London Borough of Hounslow

Clifton Gardens Resource Centre

Inspection report

59 Clifton Gardens
London
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Clifton Gardens Resource Centre on 7 and 8 September 2017. We carried out the focused inspection due to concerns raised with the Care Quality Commission (CQC) by social workers in relation to how the care plans and other records were maintained in relation to people's care. We also received 18 notifications during a five week period relating to a range of events including falls and incidents between people using the service. Registered providers need to send notifications to the CQC about certain changes, events and incidents that affect the service or the people who use it. This number of notifications was higher than expected for this size of service and over this time period.

Clifton Gardens is a care home and is run by the London Borough of Hounslow. It provides accommodation for up to 43 older people in single rooms. The majority of people at Clifton Gardens Resource Centre are living with a diagnosis of dementia. The home is situated within a residential area of the London Borough of Hounslow. At the time of our visit there were 36 people using the service.

We previously inspected Clifton Gardens Resource Centre on 5, 6 and 7 April 2016 and we identified issues in relation to the recording of the management of medicines and quality assurance. Following the inspection in June 2017, we found improvements had not been made in relation to the issues that were identified at the previous inspection. We issued the provider and registered manager with two warning notices relating to safe care and treatment of people using the service (Regulation 12) and the good governance of the service (Regulation 17)) requiring them to make the necessary improvements by 1 September 2017.

At the inspection on 7 and 8 September 2017 we found improvements had been made in relation to the administration of medicines as well as audits relating to medicines. Improvements had also been made to the recording of the daily checks carried out on pressure mattresses settings. We did identify there were still issues in relation to the accuracy of records relating to the support needs of people using the service and how they were audited.

There was a process in place for the recording of incidents and accidents but this information was not always reviewed by the registered manager to ensure appropriate action had been taken. Also the information relating to falls was not always recorded on the falls monitoring form. The care plans and risk assessments were not updated to reflect any changes in support needs or any actions taken to reduce future risks.

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

There was a clear recruitment process used by the provider to ensure checks were carried out on new care workers to ensure they were suitable and had the necessary skills to provide the care required by the people using the service.

Care workers used appropriate personal protective equipment (PPE) equipment including aprons and gloves when providing support.

We found a number of breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches relate to the safe care and treatment of people using the service (Regulation 12) and the good governance of the service (Regulation 17). Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Incident and accident forms were not always reviewed by the registered manager in addition care plans and risk assessments were not updated to reflect any changes in support needs following a fall to ensure appropriate action was taken to reduce any future risk.

The registered manager had introduced improvements in the recording of the administration of medicines and how they were stored.

There was a clear recruitment process used by the provider to ensure checks were carried out on new care workers to ensure they were suitable and had the necessary skills to provide the care required by the people using the service.

Care workers used appropriate personal protective equipment (PPE) including aprons and gloves when providing support to reduce the risk of cross infection

The rating for this key question continues to be 'Requires improvement'.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

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 a range of audits in place but those in relation to the review of care plans, risk assessments and incident and accident records were not effective in identifying issues.

The recording of the daily checks made for pressure mattress settings had improved.

Improvements had been made in the audits used to monitor the administration of medicines.

The rating for this key question continues to be 'Requires improvement'.

Clifton Gardens Resource 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 focused inspection took place on 7 and 8 September 2017 and was unannounced. The inspection was carried out by two inspectors. We inspected the service against two of the five questions we ask about services: is the service safe? and is the service well-led?. This inspection was carried out to review any improvements made following two warning notices which were issued after the previous inspection in June 2017. We also wanted to check information in relation to concerns raised by social services as to how the care plans and other records were maintained in relation to people's care. In addition we had received a higher than usual number of notifications over a five week period compared to a service of a similar size. Notifications are for certain changes, events and incidents affecting the service or the people who use the service that providers are required to notify us about.

During the inspection we spoke with the registered manager, deputy manager and two care workers. We also looked at the care plans and risk assessments for nine people using the service. We looked at the incident and accident records for the whole service recorded during 2017 and the medicines administration records for all the people on two units.

Requires Improvement

Is the service safe?

