Mrs Emma Lumsden

ApproCare

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
ApproCare is an independent domiciliary care agency which provides personal care and support for adults in their own homes. People receiving care and support had a range of needs including, older people, people living with dementia, people with poor mental health, people who misuses alcohol and or drugs, people with eating disorders, people with a physical or sensory disability and people who have a learning disability and or autism.

At the time of the inspection the service was not supporting people who misuses alcohol and/or drugs or people with eating disorders.

The agency provides care for people in the local Isle of Sheppey area and Sittingbourne. At the time of our inspection, they were supporting 59 who received support with personal care tasks

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support: Peoples needs were not always identified and recorded. Staff supported people to play an active role in maintaining their own health and well being. Staff supported people with their medicines in a way that promoted their independence.

Right Care: People's care, treatment and support plans did not always reflect their range of needs. Staff knew how to protect people from poor care and abuse. Some people told us they received kind and compassionate care. Staff protected and respected people's privacy and dignity.

Right Culture: Staff turnover was high, which meant some people did not always receive consistent care from staff who knew them well. There were not effective systems and processes in place to ensure the quality and safety of services. Some staff did not feel valued but all staff we spoke with told us they believed their work was important and they enjoyed caring for people.

The last rating for this service was good (Report published 28 March 2019).

Why we inspected
The inspection was prompted in part due to concerns received about staffing and organisational culture. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only. Based on our inspection of safe and well led we found the

service required improvement.

You can see what action we have asked the provider to take at the end of this full report.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

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

Enforcement
We have identified breaches in relation to the number of trained staff available to provide care, the assessment of people's needs, how this is communicated to people, how risks to them are identified, shared and addressed. We also found poor governance systems and processes for the service.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 well-led findings below.

ApproCare

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 Health and Social Care Act 2008.

Inspection team
The inspection was conducted by an inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was announced. We gave the service notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 31 March 2023 and ended on 16 June 2023. We visited the location's office on 31 March 2023.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is

information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

What we did before inspection
We reviewed information we had received about the service since the last inspection. This included feedback from people who told us they had used the service and people who told us they had worked for the provider. We used all this information to plan our inspection.

During the inspection
During our site visit we spoke to the registered manager and office administrator. We reviewed a broad range of documents on site and remotely including 6 care plans, quality assurance reports and recruitment and training records. We spoke to a local commissioner of care services for Kent, 5 people who use the service and 5 staff members.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- People were not always kept safe from the risk of abuse. We spoke to a staff member who told us they had repeatedly reported concerns verbally to management that a person was not taking their medicine and their health was declining. The member of staff told us, "I don't know if the manager has done anything about it." The person's presentation continued to decline. We asked the registered manager and the provider about the concerns, neither were aware of any such issues.
- Staff were not confident to identify and report safeguarding concerns to external authorities. Staff told us they had not considered escalating their safeguarding concerns beyond the management team and registered manager if they did not respond.
- There were not consistently effective processes and systems in place to safeguard people from the risk of abuse. The registered manager relied on verbal notification from staff as care records were not reviewed regularly by the management. The registered manager and provider agreed there were not established and effective systems in place to ensure risks raised with them were recorded and responded to in a timely manner.
- The registered manager did not always work in partnership with the local authority or Care Quality Commission where safeguarding concerns had been identified. The registered manager had not notified the Commission of a safeguarding incident. Statutory notifications are required to be submitted where there are allegations of abuse, serious injury to a person, death of a service user or police involvement in an incident. The registered manager told us they had not considered it appropriate for referral, however accepted this had been an oversight. They reviewed the criteria for referrals on the day of the inspection.

The provider had failed to safeguard people from abuse and improper treatment. This was a breach of regulation 13 Safeguarding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People felt safe and cared for by staff. People told us they trusted the staff and felt safe with them. A person told us, "I am honestly really happy with them."

Staffing and recruitment

- We could not be assured the provider had sufficient numbers of trained staff to support people. A person told us, "They (the staff) couldn't give me my time (for the visit) as everyone wants that time and they didn't have enough carers." Staff told us they did not always know when or if they would be working but the management, "Put more and more calls on you all the time" and often at short notice. Another member of staff told us, they are expected to do multi handed calls on their own if there are not enough staff. Another member of staff told us, they responded to the time demands being placed upon them by "Cutting

corners…We don't have time to watch them eat." The registered manager told us, such incidents should not have occurred as staff are told not to enter people's homes prior to the arrival of their colleague.

