GCH (West Drayton) Ltd

Drayton Village Care Centre

Inspection report

1 Spring Promenade
West Drayton
Middlesex
UB7 9GL

Tel: 01895430955
Website: www.goldcarehomes.com

Date of inspection visit:
27 April 2017

Date of publication:
05 May 2017

Ratings

Overall rating for this service	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

Drayton Village Care Centre is a nursing home and is part of Gold Care Homes. It provides accommodation for up to 59 older people in single rooms. The home is situated within a residential area of the London Borough of Hillingdon. At the time of our visit there were 46 people using the service.

The manager of the service was in the process of registering with the Care Quality Commission. A registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider.

We had previously inspected the location on the 6th, 7th, 8th and 13th December 2016 were we found records relating to care and people did not provide accurate information. In addition the audits carried out in relation to care records did not identify when information had not been recorded accurately. When a recording issue was noted, the audits completed in relation to the Medicine Record Administration (MAR) charts did not identify the actions taken to reduce the risk of the error occurring again.

Following the inspection we imposed a Warning Notice which required the provider to make improvements by 20th April 2017. The provider sent us an action plan which indicated that they would make improvements by this date.

We undertook an unannounced inspection of Drayton Village Care Centre on 27th April 2017 and we found improvements had been made.

We found improvements had been made in relation to the consistency of information recorded in the care plan folders and the manager reviews of all the information for each person were underway.

Global patient charts had been completed regularly and the manager was in the process of reviewing the frequency of a range of information should be recorded by care workers. The prescribed cream application records showed creams were applied as prescribed.

Weekly audits of MAR charts were carried out which identified when recording errors occurred and what action was taken.

Following the inspection on the 27th April 2017, and as a result of the improvements which we saw evidence of, the Warning Notice is no longer in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Good

We saw improvements had been made to ensure the service was Well-Led.

Improvements had been made to the consistency of the information recorded in care plan folders.

Global patient charts and prescribed creams administration forms were now being completed accurately.

Regular audits in relation to the administration of medicines were completed.

Drayton Village Care Centre

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 inspection took place on the 27th April 2017 and one inspector undertook the inspection.

Before the inspection we reviewed the records from the previous inspection carried out on the 6th, 7th, 8th and 13th December 2016.

During the inspection we reviewed the care plans for nine people and the global patient charts for eight people, as well as various audits that were completed. We also spoke with the manager, deputy manager, area manager and provider.

Good

Is the service well-led?

Our findings

During the previous inspection on the 6th, 7th, 8th and 13th December 2016 we found records relating to care and people did not provide accurate information. In addition the audits carried out in relation to care records did not identify when information had not been recorded accurately. When a recording issue was noted, the audits completed in relation to the Medicine Record Administration (MAR) charts did not identify the actions taken to reduce the risk of the error occurring again.

Following the inspection we imposed a Warning Notice which required the provider to make improvements by 20th April 2017.

At the inspection at the 27th April 2017 we saw that improvements had been made. We reviewed the care plans for nine people and the global patient charts for eight people.

We saw the majority of the information recorded on the various forms within a person's care plan folder was accurate. Some of the folders had two different types of summary sheet providing an overview of the person's health and care needs. The information on these sheets was not always accurate as these had not been updated regularly. This was discussed with the manager who confirmed they were in the process of reviewing all the information in each person's care plan folder to ensure there was consistency.

During the previous inspection we met a person who lived with seizures and there was no recording system in place to record when their seizures occurred. At this inspection, we saw a record sheet was now being used to note when a seizure occurred and its length. A detailed care plan was also in place which was reviewed monthly.

We saw seven global patient charts had been completed to identify the care provided that day. The charts showed that people were repositioned in bed in line with the identified frequency which was shown on the form. The care workers recorded which side the person was lying on and the time they were repositioned. The records indicated when the person received support with personal care and with toileting, as well as their food and fluid intake. One global chart we reviewed had not been completed for four hours. This was discussed with the manager who confirmed they would ensure this record was updated.

The forms used by care workers to record when prescribed creams were completed clearly and showed that creams were applied as prescribed. The forms included the frequency for application and a body map which indicated where the creams should be applied.

The air mattress check forms indicated that care workers were required to record if the air mattress was on the correct setting and was working correctly every time a person was repositioned or when they went to bed. We saw the frequency the record forms were completed had improved and the manager explained they were in the process of reviewing how often these forms should be completed.

The global patient charts were now stored in larger folders in each person's room which clearly indicated

which forms needed to be completed daily. The forms in this folder were checked every day to ensure they had been completed.

A weekly audit was completed to review the Medicine Administration Record (MAR) charts and the record sheets for the administration of prescribed creams to ensure they were completed accurately. The audits identified if the record charts had not been completed correctly and which member of staff was involved. The manager confirmed the information from the weekly audits was reviewed as part of a wider assessment system which identified any actions required. They also confirmed that a new system to carry out a monthly trend analysis for any medicine administration recording errors was being developed.