GCH (Acton) Limited

Acton Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced inspection of Acton Care Centre on 23, 24, 25 and 27 January 2017.

Acton Care Centre is a purpose built home that can accommodate 125 people. There are two units for people living with the experience of dementia and three units for people with nursing care needs. The home can provide high dependency care for people with complex nursing needs.

The home is situated within a residential area of the London Borough of Ealing. At the time of our visit there were 105 people using the service.

At the time of the inspection there was a registered manager 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.

The provider was registered with the Care Quality Commission for this location on 17 October 2017. This is the first rating inspection since the change in provider.

Chemicals used for cleaning were not stored securely and there was a risk of cross contamination as equipment and continence supplies were stored in people's bathrooms.

Risk assessments did not provide up to date information in relation to individual risks when receiving care. An action plan had been developed to identify how these issues would be resolved.

The provider had appropriate processes and training in place for the safe administration of medicines.

The provider had a policy in relation to the Mental Capacity Act 2005 but was not always working within the principles of the Act.

Activities were organised at the home but some of these were not always meaningful for people and when the activities coordinator was busy there were limited activities organised by other staff. The provider had identified staff across the service required training in providing appropriate activities and this was being planned. We have made a recommendation in relation to providing activities.

Records relating to care and people using the service were not completed accurately to provide a current picture of the person's needs and support provided. The provider had developed an action plan identifying issues arising from the transition from the previous provider's systems to those of the new provider. A copy of the action plan was provided during the inspection.

The provider had a range of audits in place but some of these had not provided appropriate levels of

information to identify aspects of the service requiring improvement and action had not always been taken to address issues. These issues had been identified by the provider and included in the action plan they had developed. A copy of the action plan was provided during the inspection.

The provider had processes in place for the recording and investigation of incidents and accidents.

Staff had not completed all the training identified as mandatory by the new provider. A training programme was in place to meet identified training needs.

There was a good working relationship with healthcare professionals who provided support for people using the service.

The care plans and records of daily care were task focused. The provider planned to implement a new care plan template which was more focused on people's preferences on how their care was provided.

The care plans identified the cultural and religious needs of people using the service. The provider had a complaints process in place and people knew what to do if they wished to raise any concerns.

The provider had processes in place for the recording and investigation of incidents and accidents. Each person using the service had an evacuation plan in place in case of an emergency.

The provider had an effective recruitment process in place. There was a policy and procedure in place for the administration of medicines and these were administered in a safe way.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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

Some aspects of the service were not safe.

Chemicals used for cleaning were not stored securely and there was a risk of cross contamination as equipment and continence supplies were stored in people's bathrooms.

Risk assessments did not provide up to date information in relation to individual risks when receiving care. The provider had developed an action plan identifying these issues and how they would be resolved.

The provider had appropriate processes and training in place for the safe administration of medicines.

The provider had processes in place for the recording and investigation of incidents and accidents.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider had a policy in relation to the Mental Capacity Act 2005 but was not always working within the principles of the Act.

Staff had not completed all the training identified as mandatory by the new provider. A training programme was in place to meet identified training needs.

There was a good working relationship with healthcare professionals.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

In general people were cared for by caring and kind staff but there were times when care workers and nurses did not meet people's needs.

Care workers and nurses demonstrated a good understanding of

the importance of supporting people to maintain their independence.

Care workers and nurses explained how they helped people maintain their privacy and dignity when they provided care.

Care plans identified the person's cultural and religious needs.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Activities were organised at the home but some of these were not always meaningful for people and when the activities coordinator was busy there were limited activities organised by staff on units. The provider had identified staff across the service required training in providing appropriate activities and this was being planned.

The care plans and records of daily care were task focused. The provider planned to implement a new care plan template which was more focused on people's preferences in relation to how their care was provided.

People knew how to make a complaint and there was a complaints policy and procedures in place.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Records relating to care of the people using the service were not completed accurately to provide a current picture of the person's needs and support provided. The provider had developed an action plan identifying issues arising from the transition from the previous provider's systems to those of the new provider and how these would be resolved.

The provider had a range of audits in place but some of these had not provided appropriate levels of information to identify aspects of the service requiring improvement and action had not always been taken to address issues. The action plan identified how these issues would be resolved.

People using the service and care workers felt the service was well-led and effective. Care workers felt supported by their managers.

Acton 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 23, 24, 25 and 27 January 2017. The first day of the inspection was unannounced with the following days being announced. One inspector visited the home over for four days of the inspection. A pharmacist inspector, a specialist advisor, a second inspector and an expert by experience each visited the home during the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience at this inspection had personal experience of caring for people who had dementia.