We reviewed records that showed attendance at calls was actively monitored by the registered manager and the majority of visits were attended by staff within an acceptable time-frame. Late attendance was marked due to last minute requests for care. The registered manager told us they tried to work within people's time preferences.

● We could not be assured staff had received appropriate training to support people. Staff had not completed their annual training. People told us they had confidence in the staff and were well cared for. However, staff told us all the training was online and some felt it did not provide them with the opportunity to apply the learning in practice. Two staff members told us 2 days shadowing colleagues was not sufficient to know the job and to provide safe support to people. A staff member told us, "They (the management) expect new staff to work at the same standard as someone who has been doing it (care) for years." Another staff member told us, "We are not short of numbers (of staff) just quality." They explained new staff would often be paired together and they would not be familiar with the person. Experienced staff were also relied on to train and support new staff, but no additional time was allowed for this when attending to the people. The registered manager told us staff were given additional shadowing opportunities if needed. They also confirmed staff training had been moved to online training in response to the pandemic, but they were now returning to more practical based learning completed in house, in person. They told us they had been unable to successfully appoint to the role of a field care supervisor responsible for overseeing the quality of care provided to people.

● The provider had undertaken appropriate checks prior to the appointment of staff. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management and learning lessons when things go wrong
● Comprehensive assessments of each person's physical and mental health were not conducted before accepting the care package. A member of staff told us, "Sometimes clients don't have a care plan in the purple folder (at their home)," so staff did not know how they were meant to be supporting the person. We also found people with identified learning disabilities did not have this documented within their care plans or considered, such as how this may affect their understanding of information and how they may communicate. A staff member told us, "If we get a new client, we aren't told what to do or what's wrong with them" and staff were not given additional time to review the person's care plan prior to the visit or during it.
● Staff did not monitor risks effectively. Staff did not monitor people's fluid and food intake where required. For example, a person with diabetes was required to have their foods and fluid consumption monitored. Records showed the food was left with the person but not if it was consumed. Records from a person's care notes showed they had not had bowel movements for 4 days. The care plan did not state why staff were required to monitor the persons bowel movements and/or what actions were required to be taken in response to concerns. The registered manager was unable to confirm if this presented a risk to person or was a failure in staff recording practices.
● People were at risk of potential harm as risks were not fully assessed, reviewed or mitigated. We found entries in care plans were confusing and contradictory. For example, one person who used a wheeled walker and walking stick was recorded to not use mobility aides and be at low risk of falls despite reportedly experiencing falls and dizziness.
● Lessons were not learned from incidents placing people at risk of further harm. We were not assured the provider had established and effective systems in place to record, investigate and learn from incidents when

things went wrong. The registered manager told us they spoke with staff at the time of concerns being raised but did not retain records to identify themes or learning and or share them at meetings with staff to embed best practice.
● People were signposted to the provider's complaints policy where concerns had been raised during reviews of their care.

The provider had failed to ensure risks to people were safely managed. This was a breach of regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● General environmental risks and fire hazards had been assessed for staff.
● Staff did assess and consider risks associated with some people's sensory needs and agreed with them how best to support them. Care plans we reviewed mentioned people's disabilities such as hearing or visual impairments and how this influenced how care may be provided.

Preventing and controlling infection
● We were assured staff were effectively and safely minimising the risk of infection. A staff member told us they had seen and challenged a colleague who failed to provide personal care safely.
● Staff used personal protective equipment (PPE) effectively and safely. The registered manager told us staff could collect protective equipment supplies from the office and each care plan stipulated how they should be disposed of.

