Vintage Care 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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 15 August 2016 and was unannounced.

The last inspection took place 16 and 17 November 2015, when we found breaches in Regulations relating to medicines management, consent to care and treatment and good governance. The inspection of 15 August 2016 was carried out to look at whether the provider had met these breaches. The provider had supplied us with an action plan on 13 January 2016 telling us that they would make the necessary improvements by 31 January 2016. At this inspection we found that improvements had been made. However, we found that there were still some areas around medicines management, risk management and record keeping which required further improvements.

Acton Care Centre is a care home with nursing registered for up to 125 older people and younger adults (people under 65 years old). The home is divided into five units. Two of the units, Donald Sword and Garden unit, were dedicated for people living with the experience of dementia. The other three units, Oak, Park and Westerly, provided care for people with complex healthcare needs, which included some people receiving care at the end of their lives.

The service is managed by Vintage Care Limited which is part of the Catalyst Housing Group – a housing association based in London and the South East.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

People felt the service met their needs and the staff were kind and caring. The permanent staff had a good knowledge of people's needs and how to care for them. However, the service employed a large amount of temporary staff and there was a risk that people's needs would not always be met because care records were not always accurate or individualised.

There had been improvements in the way medicines and risks were managed. However, the records around these areas were not always clear or detailed enough and people were at risk of receiving inappropriate and unsafe care because of this.

The provider had improved the way in which people's consent to care and treatment was obtained. They had carried out comprehensive mental capacity assessments and included this information in the way they planned care for each person.

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 always safe.

The provider had made improvements with the way in which people's medicines were managed, however, there were still some areas where people were at risk of not receiving their medicines safely.

The provider had not always ensured that individual risks to service users had been assessed, recorded and mitigated.

Is the service effective?

Good

The service was effective.

People were asked to consent to their care and treatment. Where people did not have capacity to consent, the provider had acted in accordance with the law and ensured that care was planned and provided in their best interests. Where people's liberty and freedoms were restricted the provider had obtained appropriate authorisation for this.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider had systems to monitor the quality of the service. However, these did not always identity or mitigate risks to people who use the service.

The provider had not always maintained an accurate, complete and contemporaneous record where individual needs were identified and planned for.

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 checked whether the provider was 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 15 August 2016 and was unannounced.

The inspection team included two inspectors, a nurse specialist advisor and an expert-by-experience. 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 supporting this inspection had personal experience of caring for a relative.

Before the inspection visit we looked at all the information we held about the service. This included the last inspection report and the provider's action plan, notifications of significant events and safeguarding alerts. We also contacted external professionals who worked with people who lived at the service and received feedback from three of these.

During the inspection we spoke with 12 people who lived at the home, seven of their visiting friends and relatives, two visiting healthcare professionals and the staff on duty, who included the general manager, nurses, healthcare assistants, catering staff, domestic staff and the activities coordinator. We observed how people were being cared for and supported. We looked around the environment. We looked at how medicines were being managed, which included how they were stored, administered and recorded. We also looked at all or some aspect of the care records for 13 people, the records of staff training and support, the recruitment records for four members of staff, records of complaints and records the provider maintained to show how they audited the service and monitored quality.

Requires Improvement

Is the service safe?

Our findings

At the inspection of 16 and 17 November 2015 we found that people were at risk because their medicines were not always managed in a safe way. The provider supplied us with an action plan telling us they would make the necessary improvements by 31 January 2016.

At the inspection of 15 August 2016 we found that some improvements had been made. In particular around the administration of medicines and the storage and administration of controlled drugs (medicines were the prescription and administration is restricted and monitored through The Misuse of Drugs Regulations 2001). However, we found that further improvements were still needed to ensure people always received medicines as prescribed and safely.

We looked at how medicines were administered, stored and managed in four of the five units.

Medicines were administered safely and appropriately and the staff told people what they were doing. People told us they generally had their medicines in a safe way. One person told us, ''We are looked after well. We get our medicines when we need them.''

