Ganymede Care Limited

The Chiswick Nursing Centre

Inspection report

Ravenscourt Gardens, London, W6 0AE
Tel: 020 8222 7800
Website: www.chiswicknursingcentre.co.uk

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good

Overall summary

We carried out an unannounced comprehensive inspection of this service in October 2014. After that inspection we received concerns in relation to night time staffing levels, moving and assisting people who used the service and access to primary healthcare. As a result we undertook a focused inspection to look into these concerns. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Chiswick Nursing Centre on our website at www.cqc.org.uk

The Chiswick Nursing Centre is a 146 bedded care home with nursing and provides accommodation, care and support for older people and younger adults, people who are living with dementia, people with mental health needs, people with physical disabilities and people with learning disabilities.

A registered manager was in place. 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.

We found that core staffing levels were maintained and there was always a nurse on duty on each floor. Occasional gaps within the rota were mainly due to care staff phoning in at short notice to say they could not cover the shift for which they were booked. We saw that the provider tried to find cover in this situation, but was not always successful. However, when this happened the size of the service enabled the nurse in charge to redeploy staff between floors to meet people's needs. The provider was recruiting to fill vacancies.

On one floor of the building we observed some practice which put staff convenience before the preferences of the people who used the service, as some people were assisted to get up earlier than they wanted to. This was brought to the attention of the registered manager who said they would ensure this arrangement did not persist.

Summary of findings

With regard to moving and assisting people with mobility needs, we saw that staff were trained in the correct techniques and their practice was monitored by in-house physiotherapists and a visiting occupational therapist. Appropriate equipment was available on each floor.

People who used the service were able to access their GP and other healthcare practitioners when they had a need to do so.

We did not revise the rating given at our comprehensive inspection in October 2014. Any identified shortfalls reflected only a small part of the care provided by The Chiswick Nursing Centre so it did not impact on our overall judgement.

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?

Good

The service was safe. We found that the core staffing was maintained, but there were occasional gaps in cover when staff members gave short notice that they could not cover a shift for which they were booked. In these circumstances it was sometimes difficult to find a replacement.

Staff were trained in correct moving and assisting techniques and equipment was available to help people with limited mobility transfer from place to place. In-house physiotherapists gave advice and monitored staff's work in this area and there was external scrutiny of practice from an occupational therapist to help ensure people's safety.

The rating for safe remains the same as the rating given during our comprehensive inspection.

Is the service effective?

Good

The service was effective. We found that people had good access to GP and other primary healthcare services.

The rating for safe remains the same as the rating given during our comprehensive inspection.

The Chiswick Nursing Centre

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of The Chiswick Nursing Centre on 17 March 2015. This inspection was carried out to follow up concerns which had been raised with the Care Quality Commission. During this focused inspection we inspected the service against two of the five questions we ask about services: Is the service safe? Is the service effective? In particular we looked at staffing levels, moving and assisting practice and access to GP and other primary healthcare services.

An inspector and an inspection manager carried out this inspection. As concerns had been raised about staff cover during the night we arrived at 5.00am when the night staff were on duty.

We spoke with six people who used the service, one relative, four nurses, six healthcare assistants, a member of admin staff and the registered manager. We observed the night staff at work and we looked at five care files, plus relevant management records, including the staff rota and the staff training records.

Good

Is the service safe?

Our findings

Two people had contacted us to allege that there were insufficient staff available to carry out care, especially at night. When we arrived at 5.00am we found that all but one shift was covered that night. In addition there were at least three additional staff present to provide one-to-one care for those people who had been assessed to need this level of support. A relative who was present overnight said that they had not been aware of anyone who was not getting the attention they required.

We looked at the staff rota from the beginning of 2015 and saw that whilst most shifts had been filled the occasional shift was uncovered. Nurses were on duty on each floor on every shift examined. Most recently gaps in care staff were the result of a small outbreak of diarrhoea and vomiting on one floor which affected staff members, as well as up to seven people who used the service at any one time. Undoubtedly the remaining staff members were very busy during that period, but the service was of sufficient size to allow the nurse in charge to redeploy staff within a shift to respond to a need elsewhere in the building. There was also an on-call system to support staff on shift if a problem arose. We saw this system worked well as senior staff were instantly alerted to our early morning arrival.