Our findings

The provider had a process for the recording and investigation of incidents and accidents but relevant information was not always transferred into the person's care plan and risk assessments to indicate if there had been a change in the person's support needs. Also appropriate action was not always taken and recorded to reduce the risk of the incident or accident occurring again.

During the inspection we reviewed the incident and accident log sheets completed during 2017 to identify where people had more than one fall or other incident recorded. We saw the completed forms had not always been reviewed by the registered manager or another designated person to ensure appropriate action had been taken to reduce the risk of reoccurrence. We then reviewed the incident and accident records with the person's care plans and risk assessment to identify what information had been recorded and what action had been taken to reduce the risk of reoccurrence.

We saw the records for one person which indicated they had experienced two falls in June 2017. The incident and accident form for the second fall stated a referral should be made to the falls service for assessment. The incident and accident log indicated the person experienced four further falls during July and August 2017. We looked at the care plan and risk assessments and these had not been updated to reflect the falls that had been recorded. The care plan and risk assessment reviews stated there had been no change in the person's support needs. There were no records of the referral being made following the fall at the end of June 2017 in the care plan or other records related to the person's care. One of the falls in August 2017 resulted in an injury requiring hospital treatment. Following the inspection the registered manager confirmed the referral to the GP had been made at the end of June and the GP had then made a referral to the frailty clinic in July. The person was assessed by a physiotherapist in September 2017.

We saw 27 incident and accident records related to falls had been completed for another person during 2017 but their fall monitoring sheet identified only seven falls were recorded. The person's care plan review record indicated the only amendments made to the documents were in June and July 2017 in relation to the person's medicines. The care plans did not indicate the number of falls experienced during 2017. The person's moving and handling assessment had been reviewed in December 2016 and only one fall had been recorded in January 2017. The person was assessed as having a good level of mobility. The person's mobility care plan had been reviewed in August 2017 confirming the GP had been asked to review the person's medicines but there was no update recorded. This shows that the provider was not adequately monitoring the number of falls the person was having, had not identified this as a serious enough risk and therefore they did not take appropriate action to mitigate the risk of falls.

The records for other people we reviewed also indicated that falls had not always been recorded and analysed, and care plans had not been updated with information relating to any incidents and accidents and to reflect any changes in support needs and to mitigate the risk of falls.

This meant care workers did not receive the guidance required to provide the support the person needed in an appropriate way and actions may not have been taken in a timely manner to reduce possible risks to the

individual.

The process for reporting an incident and accident required the care worker to complete a form with details of the event, who was involved and what actions were taken. This should be reviewed by the registered manager or the deputy manager and an investigation carried out if required. The information was then transferred to the provider's computerised records system and reviewed once the process was completed. If the person had experienced a fall the care workers should also record the information on a falls monitoring form in the person's care plan folder.

The registered manager explained that if a person had two falls within a four week period the GP would be contacted to decide if the person required a referral to the frailty clinic for assessment or other tests. Care plans and risk assessments should also be updated to identify any changes in the person's support needs and any action required to reduce possible risks when care was provided. They agreed that they were not following these procedures to make sure that any risks were identified so that appropriate management plans could be developed to minimise the identified risks.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During the previous inspection on 1 and 2 June 2017 we found the provider had a management of medicines procedure in place but care workers did not complete the Medicine Administration Record (MAR) charts accurately. We also found some liquid medicines did not have the date of opening recorded and when we looked at medicines to be administered as PRN (to be administered when required) we found discrepancies in the recorded stock levels and the actual number of tablets in the packets. Issues with the management of medicines had also been identified during a previous inspection in April 2016 and improvements had not been made. Following the inspection in June 2017 we issued the provider and the registered manager with a Warning Notice requiring improvements to be made by 1 September 2017.

When we carried out the inspection on 7 and 8 September 2017 we found improvements had been made to the way medicines were managed and administered at the service. Where issues were identified during the inspection action was taken immediately to resolve the issue.

The registered manager had implemented new systems to ensure all liquid medicines, eye drops and creams had a label completed to confirm the date of opening and the date they should be disposed of. We reviewed the medicines in three units and we saw labels were in place with the opening and disposal dates clearly recorded.