Medicines were stored securely in all units. However, the recorded temperature checks of the medicines fridge on Oak unit indicated that the temperate exceeded the safe range on most days. The temperature had not been recorded as checked on three days of the previous month. The properties of some medicines can be altered if stored at the wrong temperature. The staff told us that the fridge had been checked by the provider's maintenance team on the day of the inspection and was the correct temperature. They said that temperature appeared to be too high because of the broken thermometer. However, this issue was identified at our inspection in November 2015 and had been a continuing problem since this time. The staff continued to record the temperature shown on the thermometer and could not be sure what the real temperature of the fridge was. Therefore there was a risk that medicines were being stored at a temperature which was too high or too low and the staff were not aware of this.

The records of medicine administration were accurate and records were clear. However, in Garden Unit we found that the number of tablets of one person's medicines were not accurately recorded. Therefore there was a risk that they had been administered more than the required dose at one time. Some people were prescribed variable doses (one or two tablets) of some medicines. The administration records of these medicines for a number of people did not include the dose administered. Some medicine administration records had hand written changes to the prescribed dose which had been made by the staff at the service. We looked at the care plans and daily records for these people and the information was not sufficiently cross referenced so it was unclear why the staff had changed the dosage or instructions for these medicines. The provider kept separate records for the storage and administration of controlled drugs. These were accurately maintained, however, information about administration of these medicines was not always the same in both the controlled drugs book and the individual administration charts. Therefore it was not always clear which record was accurate.

The provider's procedure required that staff recorded the reason why any ''PRN'' (as required) medicines were administered. The staff had not always recorded this for people who had received pain relief and medicines to help with anxiety or distress. Therefore the provider could not monitor whether these medicines had been administered appropriately.

Some medicines were crushed by the staff in order for people to be administered these covertly (without their knowledge) or when they were unable to swallow tablets. In Donald Sword unit the staff used the same pill crushing device for all medicines and washed this out between uses. We were shown the washed device but found that it contained powdery residue. This meant there was a risk of cross contamination between people. We alerted the staff to this and they immediately made arrangements to purchase new devices for each individual.

The provider had made improvements in regards to the administration of medicines covertly. Where this practice took place we saw that the provider had carried out a mental capacity assessment for the individual which considered their capacity to make a decision about taking prescribed medicines and the consequences if they did not have these. The person's GP, prescribing pharmacist and staff at the service had been involved in making the decision and had signed agreement to this. The records also indicated that the person's next of kin had been involved in the decision making. However, in one case the staff had changed information on these records after the GP and pharmacist had signed the agreement. Therefore, the provider could not guarantee they had been involved in making the changes.

The records relating to the administration of medicines covertly were not detailed enough to ensure that the person always received their medicines in a safe way. There were a number of staffing vacancies at the service and 50% of the nursing staff were temporary staff, mostly from external staffing agencies. Whilst the general manager told us that the majority of agency nurses were the same regular workers, there were occasions when nurses administering medicines were unfamiliar with the home and the people they were caring for. The permanent nurses had a good knowledge of the people they cared for, but this information was not always recorded. For example, one nurse told us about two people who would usually take their medicines willingly. However, there was a multidisciplinary agreement that if they refused the staff could administer these covertly. This information was not recorded and it was not clear how they should be offered and under what circumstances the staff should decide that covert administration was necessary. In another example, one person always had their medicines administered covertly. Although we saw evidence of the multi-disciplinary agreement for this, there was no other information about how the staff should administer the medicines, for example, in food, or what type of food, whether each medicines should be administered separately or how best to support the person for the best chance of successful administration.

Some people were prescribed PRN (as required) medicines, including pain relief and medicines to support people when they became anxious or aggressive. The PRN protocols were completed with varying quality. The majority of them did not record the route of administration, frequency of administration, minimum and maximum time interval between doses, what the medication was for and the expected outcome, the reason for administration e.g. at the request of the person or care staff, a record of consideration of the person's capacity to refuse the medication or whether the medication should be offered at specific times.

For example, one person was administered a medicine for aggression. The protocol for when the staff should administer this stated that staff should give this, ''When patient is agitated.'' However, the care plan for this person indicated that they were frequently agitated. This was also confirmed by the staff. In addition we witnessed a number of interactions where the person was agitated and verbally aggressive towards the staff. The staff were unable to describe the threshold for when this medicine was required. Therefore there was no clear consistency about when the person would receive this medicine and there was a risk of

inappropriate and unnecessary administration.