Before the inspection we reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

During the inspection we spoke with 24 people using the service, six relatives/visitors and ten staff including nurses, care workers, activities coordinator, administration manager and support staff. We also spoke with the registered manager, area manager and the provider, and a visiting healthcare professional. We used the Short Observational Framework for Inspection (SOFI) in various units during the inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed interaction between people using the service and staff on all units.

We reviewed the care plans and records of daily care for 14 people using the service, medicine administration records for 59 people, the employment folders for two care workers, the training and supervision spread sheet for 93 staff as well as records relating to the management of the service and a selection of other records including safeguarding records, incident records, audit and monitoring reports and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People were not protected from the risks of infection due to poor practices. During the inspection we saw care workers had placed soiled continence products in plastic bags. Some of the plastic bags contained soiled products following personal care for more than one person. These open bags were attached to the trolleys which contained clean continence equipment and bed linens. These trolleys were left in the corridor unattended which meant other people in the unit could access soiled items. We raised this with the registered manager who informed us that care workers had been told to stop this practice some weeks previously including not attaching the bags to the trolley and dispose of soiled products once they had supported each person with their personal care. They confirmed they would speak to care workers that day. The following day we saw plastic bags which had been tied up and contained soiled products were still being attached to the trolley used.

We also saw people's wheelchairs and other equipment including walking frames were stored in their bathrooms. This equipment was used regularly by care workers. People's supplies of continence products were kept in open packets and boxes next to the toilet in the bathrooms. Care workers also kept unpackaged continence products on the trolleys used when personal care was being provided. This meant there was an increased risk of cross infection.

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

The risks to people's safety and wellbeing had been assessed, but these assessments were not always completed correctly or regularly and therefore information did not accurately reflect people's needs.

The risk assessments included a score calculated to reflect people's individual needs. The falls risk assessments for different people had not been calculated correctly which meant some people's risk level for falls was actually higher than recorded. Therefore the staff may not have been aware of the severity and likelihood of risk of falling for these people.

The skin assessment form for one person indicated the level of risk had reduced over the same period of time as they were being treated for a pressure ulcer. We looked at the records for the pressure ulcer and this had healed but the risk assessment and care plan had not been updated. The nurse confirmed the records had not been amended. Therefore staff did not have the information they needed to appropriately care for this person.

Initial needs assessments and care plans identified specific care or health issues for people but risk assessments related to these issues such as diabetes and epilepsy were not in place.

The continence and nutrition risk assessments for one person had not been reviewed since November 2016. The falls risk assessment for this person also stated the person was at high risk of falls but the result of the risk assessment should have been a medium risk based upon the information in the assessment.

We saw moving and handling risk assessments which identified the person required assistance to move using equipment. The risk assessments did not identify the types of equipment the care workers needed to use to provide appropriate and safe support for the person.

The provider had identified the issues with the risk assessments and this had been included in their action plan. A copy of the action plan was provided to us during the inspection.

We saw a number of people could not access their call bells as they had been placed out of reach. This was raised with the registered manager who confirmed they would remind care workers and nurses to check these were in reach.

During the inspection we observed care workers supporting people to go into the dining room for lunch. We saw one person was asleep in an armchair in the lounge when two care workers woke them up. Immediately the two care workers stood either side of the armchair, placed their forearms under the person's armpits and proceeded to lift the person to an almost full standing position. The person had not woken up fully and still had their knees bent as the care workers were about to remove their arms. This meant the person was not in an appropriate standing position to support their own weight. We asked the care workers to support the person to sit back in the armchair and to wait until they were more awake so they could stand in their own time. We also asked the care workers to provide the appropriate support for the person to enable them to stand unaided using the arms of the chair if able or use suitable equipment to help the person move. Earlier during the inspection we saw the person was able to walk around the unit without support. We informed the registered manager and the regional manager who spoke with the care workers and confirmed they should be aware of appropriate moving and handling techniques. Since the inspection the provider has confirmed that the majority of staff had completed a moving and handling training/refresher course with the remaining staff scheduled to attend in the following months.

We saw appropriate arrangements were in place for obtaining medicines. Staff told us how medicines were obtained and we saw that supplies were available to enable patients to have their medicines when they needed them.

As part of this inspection we looked at the medicine administration records for 59 people on three different units. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded.

Two people on one unit were prescribed warfarin tablets and we saw there was appropriate monitoring of this treatment and records showed the correct dose was being given.