The stock levels of medicines prescribed as PRN such as paracetamol were recorded on a separate sheet with the number of tablets and time administered recorded. The record sheet also indicated when the person had refused or did not require the medicine. We saw the records clearly indicated how many tablets had been administered and the current stock level.

We checked the number of tablets for medicines provided in the original packaging in each unit and we found this matched the number of tablets recorded on the log sheets.

We saw the MAR charts had been completed in full by the care workers with any additional information recorded on the relevant forms. MAR charts to record the application of creams included the directions given by the GP and had been completed regularly by care workers.

The registered manager explained controlled drugs were stored securely and were only administered by senior care workers or managers who completed the controlled drugs book. Warfarin (a medicine to thin the blood) was also administered by senior care workers or managers to ensure the appropriate dosage was given based upon directions from the GP.

During the inspection we saw the number of tablets in a bottle did not match the number recorded on the MAR chart. We discussed this with the deputy manager who explained these tablets had been provided by the hospital when the person was discharged to the home. To ensure the tablets were not contaminated the number of tablets received was based upon the contents of the bottle recorded on the label and not an actual count of the tablets provided. The deputy manager explained that it was not usual for the hospital to provide tablets in a bottle so they did not have the process in place to count them appropriately. They confirmed a pill counting tray would be ordered so an exact count of any tablets provided in this way in the future could be completed.

We saw one person had been prescribed an opioid pain relief patch with a laxative to prevent constipation. The laxative had not been administered during the week before the inspection as it was not required. The person's GP was in the process of reviewing the prescribed medicines to assess if any should be administered as PRN. The deputy manager explained in future the care worker would inform the senior care worker if the person did not require a medicine prescribed to be given regularly, for more than two days so they could be assessed and the GP contacted if needed.

The provider had policies and procedures in place to respond appropriately to any concerns raised in relation to the care being provided. During the inspection we looked at the records for safeguarding concerns which included a detailed record of the concern and any correspondence. Care workers told us they understood the principles of safeguarding and knew what to do if they had any concerns.

We saw each person had a Personal Emergency Evacuation Plan (PEEP) in place in case of an emergency which provided care workers with guidance on what action should be taken to support the person appropriately. A copy of each person's PEEP was included in their care folder and identified issues which might impact on the evacuation of the person from the home including mobility and health conditions.

The staffing levels, which were confirmed when we looked at the rotas on both Belmont and Elmswood units, consisted of two care workers in the morning and two in the afternoon with a shared floating care worker over lunchtime. Hogarth unit had three care workers in the morning and afternoon with Savoy unit having one care worker in the morning and afternoon. At night there were three care workers on duty to provide support across the home. We saw housekeeping staff provided additional support by serving breakfast in the lounges to enable care workers to support people with personal care. At the time of the inspection care workers provided by an agency were still being used regularly due to ongoing issues with recruitment of permanent care workers and some care workers being on sick leave. The registered manager confirmed there was always at least one permanent care worker on each unit per shift.

The service followed suitable recruitment practices. During the inspection we were unable to look at the recruitment paperwork for care workers as this was held by the provider's human resources department but we saw the record for two care workers which included an information sheet confirming criminal record checks had been received and approved as well as if references had been received. New care workers could not start work until a Disclosure and Barring Service criminal record check had been received. Checks were also carried out to ensure the new care worker was eligible to work in the United Kingdom.

We asked the registered manager what checks were carried out in relation to agency care workers at the

home. They explained agency care workers were requested through a separate company contracted to the provider who would contact various agencies for appropriate care workers. The external company confirmed they checked the agency care worker had completed a criminal records check within the last 12 months as well as what training they had undertaken. This included safeguarding, moving and handling, infection control and food handling.

During the inspection we saw care workers used appropriate personal protective equipment (PPE) equipment including aprons and gloves when providing support. The records indicated care workers had completed infection control training. The building was clean, tidy and there were no malodours present.

Requires Improvement

Is the service well-led?

Our findings

During the previous inspection on 1 and 2 June 2017 we found the records relating to people's care did not always provide an accurate, complete and contemporaneous record for each person using the service. At this inspection we found some records were still not up to date and providing care workers with accurate information about the person's care needs.