There were no protocols to describe how people who were unable to verbalise their pain would express this. Therefore the staff did not have the information they needed to know when to administer PRN pain relief.

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

At the inspection of 16 and 17 November 2015 we found that records of care and treatment delivery did not consistently demonstrate safe care and treatment of people. The provider supplied us with an action plan telling us they would make the necessary improvements by 31 January 2016.

At the inspection of 15 August 2016 we found improvements had been made. However, some of the records relating to areas of risk indicated that the staff had not always mitigated the risk. For example, one person who was assessed as at high risk of developing pressure sores required regular repositioning. The person's care plan and repositioning record gave contradictory information and it was not clear how often the person required repositioning. In addition the staff member responsible for the person's care on the day of the inspection gave a different account of how often the person required repositioning. Repositioning a person too often can lead to skin damage, and not enough can lead to the person developing pressure sores. Therefore it is important that records and the care provided for each person reflect their individual need.

In another example a person had been assessed as at risk of malnutrition and they had a low body mass index. Further weight loss would put this person at greater risk. However, the care plan and risk assessment around the person's nutritional need were not detailed or specific about the risks for this person. In addition the person had been weighed monthly rather than more often, which meant they were at risk of the staff not noticing and responding to weight loss in a timely manner.

Another person was identified as having problems with their sight and hearing. However, the care plan only stated, ''aging problems'' and did not identify what the person's needs were and how they should have been supported with this. In another person's care plan there was information about their use of a Percutaneous Endoscopic Gastrostomy feeding tube. However, there was no risk assessment about the care of the site of the tube or the risks of infection for the person and how these could be minimised. Without sufficient information about these risks to people and the support they required they may not have received the right care and this could have led to injury or illness.

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

Good

Is the service effective?

Our findings

At the inspection of 16 and 17 November 2015 we found that the staff did not have a clear understanding of the Mental Capacity Act 2005 and the service had not taken the correct actions to ensure that the requirements of the Mental Capacity Act 2005 (MCA) were followed. The provider supplied us with an action plan telling us they would make the necessary improvements by 31 January 2016.

At the inspection of 15 August 2016 we found that improvements had been made. The general manager had organised training and information sessions for all the staff regarding the MCA. The staff on duty were able to tell us about this and tell us how they would ensure that people were given opportunities to consent to their care and treatment.

We observed the staff offering people choices and giving them the opportunity to refuse care. The staff administering medicines, or offering personal care explained what they were doing in a way the person they were speaking to could understand.

The staff had carried out mental capacity assessments for different aspects of people's care, including administration of medicine's, use of bedrails, hoists and other restricting equipment and consent to receiving care. All assessments had been signed and dated by the person completing these and had been regularly reviewed. The assessments described the person's ability to understand the issue, how they communicated and what would enhance their understanding. They included a plan to show how care should be offered to that person.

We looked at the care plans for a selection of people who were assessed as having capacity to make decisions about their care. We saw that these included evidence of discussion with the person and their wishes regarding end of life care and resuscitation had been recorded. For people who did not have capacity, there was evidence of discussions with their family, powers of attorney or other representatives to make sure decisions were made in their best interests.

Where they were able to people had signed consent to the use of photographs, receiving care and regarding record keeping. There was also a record of verbal consent and how the issue had been explained to people who had capacity but were unable to sign their agreement.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider had made applications for DoLS where people lacked capacity. However, they had not always reapplied for authorisations before these expired.

Requires Improvement

Is the service well-led?

Our findings

At the inspection of 16 and 17 November 2015 we found that there were quality monitoring systems in place however, these were not always effective in identifying issues or used to make improvements. The provider supplied us with an action plan telling us they would make the necessary improvements by 31 January 2016.