When medicines were prescribed to be given 'only when needed' (PRN), or where they were to be used only under specific circumstances, individual when required protocols (administration guidance to inform staff about when these medicines should and should not be given) were in place. This meant there was information to enable staff to make decisions as to when to give these medicines to ensure people were given their medicines when they needed them and in a manner that was both safe and consistent.
We saw five people on another unit had their medicines administered covertly. This was managed appropriately with signed consents in place and information on how to give the medicines available. Each person had their own named tablet crusher so medicines could be administered safely.
Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use.

We also saw the provider did monthly checks to ensure the administration of medicine was being recorded correctly. Records showed any concerns were highlighted and action taken. This meant the provider had systems in place to monitor the quality of medicines management.

During the inspection we found chemicals were not stored safely around the home and could be easily accessed by people living at the home. The housekeeping staff used open trolleys when they cleaned the bedrooms, bathrooms and communal areas. The housekeeping staff kept their cleaning chemicals and equipment on the top of the trolley and when they were cleaning the smaller rooms and bathrooms they would leave the trolley unsupervised as they were unable to keep the trolley in the room with them. This was discussed with the registered manager and area manager who confirmed they would ensure the cleaning chemicals were secured when the cleaning trolley was left in the corridor. We also saw mops and buckets containing cleaning solution were left unattended in the corridor. This meant that people were at risk of being able to access chemicals that could be dangerous. We identified these issues with the registered manager and regional manager who spoke with the head of housekeeping to ensure the buckets were not left unattended.

People we spoke with said that they felt safe when they received support from care workers and they had no concerns about their safety. We saw the service had effective policies and procedures in place so any concerns regarding the care being provided were responded to appropriately. We looked at five records of safeguarding concerns raised since October 2016 and we saw information relating to the concern, notes of the investigation, copies of any referral documents, any actions taken and the outcome recorded. We also saw a root cause analysis was carried out reviewing the actions taken and outcomes.

We asked people if they felt there were enough staff to provide appropriate care. They told us "I believe they could do with more staff. A few of the agency staff are not sufficiently trained. [For instance] they have put my pad on back to front a couple of times. Nine times out of ten it is language difficulties. I have to point to things, such as a knife or fork or spoon", "The staffing levels up here [should be] three carers, not two. Some of the agency staff are good, others are not. There is a language barrier; they need to understand English" and "There are two [sorts of] staff. There's a big gap between permanent staff and agency staff. They should work together to produce good care. Sunday is the worst day in here." We asked the person what they meant by the comment that care workers and nurses do not "work together". They told us there was "like fighting" between the two groups. Another person told us there used to be five staff on their unit and now there are only ever four or even three as the staff are moved around the home when they are short.

We asked care workers and nurses if they thought there were enough staff to provide appropriate levels of support and we received mixed feedback. They commented "There are enough staff" and "If you have permanent staff they are familiar with the residents, they know what they are saying even if they can't speak. The occasions with staff from outside agencies coming for a shift can be stressful. This is rare but when it does happen this is pressurising."

At the time of the inspection there were 22 people being cared for in Oaks Unit, 25 people being cared for in Park Unit and 12 people being cared for in Westerly Unit. These units provided nursing care and support for people with long term conditions and those receiving palliative care.
There were 21 people being cared for in Garden Unit and 25 people being cared for in Donald Sword Unit. These units provided care for people living with dementia but they may also have other medical conditions requiring support. Many of the people living in Acton Care Centre required a high level of support due to the nature of their care needs. During the inspection we looked at staff rotas for all five units. On four of the units there were five care workers and a nurse on duty during the day and two care workers with a nurse at night. Westerly Unit had one nurse and two care workers on duty during the day and night shifts due to the

lower number of people being cared for in that unit. The regional manager and registered manager explained a recruitment programme was under way with the aim to reduce the reliance on agency staff and provide consistency of care workers and nurses.

We looked at how accidents and incidents were managed in the service. There was a policy in place and a clear process for recording. The registered manager explained a record form was completed when an incident or accident occurred. The record included information about the incident or accident, who was involved and what actions were taken. We noted that two different forms were being used as record forms from the previous provider and the new provider were still in use. The new forms required the registered manager to review whereas the old form did not. The registered manager confirmed the completed forms were reviewed and an investigation carried out if required. During the inspection we looked at 15 incident and accident records completed since December 2016 which contained information on the event and action taken.

We saw Personal Emergency Evacuation Plans (PEEPs) were in place on each unit in case of an emergency which provided care workers with guidance on what action should be taken to support the person appropriately. We saw the plans included information which identified if people could understand what the fire alarm was, any visual, hearing or physical issues to consider when evacuating them from the building and any specific equipment that was required. We saw the plans had been updated within the previous three months.

