GCH (Alan Morkill House) Limited

Alan Morkill House

Inspection report

88 St Mark's Road
London W10 6BY
Tel: 020 8964 1123
Website:
www.goldcarehomes.com/alan-morkill-house.html

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on 18 and 20 November 2014.Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to care and welfare; assessing and monitoring the quality of the service and cleanliness and infection control.

We then carried out an unannounced focused inspection on 21 and 23 April 2015 to see whether these improvements had been carried out. At this inspection, we found that the provider had made the required improvements, however we found that the service was in breach of legal requirements with regards to staffing levels. Following the publication of this report, the provider contacted us to say which measures had been taken to meet these requirements.

After that inspection we received concerns in relation to staffing levels and training of staff. As a result we undertook a focused inspection to look at these concerns and check if the provider had taken action to meet legal requirements around staffing. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Alan Morkill House on our website at www.cqc.org.uk

Alan Morkill House is a residential care service providing care for up to 49 older people, many of whom have dementia or mental health needs. At the time of our inspection, there were 43 people living in the service. The service consists of three floors with two units on each floor, and a further unit on the ground floor. Each unit accommodates 7 people. The units on the second and ground floor accommodate the people with the highest needs.

The service is required to have a registered manager. 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.

Summary of findings

There has not been a registered manager since August 2014. The service appointed a manager in August 2015, but at the time of the inspection she had not yet submitted her application to become the registered manager.

We found the service was not safe. Staffing levels were inadequate to meet the needs of people who used the service. Dependency tools did not take account of the need to provide 2:1 support to people who required it. Floating support staff were required in order to ensure that two members of staff were available to support people when needed, however this was not adequately provided, and at times absent.

The provider did not have an adequate system in place for monitoring the training and competency of staff who administered medicines, which meant they could not be certain that staff had received this training. Steps had been taken to address this, but not all staff had had observations of their competency to administer medicines.

We made one recommendation in relation to the observation of staff competency in administering medicines. We found one breach of the Regulations around staffing. You can see what action we told the provider to take at the back of the full version of the report.

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?

Inadequate 

We found that action had not been taken to improve safety. Staffing levels were still inadequate to safely meet the needs of people who use the service.

One staff member worked in each of the seven units which make up the service, with additional staff members to support them when more than one staff member was required. However, this floating support was not always provided. Staff and people who used the service expressed their concern at the impact this was having on the safety of the service.

Medicines were not always managed safely. Not all staff had had assessments of their competency to administer medicines, and the provider did not have systems in place to monitor this

Alan Morkill House

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.

We undertook an unannounced focused inspection of Alan Morkill House on 9 November 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 21 and 23 April 2015 inspection had been made. The team inspected the service against one of the five questions we ask about services: is the service safe? This is because the service was not meeting some legal requirements. We also looked into the safe administration of medicines, as we received information which suggested that staff training was inadequate.

In carrying out this inspection, we observed the number of staff in the building at the time of our arrival. We checked rotas and staff allocation sheets and looked at staff dependency tools, as well as records concerning the safe administration of records. We spoke to the area manager, head of care, manager and deputy manager, as well as four people who used the service and one relative. We also spoke four care staff. Following our inspection, the provider supplied us with further information about staffing rotas and staff training on medicines.

At the time of our inspection, the service was not displaying the rating it had received from previous inspections, which is a legal requirement. However, this was rectified during our visit and there was a copy of the previous report available in the lobby.

Inadequate

Is the service safe?

Our findings

During our previous inspection in April 2015, we found that staffing levels did not enable sufficient staff to be deployed to meet the assessed needs of people who used the service. We were informed by the provider that staffing levels had been increased from seven to ten staff members during the day. At the time of our visit, we observed 8 care staff on duty and one senior. This indicated that this action had not been carried out.

The service was not always safe. People told us "I feel safe enough, I've never been attacked", but also that "there are not enough staff on duty."

We were shown a staff allocation tool, which indicated how many staffing hours would be allocated per person based on their needs. However, we found that this tool was limited in its scope, particularly as it did not take account of how many staff may be needed to support each person with certain tasks at a time.