There was a relatively high usage of agency staff to fill gaps, however, records showed that the same agency staff tended to be used to ensure continuity for people who used the service. Recruitment to permanent posts was on-going and induction training was offered as part of a rolling programme to minimise delays. At the time of the inspection there were the equivalent of 2.4 full-time vacancies for care staff. As far as we could ascertain from interviews with staff and examination of the records, the main reason gaps on the rota were sometimes unfilled was late notification of absence by the care staff member who was booked for the shift. This made it hard for both the provider and the agency to find cover at short notice.

We did, however, find a problem on the third floor. Night staff said they were under instruction to get six people up before the arrival of day staff at 8.00am and to carry out personal care for all, even those who were sleeping, from 5.00am onwards. Staff were in the process of getting three people up when we arrived. We asked if this was people's choice and staff told us it was not. This practice was for reasons of efficiency rather than due to staff shortages, but it was an approach which did not put people who used the service first.

When we discussed this with the registered manager he said there was no general instruction in place about getting a certain number of people up before the arrival of the day shift. He also stated that he did not expect people who were sleeping to be woken for personal care unless there were specific tissue viability issues. As we found a more person-centred approach on the other floors this confirmed what he told us. The registered manager said he would address the problem on the third floor.

On other floors we found that the people who used the service who were up early wanted to be up early. One person told us, "I have got up at five o'clock [in the morning] all my life." Another person was sleeping in a chair in a lounge. Their care plan clearly showed that this person preferred to sleep overnight in the lounge and asked staff to provide a blanket and dim the lights; they had followed these instructions. A third person who was up early said they had asked staff to sit them in a chair as they were having difficulty breathing and felt better when sitting.

CQC was also contacted about staff members allegedly taking short cuts when moving and assisting people with restricted mobility, rather than using approved techniques. We found there were arrangements in place to reduce the risk of this happening.

We looked at the service's induction programme for new staff and saw that the topic of manual handling was the only item on the agenda for the third day of induction training. Participants also had to complete a work book on the topic; we saw nine recently completed work books which demonstrated that the topic had been understood. The training was carried out by one of the in-house physiotherapists. The service had also arranged for sessional input from an occupational therapist to provide extra scrutiny and advice in complex cases. Both the physiotherapist and the occupational therapist were qualified manual handling trainers.

Existing staff received manual handling refreshers in-house, the service was moving from providing care staff with an annual day of training on this topic to providing a six monthly half day of training. We looked at the staff training records and saw that the few who were slightly overdue

Good

Is the service safe?

their refresher training were either booked on to the next course or were away from the service on maternity leave or had other long term absence. Email evidence was provided to confirm this.

We spoke with the physiotherapist who told us that they and their two colleagues were constantly available to give advice and when "walking the floors" of the service they would "pull staff up" if they saw them using an incorrect procedure. They were unaware of any instances of staff failing to use hoists in order to save time.

Moving and assisting equipment was available on each floor and easily accessible. It was inappropriate for us to observe it in use for personal care for reasons of privacy and dignity, but we heard staff reassuring one man through a bedroom door as they used a hoist. We saw that risk assessments for moving and assisting were in place for people who required them, but risk management plans could be further developed to provide better guidance for staff. For example, when hoists were required, the risk management plan did not record the size of the sling to be used in three of the plans we looked at.

Staff members who were not involved in providing personal care were trained in manual handling of loads. The catering manager was trained to deliver this.

Good

Is the service effective?

Our findings

People had contacted the Care Quality Commission (CQC) because they were concerned about the public campaign being conducted by a local GP practice which was assigned to the nursing home in 2014. The GP practice, as evidenced by its website, had pointed out to the Department of Health and clinical commissioners that providing care and treatment to people staying at the nursing home represented a massive increase to its workload. People who contacted CQC were worried that this campaign would impact on people who used the service, but we found they still received good access to healthcare.

Four members of nursing staff (two day staff and two night staff) told us they had no difficulty getting primary healthcare support when needed. We heard nurses on the phone liaising with the GP practice about home visits and we saw written evidence of input from GPs and other healthcare professionals who attended the home by appointment.

We also saw a recent email in which the local clinical commissioning group (CCG) had just confirmed that it would fund two sessions each week from a geriatrician to assist with the provision of healthcare to the home. A start date was not confirmed at the time of inspection.