The service followed suitable recruitment practices. The administration manager explained applicants were asked to provide the contact details of three people that could provide a reference and their employment history. Applicants also completed an English comprehension test as part of the process. A Disclosure and Barring Service (DBS) check to see if the new care worker or nurse had a criminal record was carried out following the interview. We looked at the employment records for two new staff who had been recruited since the new provider took over the service and saw appropriate checks had been carried out during the recruitment process. The service also had a number of agency care workers and nurses working at the home. We asked to review the records for these agency staff and the area manager provided a folder which contained the information sheets for a large number of care workers and nurses. The information sheets included a photograph of the agency staff member, their training, previous experience and date of their DBS check as well as the registration details for nurses. We noted from the information sheets that a number of the care workers had not completed recent training and did not have current DBS check in place. We also saw some of the nurses did not have current registration in place. We asked the area manager and registered manager if these agency staff were being regularly booked for the home. They confirmed they had not worked at the home recently and they would ensure this information was removed leaving the information sheets for agency staff currently being booked.

Requires Improvement

Is the service effective?

Our findings

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 Act 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.

During the inspection we saw a spread sheet which indicated which people had been assessed as having capacity to make decisions regarding their care and where applications for DoLS authorisation had been made for people where it was felt they did not have capacity. The spread sheet indicated that some applications for DoLS authorisation had been made up to 18 months previously. The registered manager confirmed they were in contact with the local authority to monitor the progress of each application. The spread sheet also showed when authorisations needed to be renewed.

Where an application or DoLS had been authorised there was no reference to this in the care plans including the specific care plan related to confusion. Therefore information about the authorisation and any individual conditions was not available for the staff who were caring for people meaning that care may not always be appropriate and lawful.

We saw that some people had not signed the consent paperwork or other documents. The consent records for one person had been signed by their next of kin but the person's care records did not indicate that they lacked capacity to make decisions or if a Lasting Power of Attorney (LPOA) was in place. A Lasting Power of Attorney in health and care matters legally enables a relative to make decisions in the person's best interest as well as sign documents such as the support plan on their family member's behalf. This meant that people were not appropriately supported when decisions about their care were made to take into account their wishes whenever possible.

The Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) completed for one person stated they did not have capacity but there was no record of any discussions with relatives about this decision. The form indicated that two healthcare professionals had completed the form. Other records indicated the person had regular contact with their relatives which meant that the relatives were not involved in the discussion even though they could be contacted.

The summary information sheet for one person stated they lacked capacity but the record also showed they could make basic decisions in relation to their care. Therefore the staff did not have clear and consistent

information about when this person was able to make certain decisions.

The records for people without capacity but for whom an application for DoLS authorisation was not suitable did not identify if any best interest decisions had been discussed. Therefore decisions about their care and treatment were being made in a way which may not always reflect their individual best interests.

During the inspection we saw mental capacity assessments had been carried out during April 2016 stating one person had capacity to make decisions regarding general care, the use of a hoist and administration of medicines. A care plan which had been reviewed in January 2017 stated that the person no longer had capacity to make decisions but there had not been any capacity assessments since April 2016 to explain why this change had been recorded.

This issue was also identified in relation to another person with their only assessment of capacity to make decisions being carried out in July 2016 which stated they had capacity. Care plans reviewed later in the year stated the person did not have capacity but there was no evidence of a capacity assessment having been carried out supporting this.

The above paragraphs demonstrate a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we looked at the training records for 93 staff including care workers, nurses and the support staff at the home. The area manager explained that the provider had introduced the training courses they viewed as mandatory for staff to complete but this list differed from that of the previous provider. The training records we saw indicated that a number of staff were not up to date in relation to moving and handling, fire safety, safeguarding adults and infection control. The registered manager and area manager confirmed an assessment of the levels of training had been carried out and a programme had been developed to meet the current training needs of the staff. This programme had been scheduled over the first six months of 2017. A number of training sessions had already been organised since the provider took over the service but attendance levels at some of these had been low. The area manager explained that the training courses were arranged with an external provider and there had been issues with releasing care workers to attend. The area manager provided us with a copy of the training programme for 2017 which identified that the courses required to meet the training needs had been arranged.

The administration manager explained new care workers and nurses completed an induction programme over a week which included sessions watching training videos on fire safety, moving and handling and infection control as well as practical training sessions. The new care workers also completed the Care Certificate over their probation period. The Care Certificate identifies specific learning outcomes, competencies and standards in relation to care. We were unable to review any Care Certificate workbooks as these were still with the new care workers being completed.