The manager told us that staffing consisted of seven staff, one allocated to each unit and two floating support staff, who could provide support to their colleagues at times when an additional member of staff was required. We found that rotas were not readily available, and did not reflect who was working in the building as they excluded some agency staff. Therefore, we looked at the staff allocation sheets for the previous three weeks, which showed which areas of the building staff were allocated to work in on each day. These showed that on a regular basis there was only one floating support staff member on duty during the morning period. Over a two week period, there were no floating support staff on duty at all on six shifts. This meant that most of the time, it would not be possible to deploy an additional member of staff to support the six individuals who required two staff to safely transfer them.

People told us about the impact the staffing levels had on them at mealtimes. People said "It is always short of staff" and "We have to wait longer to get breakfast." We observed lunch being served and noted people who needed support to eat were left unattended as the single staff member was with people who preferred to stay in their rooms. People had to wait up to twenty minutes for their food to be served. At one point, we observed that the staff member was supporting one person to eat, and we asked what would happen if somebody needed to go to the toilet. The staff member told us that they would have to cover the food for people who needed support, and to go to the office or upstairs to fetch help. The manager told us that staff would be expected to use the emergency alarms in this situation, however staff we spoke to did not feel that was appropriate. We noted that the building had a set of radios that staff could use to communicate, however these were not in use.

Staff told us that they felt stretched on their own, "I have to do everything, all the personal care, medicines, food, toileting…most people [on this unit] have very high needs." "We have asked for more staff, but Gold Care say no." Several staff we spoke to had raised concerns that staffing levels were not safe, but feared repercussions if they raised their concerns with CQC. Following our inspection, we received information that staff were being asked by managers what they had said to our inspection team.

We noted that the building was equipped with CCTV, however the monitors for this were at the staff desk in the lobby, which was unattended for most of the time we were there. People told us "There are not enough staff on duty to monitor the CCTV, there isn't even anyone to open the door", and "They need more people here on the desk to open the doors." The deputy manager told us that the keycode was on display by the front door in a manner that would make it more difficult for a person with dementia to use. However, there was no way to monitor if someone had left the building as the CCTV station was unattended. This meant that people were at risk of leaving the building even though it may not be safe for them to do so.

Although an evacuation plan was in place, and displayed in the manager's office, two people we spoke with were wheelchair users, and expressed concern that the design of the building would make it difficult to exit in the event of an emergency. One person told us "If I had to escape in a panic, like in a fire, I would be really concerned, especially if staff are attending to those who are helpless….it isn't really designed for wheelchairs." This meant that due to the design of the building, in the event of an emergency evacuation, there may not be sufficient staff to escort everybody out safely.

The issues above relate to a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Act 2008 Regulations 2014.

Inadequate

Is the service safe?

The provider did not have adequate systems in place for ensuring staff had the right skills to administer medicines. We saw that only seven staff members were recorded on the audit tool as having received medicines training and assessments of their competency to administer medicines. We were told by a manager that these were the only staff permitted to administer medicines. We therefore looked at medicines administration records, and identified staff who had administered medicines in the past month. These staff were not on the list of staff who had had medicines training, however by looking at their staff files and other records we identified that they had had medicines training, however several had not had assessments of competency. This meant that people were at risk of errors in the administration of their medicines. After our visit, the provider updated their audit tool in order to record this information.

We noted that since our last inspection, the provider had installed air conditioning in the rooms where medicines were stored, and that records were in place that showed the temperature was checked on a daily basis. A monthly audit had been carried out of medicines charts and steps were taken to ensure that errors and anomalies were addressed by the head of care. Specimen sheets were in place to ensure that staff names could be identified by their initials on the medicines records, and the provider was in the process of updating these.

We recommend that the service seek guidance from reputable sources about ensuring that all staff administering medicines have an assessment of their competency so that medicines are managed safely at all times.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed at the service.Regulation 18 (1)

The enforcement action we took:
We issued a warning notice.