us that the care manager had completed a care plan review with them. They said, "Yes [care manager name] did." They also said that the care manager asked if the care was provided in a way that the person liked. The person told us, "They [staff] always double check everything" and "if I have any major problems they're always there to help me."

Technology was used by the service to record the times care staff visited people in their homes and the length of the visit. This enabled the provider to monitor visits to people while also tracking staff whereabouts. A person said, "The carers are nearly always on time. If someone is very poorly, they have to stay with them. They phone and let me know. I'm very comfortable with them." This showed that the systems supported people to receive a responsive service.

People understood the complaints process. Care plan records in people's homes contained copies of the providers complaints policy. Complaints were recorded and reviewed. One person's relative had stated that their father's calls were late and that he didn't get a weekly schedule. This had been addressed and resolved. Complaints were recorded, handled and responded to appropriately. The care manager and assistant manager were working to improve the access to this policy document with the text provided in a larger size for people to read more easily. This would better support those people with visual impairment. Staff worked towards best practice legislation, namely the Accessible Information Standard (AIS). This legal standard was introduced by the government in 2016 to make sure that people with a disability or sensory loss were given information in a way they could understand.

People and their relatives were positive about the management team and felt able to raise concerns or complaints as they felt necessary. One person said, "The girls are lovely and the care has been fine. I haven't got any complaints." Another person told us, if they had any complaints, he would "call the office." A relative said, "I've never had to make a complaint" and "[care manager name] is lovely. She came to meet me. She took over twice one Sunday when she couldn't find anybody else."

People did not receive end of life care from the agency at the time of this inspection. We saw that people who may have chosen not to be resuscitated did not always have clear information in their records to inform staff of their wishes. Following this inspection, the registered provider and care manager provided us with information that demonstrated this had been addressed appropriately and staff had the information they required to make sure people who wished to be resuscitated and those who did not was clear. Care plan folders identified if people did or did not wish to be resuscitated with a 'do not attempt cardiopulmonary resuscitation' 'DNACPR' form in place when required. These forms are completed by a medical professional,

either with the person or in the person's best interests if they are not able to give their views of their preference regarding resuscitation. When this is in place a person would not be resuscitated. This then enabled people to die with dignity when it had been agreed that resuscitation was not appropriate.

Requires Improvement

Is the service well-led?

Our findings

The service was not always Well-led. There had not been a registered manager in post for over 24 months. The Care Quality Commission [CQC] requires that registered providers will have 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. At the time of this inspection the care manager had submitted an application to become the registered manager, although had not yet had the 'fit person's interview' to finalise the application process.

The provider had recently had their franchise contract terminated due to ongoing quality concerns that the franchise organisation had made us aware of. They were now operating as a single location provider. The registered provider felt this would be more positive for their business. Following this inspection, the registered provider agreed to enable the care manager and assistant manager to take a more active management role in the day to day running of the service. The service is rated as 'Requires improvement' in this key question until sustained improvement and progress is shown in the management structure and organisation of the service with a permanent registered manager.

People gave some mixed views about the management of the service. One person told us, "I've met [care manager name]. She's very nice. She came around. It's [service] very well run." Another person said they had not spoken to the care manager, or, "met anyone from the management team" and had only spoken to "admin staff." They also said, "I wouldn't say I'm unhappy but it could be better organised" and that, "sometimes it's erratic about who's coming and when which is a little bit annoying. I have to phone." However, the staff were very positive about the new management team. One member of care staff said that the management was "good" and that, "The managers have changed recently and the ones we have had now are really good. We have supervisions and spot checks." Another member of staff said, "[care manager name] is the best move [registered provider name] has ever made. She's not frightened to get her hands dirty and she always makes time for the staff. I think she's lovely, she's a real asset." This indicated that there had been some changes to the management structure which were positive for the organisation.

The provider had reviewed the aims and objectives of the service following the recent changes and separation from the franchise company. One of the core aims and objectives of the service was, 'to encourage and promote the independence and safety of all of our customers.' We found that the management team and care staff demonstrated passion, dedication and enthusiasm to support people to maintain independence where possible. One person had recently suffered a stroke and had been very sensitively supported and encouraged by care staff to complete their daily exercises and to mobilise. This had a positive impact on the person who was seen to be happy with the staff support and encouragement provided to them. Their partner told us that the management were, "very good" and complimented the care staff that we observed. They said, "They're all wonderful but these two in particular [care staff] are lovely."

Care staff felt able to influence their roles and the care they provided to people, and felt listened to. One member of care staff told us, "She's so supportive [registered provider name]. She asks for our input because

of our experience. She's acted on our input and we asked if we could have calls allocated to us for a person so we could help with physio, to make a difference. We were supported to do this."

The care manager said that they operated an "open door policy for care staff." We observed that care staff accessed the care manager's office freely and were welcomed by the care manager who took the time to listen to their comments.

The management team completed audits to monitor the quality and safety of the service. People were listened to and their views were sought. Surveys had been completed to seek people's views of the service they received. This had been analysed which showed that feedback was positive. Monthly document audits were also completed for people's care records. The new care manager had analysed the records audit for one person which identified some 'gaps' in records and the action required to address this. The new management team were positive about the positive changes that had been implemented in a short period of time since the franchise contract had been terminated. The assistant manager said, "We've come a lot further forward in a short space of time than I thought we would with the support of [care manager name]. I feel like they have been here forever which is a really good feeling. I can say anything to her. It's really nice."

The provider had some awareness of wider best practice guidance and had 'signed up' to the 'social care commitment.' This was a national quality pledge which was supported by the Department of Health and the Care Quality Commission [CQC]. It consisted of a 'promise made by care providers to those who need care and support' with a 'commitment to high quality care.' We found that the management team reflected these values in their desire to provide a good quality service for people.

External health and social care professionals were involved with the care and support of people supported by the service. There was an open approach to communication with evidence of the registered provider and management team working proactively with social services and health professionals as people's needs dictated.