The area manager confirmed all staff would be having regular supervision meetings with their line manager in addition to an annual appraisal to ensure they felt supported following the change in provider and the introduction of new processes and procedures. We saw records which showed regular supervision meetings were held.

We saw there was a good working relationship between the service and health professionals who also supported the individual. The care plans we looked at provided the contact details for the person's General Practitioner (GP). During the inspection we spoke with a visiting healthcare professional who told us "The care and management of palliative patients are very good. Staff identify promptly if someone's condition

changes and they ring. We will give advice and they listen to what I have to say and they take advice. They use their 'savvy'. We have been able to do a clinical meeting with the GP and senior nurse and get a plan done. They understand family distress and they do end of life care very well indeed."

We asked people what they thought of the food provided at the home. Their comments included "The food is lovely. You can pick off the menu. The puddings are very, very good", "Meal times could be a bit more punctual. The food is brilliant" and "The food at lunchtime is very good but not the evening meal when you get soup and something else. There could be more variety." The registered manager explained on the three nursing units' people had their main meal at lunchtime while on the units providing dementia care the main meal was in the evening as they had found this helped people to sleep. At the time of the inspection this was being reviewed.

The catering manager explained they had detailed records which included identifying which people had their relatives help select their meals. They confirmed menus using pictures of the options each day were being developed. There was a dietary requirements folder for each unit providing information on each person including their preferences and any religious or medical dietary requirements. When a person was identified as requiring palliative care a form was completed to identify if the person preferred any specific meals or if their dietary requirements had changed.

Requires Improvement

Is the service caring?

Our findings

We asked people who used the service for their views on the care workers and nurses at the home. We received mixed comments which included "It's a joke. It's not good. Some of them are good, some of them are not so good", "So far [the care has] been very good….. I've been happy with it here", "The staff are wonderful, and the night time ones as well. Sometimes you get it a bit iffy with the temporary staff. The permanent ones are good", "If I said anything bad about the staff here I would be telling a lie. I can make a joke and laugh. I know everybody. For me they are very good….. I couldn't do anything for myself [when I came here] but now I am much better", "The staff are wonderful. It's all done for me. I don't have to ask" and "They are looking after me very well. The new owners are finding their feet",

Other comments included "I like it here. Everyone's lovely and that's the truth; I'm not just saying it", "I have no complaints [about how they are looking after me]", "I couldn't fault the staff. They're very polite. I've never come across anyone rude. They do whatever they can to help you", "I've been here three or four months. I'm very well looked after by very polite and capable staff… They are punctual with medications but sometimes on changeover they can be a bit delayed but they try to come to me soon as they can" and "The staff are very good. Every one of them is very caring…. Sometimes the temporary ones are not "all that."

Relatives and visitors commented "We've noticed that the staff have changed since the new owners took over. You don't recognise anyone anymore. It's not the same. Something is missing", "[Our friend] has been very pleased with the nurse" and "All of the staff are very good but the service is very rushed; they have no time."

In general people were cared for by kind and gentle staff. Throughout the inspection we saw examples of care workers and nurses having an understanding of people's specific needs and they knew how to communicate appropriately with the people they supported.

We saw one nurse administering medicines in a person's room and they spent time chatting first. The content of the conversation indicated the nurse had a good knowledge of the person's current situation and communicated with them in a personalised and sincere manner.

One person explained they were at increased risk of developing pressure sores but care workers regularly repositioned them and they had never developed a pressure ulcer as the staff understood her care needs. They said "I like it here. I've been here a long time….. They look after me very well."

However, there were times during the inspection we saw the care and support in place did not meet the needs of the people using the service. One person commented "I feel so lucky to be here…..95% [of the staff] are lovely…. The staff are very professional, very friendly. There is usually a smile of their face but they are very busy. I try not to buzz too much; I wait until I have two or three tasks. They usually come quickly but sometimes it takes a bit longer and I may turn my buzzer off. If two of them are occupied a third may come and let me know.… I believe they do need more staff… When [first name of carer] is here I'm washed at 7am." This person explained they liked to get up early but that was dependant on a specific care worker

being available whose shift started earlier. This meant they had to wait until later to get up. We asked if the night staff could support them to wash early and they said this support had never been offered.

While we were speaking with another person they asked us to draw their curtains and open the window. There was an empty beaker and drink bottle on the table and the jug of water was out of reach as it was located across the other side of their room. The person could not access any tissues so used their sheet to wipe their nose. The call bell was also out of reach of the person.