At this inspection we saw that improvements had been made. However, the provider's audits did not always identify when something was wrong. For example, the provider undertook regular audits of medicines management. However, these had not identified some of the areas of risk that we found. In addition the provider had failed to respond appropriately to risks they had identified. For example, the medicines fridge in one unit consistently showed a temperature which was too hot for the storage of some medicines. The staff continued to record the high temperature daily. The provider told us they had identified that the thermometer was incorrect, however, they had not changed or repaired this despite the fact it was identified at the inspection of November 2015.

The provider had not always maintained a complete, contemporaneous and accurate record for each person. There were care records which included care plans for each person. However, some of these had not been completed and there were gaps where information about the person's needs had not been recorded. For example, one person had a specific health condition which affected all aspects of their daily life. Although the health condition was recorded, there was no care plan to identify how the staff should support this person with their condition or how this affected other aspects of their life. From speaking with the permanent nurses at the service, we found they had a very good knowledge of people's individual needs and how to support them. However, this knowledge had not been recorded in people's care plans, which meant there was a risk that their needs would not be met if they were supported by other staff. In another example, the staff spoke about a person who had been resistant to care. They said that they had discussed how they should offer care with the person's family member. They also told us that they had certain techniques for responding to challenges from the person to ensure that their needs were being met appropriately. However, the person's resistance to care, how they presented challenges, the discussion about this with the relative and how the staff should respond to this was not clearly recorded. The person's care plans regarding assistance with washing and administration of medicines, areas the staff described as particularly challenging, were not significantly different from three other people's care plans in these areas which we looked at.

Some of the information in care plans was contradictory. For example, people's social interests and hobbies which had been recorded in one part of their records were not reflected in their care plans or in the social activities they were offered.

Care plans did not set out in detail the action which needed to be taken by the staff to ensure that all aspects of the health, personal and social care needs of the person were met. Some care records included a profile which detailed information about their likes and dislikes. These plans also contained bullet point guides for staff on, 'What is important to me'' and ''This is what I like.'' Some plans also included life stories

with photographs which families had helped to complete. However the information from these was not transferred to the care plans regarding their health needs, personal care, social interests and nutritional needs. Therefore there was a risk that their individual needs would not be met. The care plans we looked at contained similar information from person to person and there was limited information about their individual needs and how these should be met. Some people did not have any personal profile, life history or bullet point guides and the only recorded care needs were within the care plans which were not individualised.

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

People told us about how they felt about the service. Their views were mixed, although people generally felt the staff were kind, caring and polite and most people felt the service met their needs. Some of the comments from people living at the service and their relatives included, "He's quite pleased with everything'', "I find it very good. I live here [now] but if I went home I would be alone all the time. There's always something happening here and we have church activities and exercises too. There's a hairdresser here. I've never made a compliant", "I'm very well looked after. I couldn't complain about anything", "It might be better to encourage [our relative] to get out of bed", ''All the staff are so kind", "I can't say I have ever disliked [living here]", "If you don't spell everything out from A to Z they do not hear. I think that this place is understaffed, it is short of necessary funds and they are not able to pay enough attention to their patients who may be quite unwell; I don't blame the staff, I just don't think they are sensitive enough and they have not been well enough trained. But they are willing", "It's very lovely here. I enjoy it very much. The staff always ask if [what they are doing] is alright with me", "The treatment is working'' and "I find it alright here. They treat me alright. I've got nothing to complain about."

The provider had asked people living at the service and their representatives to complete surveys about their experiences. The most recent surveys were conducted in April 2016. People had generally commented positively and felt they were given choices, had access to the care they needed and enjoyed the food. Where people had identified concerns the provider had completed an action plan to state how they were going to address these concerns.

The provider had a number of audits which the staff and managers carried out. These included audits of care records and care provided, an analysis of accidents, incidents, wounds, pressure sores and complaints and checks on the environment. The general manager completed a monthly report which included an analysis of incidents, accidents, complaints, staff training and staffing levels. They regular met with the commissioners to discuss the service and improvements they were making.

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 ensure that care and treatment of service users was provided in a safe way because they had not always assessed or mitigated risks and they had not ensured the safe and proper management of medicines. Regulation 12 (2)(a), (b) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not always assessed, monitored and mitigated the risks to service users or maintained an accurate, contemporaneous and complete record in respect of each service user. Regulation 17(2)(b) and (c)