GCH (Acton) Limited

Acton Care Centre

Inspection report

48 Gunnersbury Lane
Acton
London
W3 8EF

Tel: 02088965600

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Acton Care Centre on 1 July 2017. This inspection was in response to concerns that had been raised in relation to the care provided in the Garden Unit which provides care and support for people living with dementia. The concerns were in relation to the number of care workers on duty in the Garden Unit and recording of incident and accidents in relation to two people.

This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Acton Care Centre on our website at www.cqc.org.uk. At the last inspection the service was rated 'Requires Improvement' in all key questions and overall. We have not amended the ratings of any key questions at this inspection.

Acton Care Centre is a purpose built home that can accommodate up to 125 people. There are two units for people living with 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 26 people receiving support in the Garden Unit.

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 service was last inspected in January 2017 and was rated Requires Improvement with breaches in relation to infection control and complying with the Mental Capacity Act 2005. The overall rating for the service has not changed following this focused inspection.

One of the concerns raised was about staffing levels on the unit. We found that overall there was adequate numbers of staff on the unit. Whilst care workers were not always available during the morning at busy times to be with people in the lounge, people using the service did not experience extended waiting times for support from care workers. The registered manager agreed to review how staff were deployed on the unit.

In regards to the recording of incidents and accidents, we noted that appropriate records were completed when these occurred with detailed information and any actions taken by staff to manage these. We also found that whilst risk assessments and care plans were reviewed monthly, these were not updated immediately after an incident or accident had occurred so where necessary appropriate actions were taken to prevent reoccurrence. We discussed this with the registered manager who agreed to review this shortfall.

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 Care Quality Commission was contacted with concerns relating to the number of nurses and care workers on duty during the weekend in the Garden Unit were not sufficient to provide appropriate support for people using the service.

We visited the unit on a Saturday to check the staffing levels in the Garden Unit. At the time of the inspection there were 26 people living on the unit. Fourteen people required the support of two care workers for personal care and 12 people required the support of one care worker for personal care. This included two people with one to one care day and night with a second person who had one to one support from a care worker between 10am and 8pm. We looked at the care plans and risk assessments for these three people which clearly explained their support needs and the requirement for one to one support.

There were seven care workers and one nurse on duty when we visited which included three care workers who provided one to one support for specific people. There were four permanent care workers and three care workers from an agency on duty. The agency care workers regularly worked in the unit so they knew the needs of the people.

During the inspection we saw people did not experience extended waiting times for support from care workers but we observed 10 people were seated in the lounge with limited interaction with care workers and no supervision for over 15 minutes while they were supporting people with personal care. We saw some of the people in the lounge required support from one care worker to stand and walk around the unit. As they were unsupervised this increased their risk of falls. Once the care workers had completed supporting people with their personal care they were able to spend time with people in the lounge. We spoke with a care worker who told us, "It is OK when we are doing personal care as there are always two of us but we have to keep the lounge in mind as there are people sitting in there while we are busy. A care worker or someone just to be in the lounge during the busy morning period would be good so we can focus on personal care." We saw the people who received one to one support during the day would spend time in the lounge, other parts of the unit as well as their rooms and the care worker

accompanied them and ensured they were appropriately supervised.

We discussed this with the registered manager who confirmed they would review how the care workers identified for one to one care could also interact more with other people when they were in the lounge providing support for their allocated person. The registered manager also told us they would review if additional support was required in the lounge during the morning when other staff were busy providing personal care to people in their rooms.

We were also contacted with concerns relating to incidents and accidents in relation to two people living in the Garden Unit which were not being recorded appropriately.

We reviewed all incident and accident records for these two people as well as their care plans, risk assessments and the daily records of care completed by the care workers describing the support provided. We saw that appropriate records were maintained where people had incidents and accidents including body maps, where people had sustained an injury indicating where the injury was located as well as photographs of the injury. Where people sustained injuries, staff had acted appropriately and in one case a person had been taken to hospital to be checked. Information in relation to falls was recorded on the falls record sheet with dates and a brief description of what happened to monitor people's falls.

Where a person has had a recent fall and sustained an injury, the risk assessment and care plan had not been reviewed to identify any changes in the person's needs and if additional action was needed to help prevent further falls, such as a referral to their GP. We discussed this with the registered manager who told us that, as the risk assessment and care plans were reviewed monthly, any issues identified would have been included when reviewed during July 2017. They agreed when an incident or accident occurred, the relevant risk assessment and care plan would be reviewed and updated as soon as possible. The registered manager also confirmed they would check with the local authority safeguarding team to see if this injury should be reported.

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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 focused inspection took place on 1 July 2017 and was carried out by one inspector. We inspected the service against one of the five questions we ask about services: is the service safe? Following concerns were raised in relation to staffing levels and the appropriate recording of incidents and accidents on the Garden Unit.

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 the registered manager, head of nursing, a nurse and a care worker. We also looked at the care plans, risk assessments and daily record of care for five people using the service. We looked at the incident and accident records for the Garden Unit.

Requires Improvement

Is the service safe?

Our findings

There were an adequate number of care workers and nurses on duty on the unit. The way care workers were deployed was being reviewed by the registered manager.

Information regarding incidents and accidents was recorded with any actions that had been taken. Risk assessments and care plans were reviewed monthly but were not updated after an incident or accident to prevent a reoccurrence. The registered manager agreed to review this issue.