Also, due to the layout of some of the bedrooms, the only location care workers could place water jugs and other drinks was at the end of the bed which meant these could not be reached by the person who was in bed. We informed the care workers when this was identified and they ensured people could reach both their call bell and a drink.

While we were speaking with another person who had recently moved to the home and they told us their name was "Y". We noted that the care worker called the person "X" and the name on their bedroom door was "X Y" so we asked why this was. They told us "Somehow they turned it around in the system and I became X Y." There was a "Do Not Enter" sign hanging on the outside of the bedroom door. The person confirmed it had been there since they arrived and they did not know why it was there.

Care workers and nurses we spoke with demonstrated a good understanding of the importance of supporting a person to maintain their independence. They told us "Let them do things for themselves if they can", "Encourage them, so they do for themselves what they can. Supervise but encourage them to do things for themselves and respect their wishes" and "I try to encourage them to do as much as they can for themselves. If you don't use it you lose it."

We also asked care workers and nurses how they supported people to make decisions about their care and day to day life. They told us "People can be upset and call you things, but that is OK and you can go away and come back later. They calm down", "Some people have capacity. Others we have to think for them but also listen to them" and "Everything is done in the best interests of the actual residents."

We asked care workers and nurses how they helped people maintain their privacy and dignity when providing care. They commented "Close the door, windows and curtains. For example I say to people 'Good morning I am here to do your personal care. Would you like to do this with me?' and I knock on doors, be polite. Always speak English but I have spoken my language once with a person who also spoke it", "Make people comfortable and feel at home. This is their home. Ask do you want this, can I do this for you and get their consent. Ask if people want their door closed and always ask as wishes change – ask day by day" and "Address by the person's preferred name, when washing them keep them covered. Respect if the person wants to talk or not. Giving them choices of meals and when to get up and go to bed."

We spoke to one person who told us they were Resident of the Day earlier that week and they commented they enjoyed this as they were given a packet of jam tarts instead of plain biscuits with their mid-morning drink and they had been able to choose whatever they wanted to eat for supper. The Resident of the Day system meant a specific per day was identified, their records were reviewed, their room was deep cleaned and they could choose what they wanted to eat including items not on the menu.

The care plans identified the person's cultural and religious needs. A care worker told us "There is a multicultural mix of staff and all are expected to speak in English. We respect people's religious and cultural beliefs. We celebrate different special days including birthdays with cakes provided. Sometimes families come and sometimes we are the family and make it nice."

Requires Improvement

Is the service responsive?

Our findings

We asked people what they felt about the activities arranged at the home. They told us "[The activity co-ordinator] is a nice lady. She puts herself out. I think it's too much work for her sometimes", "I like Bingo and when the singers come, as ways to pass the time" and "I watch TV, read and write letters, listen to the news. I try to occupy my mind."

During the inspection we saw that activities were organised but some of them were not always meaningful for the people using the service. We saw when a main activity had been arranged in one unit there were not alternative activities organised in the other units. We saw people were in the lounges with the television on, often with subtitles and the sound turned down. Sometimes there was also music left on but care workers and nurses were not interacting with people or giving them a choice of what to watch or listen to. We saw in two different units the care workers or nurses sitting in the lounge either watching television or completing paperwork and not communicating with people seated near them.

An activities coordinator worked at the home and there were schedules displayed on noticeboards in the units. The activities coordinator told us they were very busy and providing activities across the home was too much work for one person. The area manager confirmed they were advertising for an additional activity coordinator.

We spoke with one person who was sitting in a lounge reading a newspaper and they told us "This is no good to me because I can't read it. I could read it if it was bright enough." There was a row of armchairs which prevented the person from sitting nearer the light. A care worker who spent the majority of time in the lounge where the person was seated did not try to resolve the issues and make it easier for the person to read their newspaper. When the care worker approached the person the care worker stayed standing up and the person replied: "You're talking too quietly. When I am down here I can't hear you up there."

We heard music was turned on in one unit following lunch and immediately a couple of people who had been sitting motionless started to move their hands in time seeming to enjoy it. We noted that the care workers did not ask people if they wanted to listen to music or what type they preferred. Later we heard a member of staff announce two first names and say: "You're going to Bingo" and she instructed another member of staff to: "Take them down." The people were not asked if they wanted to go to bingo and other people in the lounge were not given the option to attend.

We observed the bingo session one afternoon which was attended by more than 12 people and supported by a volunteer, the activity coordinator and a care worker who chatted and sang with people around the games creating an upbeat atmosphere. We observed good interactions such as the care worker reassuring someone who had come without their handbag that it was safer upstairs and the person accepted this. There were many people in wheelchairs and this did make the room feel crowded as it was already being used to store other moving and handling equipment. We discussed this with the registered manager as there were other large lounge areas available around the home which would provide people with more room.