Using medicines safely
● People were supported by staff who followed systems and processes to prescribe, administer, record and store medicines safely. Staff told us they had completed training in medicines management. We found medicines records had been completed appropriately.
● People received support from staff to make their own decisions about medicines wherever possible.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We were assured the service was consistently working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- Governance processes were ineffective and failed to hold staff to account and ensure the provision of good quality care and support. Daily notes completed by staff showed risks were not effectively identified, monitored, escalated and responded to. For example, records did not include actions taken by staff to reduce/manage the risks of people not taking their medication, failing to have bowel movements for days or confirming people's food and/or fluid consumption.
- The provider failed to invest in staff by providing them with quality training to meet the needs of all individuals using the service. Staff were required to undertake training in their own time. This was completed online (with the exception of the 2 day shadowing on induction) without any practical elements or discussion with others. Staff told us their practical assessments were pre-populated and they were not spot checked during visits to ensure standards of care were maintained. The registered manager and provider confirmed regular checks had not been conducted on staff. The had recently appointed a field care supervisor role who would be fulfilling these responsibilities.
- The registered manager/provider did not operate effective systems to ensure staff were always up to date with training. For example, we found staff were overdue training. One staff member had not completed 17 of their 22 training modules. They completed them 5 months later and during this period had continued to provide care to people. People we spoke to did not raise concerns relating to the standards and safety of care provided to them.
- Staff told us they were not able to deliver good quality support consistently. A staff member told us, they often run over on time with new clients as they try to, "Figure out how they (the person) likes things done." Staff told us the management placed unrealistic demands on staff, "They (the management) are taking on clients even if they don't have enough staff…we are not paid for the additional support (they provide to people), but the times (allocated to visits) are unrealistic." The registered manager and provider told us assessments were in place for all new people. They confirmed retention of staff had been a challenge, but staff were always asked if they wanted to work additional hours, this was not assumed. The registered manager and provider told us they would speak with all staff individually to understand their experiences of the service and how they may improve them.
- The registered manager had not completed some safeguarding notifications as required.

The provider had failed to ensure effective systems and processes were established and operating effectively to assess, monitor and improve the service. This was a breach of regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● All staff were required to complete the Care Standards Certificate to pass their probation and be appointed as substantive staff. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

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

● Not all staff felt respected, supported and valued by senior staff. Staff reported differential treatment amongst them with one telling us, it is "Not what you know, but who you know." Another staff member told us, "A lot needs to be improved, they shouldn't make staff work, you should not have to do training in your own time and longer shadowing (for new staff) is needed." Staff told us retention of carers was poor. A staff member told us, "There is a revolving door in the office with changing staff, people don't need this."

● The registered manager did not set a culture that valued reflection, learning and improvement or was receptive to challenge and welcomed fresh perspectives. Meetings were not held with staff to share experiences, information or learning. A staff member told us, "I don't go in the office to do anything" and communication is poor with some staff.

● The provider/ registered manager and senior staff were not alert to the culture within the service. Some staff told us they felt unable to raise concerns with managers without fear of what might happen as a result. Two staff members told us, if they complained they were, "Put on the naughty step" and their hours were reduced having a financial impact on them. Whilst others reported positively on the registered manager acting addressing concerns. A staff member said, "They (the registered manager) were supportive and told me it would be dealt with, it was." The staff member no longer works for the service.

●People reported receiving person-centred care. A person told us, they had a "very special carer, it is nice to have the same person all the time, she is very, very respectful, has a lovely manner. I am very happy with my care."

● The management team were responsive to some of their staff's individual needs. For example, one staff member told us the registered manager had supported them when they had reported concerns relating colleagues conduct towards them. They also told us the provider had been understanding and supportive with their mortgage application.

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

● Some staff lacked confidence in the registered manager discharging their legal responsibilities. Staff told us they had reported concerns to management, these had not been recorded as a complaint. Staff told us, the management team had asked them to apologise to a person on their behalf but they did not provide information to them on actions taken to address the complaint or provide assurance to the person that there would not be a re occurrence. The registered manager and provider could not recall this incident and confirmed records were not recorded of all interactions. They accepted this as a learning point.

Continuous learning and improving care

● The registered manager failed to identify and share learning with staff from complaints and incidents. For example, we found people had raised concerns to staff during reviews of their care. No response had been recorded to the concerns. Staff told us they occasionally received feedback on the quality of their care notes, but no learning was formally shared by the management team with staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff were not effectively engaged with by the management team to help improve the care provided. Staff

told us they had received a feedback questionnaire and had asked for team meeting to be reinstated, they had not. A staff member told us, "There is no communication. We don't get told anything." A staff member told us they had not been offered the opportunity by the registered manager to speak with the Care Quality Commission as part of the inspection process and provide feedback on their experience of working for the service. The registered manager acknowledged they did not frequently or formally engage with staff, but staff had access to information to contact the regulator in their employee handbook and promoted in posters encouraging people to share their experiences.

● The provider sought feedback from people. Care reviews had been held with people and their feedback had been positive about the staff and service. A person told us, "I appreciate everything they (the staff) do. I have a laugh with them (the staff) and have no problems."

Working in partnership with others

● Staff worked in partnership with some healthcare professionals. We found shared care agreements were in place with the district nursing team to monitor skin viability for people and people had chiropody appointments arranged.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to people were safely managed.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to safeguard people from abuse and improper treatment.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure effective systems and processes were established and operating effectively to assess, monitor and improve the service.