The findings of this inspection show that when people sustained falls, the provider did not ensure their strategy to prevent falls were fully implemented at all levels. They had had not fully identified the number of falls sustained by individuals within the service and had not taken robust action to help manage falls. The systems to monitor if enough action was being taken to prevent falls, were not effective. As a result the provider did not always identify that care plans or risks assessments were not updated after falls and accidents and incidents. The provider also did not monitor whether appropriate actions were being taken by staff and if appropriate referrals were being made to healthcare professionals to help prevent falls and to ensure the safety of people.

Information regarding falls was recorded inconsistently between the incident and accident records and the various documents in the care records for people using the service. We saw the falls monitoring form for one person had been completed seven times during 2017 but there were 27 completed incident and accident forms for the same period. The falls monitoring form for another person indicated they had experienced five falls during 2017 but there were 12 incident and accident forms completed for that person during the same period. The information recorded on the falls monitoring form was used by the senior care workers when as part of the care plan review process to identify if there had been any changes in the persons health and support needs. As the falls information was not always recorded this information was often inaccurate when used to identify any changes in care needs.

The care plan for one person indicated they should be given diazepam if they experience anxiety but this medicine was not recorded on the MAR chart or in any other care document. We asked the registered manager if the person was currently being prescribed this medicine. They confirmed this medicine had not been prescribed during 2017 and had only been prescribed for a specific time period not indicated in the care plan. The information provided in the care plan was not consistent with that recorded on the MAR chart. We saw the care plan updated in June 2017 for another person indicated a meeting was required to review the need for their medicines to be administered covertly as they often refused them. There was no follow up information in the care plan or the MAR chart and when we asked a care worker they told us they were not aware of any issues with the medicines and the person was happy to take their prescribed medicines. We also saw care workers had been completing food and fluid monitoring sheets for the person but these had been stopped in August 2017 but there was no record of why this had occurred and if any further assessments were required to monitor if the person's nutritional needs were being met. This meant the information in the MAR chart as to how medicines should be administered was not consistent with the information recorded in the care plan which may have resulted in the person receiving their medicines inappropriately.

The falls risk assessment for another person indicated a sensor mat should be used in the person's bedroom but this was not reflected in the care plan. The care workers would not have been aware a sensor mat should be in place to reduce the risk of falls if they only checked the care plan and did not review the risk assessment. The weight records indicated this person had experienced a loss of weight during the previous four months but there was no record of any action taken to identify the reason for this and how to respond to the person's changing nutritional needs.

The provider had a process in place for the audit the care plans and risk assessments but this did not indicate the issues identified during the inspection. When a senior care worker reviewed the care plan, risk assessment and PEEP they would record there were no changes in the person's care needs but information in other documents related to the support needs of the person indicated there had been changes which could affect how care should be provided. This meant the care plans did not reflect the current support needs of the person. When checks were carried out on the person's records these were to ensure the monthly review of care plans had been completed but not if the care records were accurate.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During the inspection on 1 and 2 June 2017 we saw the audits in relation to the management of medicines were still not effective to enable the provider to identify issues. This was also identified during a previous inspection in April 2016. During this inspection we found the audit system for medicines had been improved with regular checks carried out in relation to the storage and recording of medicines when administered.

At the previous inspection we also saw daily checks carried out on the air pressure mattresses were not always recorded to ensure the person was receiving appropriate support to reduce the risk of developing pressure ulcers. At this inspection we saw the air pressure mattress checks were now carried twice a day by an allocated care worker. This meant the care worker was aware of their responsibility and the senior staff knew who would be carrying out these checks. The records were reviewed by the duty manager every day. We saw the records had been completed regularly during the two weeks before the inspection.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care was provided in a safe way for service users. Regulation 12 (1)

The enforcement action we took:

We have issued a warning notice to the provider telling them they must make improvements by 15 December 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not assessed, monitored and improved the quality of the services provided. Regulation 17 (1) (2) (a) The provider did not have a system in place to maintain an accurate, complete and contemporaneous record in respect of each service user including a record of care provided and any decisions taken. Regulation 17 (1) (2) (c)

The enforcement action we took:

We have issued a warning notice to the provider telling them they must make improvements by 15 December 2017.