Some people we spoke with confirmed they had their own computers and could access the internet. One person told us their relatives had given them a tablet computer and they were learning how to use it. The provider had identified staff across the service required training in providing appropriate activities and this was being planned.

We recommend the provider reviews guidance on providing meaningful activities in care homes.

During the inspection we saw most people's care plans had been reviewed monthly but were not written in a way that identified each person's wishes as to how they wanted their care and support to be provided to guide care workers and nurses when providing support. We saw that each person had a folder containing a range of care plans relating to aspects of their daily care and the person's support needs. The care plans were task focused and did not identify for care workers and nurses how people preferred their care to be provided. The daily records completed by care workers and nurses, which described the care received by each person, were also focused on the daily care tasks and not the experience of the person. This did not provide a complete picture of the person during each day.

We raised this with the area manager who explained when the provider took over the service in October 2016 the issue of the care plans was identified in a review of the service. They told us an action plan had been developed which included implementing the care plan template used in other homes owned by the provider. The area manager showed us the action plan and explained as part of the process care workers and nurses would be completing training on writing person-centred care plans during 2017. The new care plan templates would identify people's preferences for their care in more detail and we were told these would be implemented during the first six months of 2017.

People's needs were assessed prior to them using the service. We saw detailed assessments were carried out before a person moved into the home to identify if the appropriate care and support could be provided. These assessments reviewed their individual support needs including mobility, social and health issues and were kept in the person's care folder. This information was used in the development of the care plans. The registered manager explained they reviewed referrals from the local authority or Clinical Commissioning Group to ensure the service could provide appropriate care and that the home was suitable for the person. If possible they would arrange for the person or relatives to visit the home and they would discuss their care needs with them. If the person was identified as requiring palliative care, the palliative care team and doctors would be contacted to ensure the move to the home was in the best interest of the person. The registered manager told us no admissions were accepted after 12 noon on a Friday as this was after the GP had visited so they could not assess the new person ahead of the weekend.

People using the service confirmed they knew how to make a complaint in relation to the care provided. We saw there was a complaints policy and procedure in place. Information on how to make a complaint was displayed in communal areas around the home. The area manager confirmed information on the complaints process would be included in the 'Resident Handbook' which was being rewritten at the time of the inspection. During the inspection we looked at one complaint record which had been received during December 2016. The record included any related correspondence, investigation and the outcome of the complaint.

People using the service and their relatives could provide feedback on the quality of the care provided. The registered manager confirmed the provider was planning on sending a questionnaire to people using the service and relatives during 2017. The area manager explained regular meetings were being held for people using the service and their relatives following the change in provider. We saw the notes from the recent meeting. One person we spoke with told us they were in the lounge one day when the first 'Residents and

Relatives' meeting was held. They said they were not sure what was happening to begin with but they found the meeting "interesting" but said they felt that the chair allowed too much time to be taken discussing the commercial plans of the new owners, stressing the meeting should have concentrated on service delivery and concerns. Although minutes of the meeting were available at reception, a copy had not been distributed to the person who attended or to other relatives to whom we spoke with and who had attended.

Requires Improvement

Is the service well-led?

Our findings

Records relating to care and people did not always provide an accurate, complete and contemporaneous record for each person using the service.

We looked at the records for one person and found the risk assessments for five other people using the service had been placed in their folder. Copies of these risk assessments were available in each person's own care folder. This had not been identified when the care plans and risk assessments had been reviewed each month.

During the inspection we reviewed the fluid intake charts, repositioning records and food records for people on one unit at 3pm and saw they had not been updated that day. This meant that care workers and nurses did not have accurate records to indicate the actions taken and each person's food and fluid intake.

The fluid intake record for one person indicated on the 23 January 2017 the total fluid intake was 200ml but the food record for the same day indicated the person had consumed 1000ml of fluid. We also saw there was no fluid intake recorded on four days during January 2017. The food intake record had not been completed on eight days in January.

The care plan for another person indicated they should be repositioned every two hours as they were unable to leave their bed. We saw the repositioning records had not been completed over a four hour period on the 9 January and between 2pm and 8pm and midnight and 4am on the 15 January 2017. On the 18 January we saw the records indicated the person had not been repositioned for eight hours overnight. We saw care workers had recorded that the person had been repositioned but not the times it occurred on the 11, 13, 15 and 22 January 2017. The records were reviewed at 3pm on 23 January and these had not been completed with the repositioning so far that day.

