Bupa Care Homes (CFHCare) Limited

Gallions View Nursing Home

Inspection report

20 Pier Way
Thamesmead
London
SE28 0FH

Tel: 02083161079

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07 March 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced focused inspection on 7 March 2016. At the last comprehensive inspection of this service on 25 and 26 November 2015 breaches in legal requirements in relation to safe care and treatment and monitoring the quality and safety of the service were identified.. We took enforcement action and imposed a condition on the provider's registration so that we could monitor the action being taken by the provider to address the concern we found. We required the provider to submit information to us on a monthly basis and this came in to effect on February 2016. The service was due to be inspected within six months. However, within this six month timescale we received concerns about the service and we carried out a focused inspection on 7 March 2016.

Gallion's View Nursing Home provides personal care and nursing care to older people and those living with dementia. The service can accommodate up to 120 people in four separate buildings with 30 single rooms in each. Each unit has a dining room and sitting areas. At the time of this inspection 101 people were using the service

The service had a registered manager who has been in post since 2011. 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 this inspection we found continued breaches of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

Risks to people had not always been identified or properly assessed, and action had not always been taken to manage risks safely. CQC is considering the appropriate regulatory response to resolve the problems we found and will report on any action taken when it is completed.

Systems the provider had in place to audit and check the service were not effective. These checks covered aspects of the service including; equipment, the accuracy of people's records and staff training. CQC is considering the appropriate regulatory response to resolve the problems we found and will report on any action taken when it is completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

We looked at some aspects of the service under this key question.

Following incidents that occurred, risk assessments were not carried out. People's experience of pain was not assessed.

Following incidents care plans were not updated to provide guidance for staff on how to manage people's risks.

Appropriate equipment was not used to ensure people's health and safety.

Is the service well-led?

Requires Improvement

We looked at some aspects of the service under this key question.

Systems the provider had in place to audit and check the service were not effective

There was a failure to maintain an accurate, complete and contemporaneous record in respect of service users, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Gallions View Nursing Home

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.

This unannounced focused inspection took place on 7 March 2016 and was undertaken by two adult social care inspectors. This focused inspection was to follow up on concerns received. We therefore only inspected the service against two of the five questions we ask about services: Is the service safe? and Is the service well-led? We looked at the aspects of these key questions related to the concerns we had.

We did not speak to people who used the service as part of this focused inspection. However we spoke to the clinical lead, the clinical manager, the administrator and one member of staff. We looked at records which included eight people's care records and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

We did not review all aspects of this key question as we focussed on the safety of people in relation to two specific serious incidents.

We reviewed the care files for people using the service. Risk assessments were not always undertaken and care plans had not updated to reflect changes. For example we found a risk assessment had not been carried out for one person with regards to their safety when consuming hot drinks and the person's care plan had not been updated to reflect a change in their needs. This meant there was no information or guidance for staff working within the service to make them aware of the potential risks and to ensure people were sufficiently protected from this.

Pain assessments were not always in place for people who may experience pain. For example, we identified that two people who were receiving pain medicine, or had reported pain following an incident, did not have their pain assessed and recorded by staff in order to mitigate the risk of ineffective pain control. Where a person had sustained injury, a body map record was not completed to ensure injuries were monitored for any deterioration. Care and treatment was not delivered in a safe way

When we brought the issues we identified to the registered manager's attention, action was taken immediately to put the necessary risk assessments in place and up date the relevant care plans.

We also found that on one occasion important information from a person's pre-admission assessment had not been recorded in their care plan so that staff had access to information in order to provide safe care and treatment.

Some staff were not aware of basic first aid that should be administered following a medical emergency. The registered manager told us that the provider wanted all staff to undertake first aid training. However, when we looked at first aid training records we found that 10 staff members out of 41 had not undertaken basic first aid training. Records also showed that medical attention had not been sought promptly for two people involved in incidents.

The above issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Requires Improvement

Is the service well-led?

Our findings

We focussed on aspects of this key question at the current inspection related to the incidents of unsafe care and treatment. We have not revised the rating for this key question as we have not considered all aspects of the service at our focussed inspection

At our previous inspection on 25 and 26 November 2015, we found audit systems used to monitor the quality of the service was not always effective. Following this inspection CQC took action requiring the provider to submit information about in respect of risk assessments and records of care delivery for all people who used the service.

At our focussed inspection of 07 March we found a breach of regulation in regard to safe care and treatment. We found the provider's systems and processes to monitor quality and safety had failed to identify and address all these issues. Although the registered manager was monitoring the quality of care planning and risk management, the checks had failed to identify the risks we have reported on here. The service had not yet made the required improvements to their quality monitoring systems in order to mitigate risks to people and improve quality of care.,

We also found that systems did not identify the failure to maintain an accurate, complete and up to date record in respect of people who used the service. This included a record of the care and treatment provided and of decisions taken in relation to the care and treatment provided. The service used written handover sheets to inform staff of changes in needs from one shift to another which were in tick box form. There were no details recorded on the handover sheets about specific issues relating to individual people using the service that staff taking over needed to be aware of. The provider had not taken steps to mitigate the risks associated with unsafe care because clear information was not provided on people's current needs.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Following the issues identified the registered manager told us that all care plans and risk assessments were under review. The provider had begun booking staff for refresher training in manual handling. The provider had produced new handover sheets to guide staff to record all relevant information about a person's condition. However, at the time of our inspection we were unable to fully assess the effectiveness of these measures, and we will check on this at our next inspection.