We reviewed the repositioning record for another person which showed they had been positioned on their back for 12 hours. The records indicated that the person had refused to be repositioned at the start of the day but there was no indication that the case workers had attempted to reposition the person again. The repositioning records for three different people were reviewed at 11.30am on 25 January 2017 and found the records had not been completed for that day. We saw they had been left in one position for up to six hours on two different days. We noted the repositioning records for some people did not indicate the frequency the person should be repositioned.

The maintenance staff carried out checks of the setting of the pressure relieving air mattresses used around the home. We looked at the record sheet used which listed the recorded weight of each person to ensure the setting was correct on the mattress. The sheet indicated the weights recorded were the most recent record but we compared this record to the weight records kept on the units and found in some cases there were large differences in the two figures. We saw the differences in actual weight compared to the maintenance check list for some people were as much as 10kg higher or lower. This meant the pressure relieving air mattress may have been at the wrong setting to prevent pressure ulcers from developing. The registered

manager explained the weight records might have been incorrect as there were three types of weighing scales used at the home which were moved between units so may not be calibrated accurately. In addition care workers did not record which set of scales were used each time they weighed a person so there was no consistency in the recording.

We looked at the application of prescribed creams records for five people and saw the records indicated that the creams had not been applied as prescribed. We also saw some record charts stated the frequency of application as 'Daily/PRN' which meant there was no clear guidance on how often the cream should be applied. The provider explained this term meant the cream should be administered daily but there was no specific time it should be applied.

The provider had a range of audits in place but those in relation to risk assessments and records of care were not effective in identifying issues. During the inspection we identified a number of issues including risk assessments that did not always provide current information on possible risks, infection control and people's capacity to make decisions. In addition when other records had not been completed in full or accurately this had not been identified through the audits in place.

The provider had developed an action plan identifying issues arising from the transition from the previous provider's systems to those of the new provider and how these would be resolved. A copy of the action plan was provided during the inspection.

A range of other audits had been regularly completed by the registered manager. These included an audit of pressure ulcer records which reviewed if a person had a pressure ulcer on admission, the level and what action was taken. An audit was completed regularly in relation to the Controlled Drugs prescribed for people using the service. The audit reviewed which person had been prescribed Controlled Drugs, where they were located, the balance of the stock of the drugs and the use by date.

The area manager explained monthly Joint Operating Group meetings were held with the Clinical Commissioning Group and local authorities that commissioned services from the home. An audit was completed in relation to incident and accidents, safeguarding, complaints, admission and discharge rates to be discussed at the meetings.

At the time of the inspection there was a registered manager 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.

Care workers and nurses were also asked their view of the culture of the service and if it was fair and open. They told us "It is very transparent here and this way things tend to go better. You don't feel like you are left out. We are all here for the residents", "Staff are approachable. If any problems I would talk and ask" and "We don't know yet, they are new so I can't say. No issues as yet."

We asked the care workers and nurses if they felt supported by their manager. We received mixed comments "The nurses are supportive and I feel able to go to them", "The manager is very supportive, will come and explain things. The area manager is also supportive. If you do something wrong she is supportive and you feel you want to learn more" and "The manager has too much going on. Sometimes, the choice of words from senior management is sharp."

The registered manager confirmed regular meetings were held with all staff to provide support during the

transition period with the new provider and the new processes and procedures were implemented.

We asked people using the service and relatives if they felt the service was well-led. Their comments included "I've seen general improvement since the new owners took over. [For instance] [my relative's] room is kept cleaner", "[The manager's] a lovely woman, she is. You can talk to her, she's always willing to listen. Any complaints you can go to her" and "They are looking after me very well. The new owners are finding their feet."

We asked care workers and nurses if they felt the service was well-led. They told us "The manager is very active, come around and checks us all the time. It is very good. Supportive and approachable", "Now we have long term agency nurses this is much better", "The new company wants to move away from the hospital feel and make it more of a care home", "Dementia is very challenging and you need to work as a team to support your residents" Other comments included "I want to help raise the standards. I want to be proud of where I work. I love it here, I love my job", "Feels like good teamwork with the heads of department and we will get to know the new management" and "I am very happy here. We are a perfect team. I like all the girls and we do things in a good and positive way."

Other comments from care workers and nurses in relation to working at the home included "I love Acton Care Centre and working here for the residents. I try as much as I can to put things right" and "I enjoy working here, working with elderly people. I love my job"

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
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not have processes in place to prevent and control the spread of infection. Regulation 12 (2) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not ensure service users were not deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (5)