Vintage Care Limited

Acton Care Centre

Inspection report

48 Gunnersbury Lane
London
W3 8EF
Tel: 020 8896 5600
Website: www.chg.org.uk

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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 16 and 17 November 2015 and was unannounced. We last inspected the service on 22 September 2014 and found there were no breaches of Regulation. Acton Care Centre is owned and managed by Vintage Care Limited. The home is registered to provide accommodation, personal and nursing care to up to 125 people. There are five units and two of these are for people living with the experience of dementia. The service provides nursing care for older and younger adults (people under 65 years) with complex care needs and also provides palliative nursing care.

At the time of our inspection 104 people were living at the service. The registered manager left the service in 2014. We had received registration applications for two managers since April 2014 but both applicants left the service before the registration process had been completed. A new manager had been appointed and they were in the process of applying for registration. 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

People did not always receive their medicines safely. Effective systems were not in place to ensure medicines were stored, administered, recorded and disposed of in a consistent and safe manner.

Accurate and complete records of care and treatment were not being maintained, which put people at risk of unsafe and inappropriate care.

People's capacity to make specific decisions about their care and treatment had not always been assessed. We found the provider had not always taken the correct actions to ensure the requirements of the Mental Capacity Act 2005 (MCA) were met.

There were quality monitoring systems in place, however, these were not always effective in identifying areas where the quality of the service was not so good or used to make improvements.

People were cared for safely by a staff team who received appropriate training and support to meet their needs. People and relatives told us the service was safe. Staff knew how to protect people if they suspected they were at risk of abuse or harm. Risks to people were assessed and management plans to minimise the risk of harm or injury were in place.

People's health and wellbeing needs were monitored and advice was sought from health and social care professionals when required. The staff worked closely with other professionals and services so that people received consistent care. People were involved in the planning of their care which meant their care preferences and choices were identified so they could be met by the staff.

People had positive relationships with staff and people were treated with kindness, dignity and respect. Staff working at the service understood the needs and choices of people, and worked closely with people that were important to them.

The staff responded positively and inclusively to people's changing and diverse needs. Spiritual support was available to all people and their relatives. People and their families were supported to receive individualised end of life care and support.

A complaints procedure was in place. People's concerns and complaints were listened to, addressed in a timely manner and used to improve the service.

There was a positive culture within the staff team with an emphasis on providing a good service for people. Staff were supported, felt valued and were listened to by the management team.

Staff worked with other agencies and used best practice guidance to implement improvements in care practice.

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

Requires improvement

The service was not consistently safe.

People were at risk because their medicines were not always managed in a safe way. Records of care and treatment delivery did not consistently demonstrate safe care and treatment of people.

The risks associated with people's support were assessed, and measures put in place to ensure staff supported people safely.

Staff were knowledgeable about how to recognise signs of potential abuse and aware of the reporting procedures.

There were sufficient numbers of suitably qualified staff to meet the needs of people who used the service. The provider made appropriate checks on the suitability of staff before they started working at the service.

Is the service effective?

Requires improvement

The service was not consistently effective.

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.

Where restrictions to people's liberties had been identified applications had been made to the local authority for authorisation.

Staff were skilled, experienced, trained, supervised and supported and had the skills and knowledge to care for people effectively.

People had access to healthcare professionals to meet their needs and the service worked well with other healthcare professionals to coordinate people's care. People's nutritional needs were met and they had food and drink that met their individual preferences.

Is the service caring?

Good

The service was caring.

People had positive relationships with staff and were treated with kindness, dignity and respect.

Staff working at the service understood the needs and choices of people, and worked closely with people that were important to them.

People and their families were involved in their care and were asked about their preferences and choices. Staff respected people's wishes and provided care and support in line with those wishes.

End of life care was provided in line with people's wishes and preferences.

Summary of findings

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were developed which set out how these should be met by staff. People received personalised care that was responsive to their needs.

People were supported to take part in activities and interests they enjoyed.

People and their relatives knew how to make a complaint if they needed to. Suitable arrangements were in place to deal with people's concerns and complaints.

Is the service well-led?

Requires improvement

The service was not consistently well -led.

There were quality monitoring systems in place however, these were not always effective in identifying issues or used to make improvements.

People's relatives spoke highly of the management and staff team.

There was a positive culture within the staff team with an emphasis on providing a good service for people.

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 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 was unannounced and took place on 16 and 17 November 2015. The inspection team consisted of three inspectors, a pharmacist who was a specialist advisor for CQC looking specifically at how people's medicine needs were being met 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 on this inspection had personal experience of caring for an older relative and using health and social care services.

Before the inspection we gathered as much information as we could about the provider. We asked them to complete a Provider Information Return (PIR). This is a document where the provider tells us key facts about the service and also explains how they believe they are meeting the Regulations. We looked at notifications of significant events, including safeguarding alerts and complaints which we had received about the service.

During the inspection we spoke with 19 people who used the service, 11 visitors and 25 members of staff, including the general manager, the manager, care assistants, senior carers, nurses, the catering manager, catering staff and other administrative and maintenance staff. We spoke with a visiting minister and two healthcare professionals. We used different methods to obtain information about the service. This included talking with people using the service and their relatives and meeting with staff. As some people were not able to contribute their views to this inspection, we carried out a Short Observational Framework Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We looked at ten people's care plans, medicine management records for 22 people and we reviewed other records relating to the care people received and how the service was managed. This included some of the provider's checks of the quality and safety of people's care, health and safety, staff training and recruitment records.

Requires improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe at Acton Care Centre. They were positive about the care and support offered at the service. Comments we received from people included "I feel safe and looked after" and "yes I feel safe here, it's lovely in here, the staff are lovely."

Another person told us they received their medicines on time and staff responded quickly when they activated the nurse call system.

However, we found concerns with how the service ensured that people were provided with safe care and treatment.

The provider did not have suitable arrangements to protect people against the risks associated with medicines. We looked at the storage, recording of receipt, administration and disposal of medicines and people's records in relation to the management of their medicines. We looked at the medicine administration records (MAR) for six people who had been prescribed an anticoagulant medicine which was to be administered in variable doses. For one person the nurse had administered a 1mg tablet on a particular day when the person had been prescribed a 2mg dose. For a second person we saw that a 3mg dose had been administered instead of a 2mg dose and for a third person the record showed that 2mg had been administered instead of 1mg.

For two people we saw that medicines were not administered as prescribed. For one person their asthma inhaler had only been administered daily when it had been prescribed to be given twice a day. For the second person we saw that there were gaps in the recording of weekly medicines that had been prescribed. We asked the nurse about this who was unable to say whether this was a recording error. This meant that people were placed at risk because their medicines were not being administered in line with the prescriber's instructions.

We looked at medicine administration records for two people who received their medicines via a Percutaneous Endoscopic Gastrostomy **(**PEG) tube (a means of receiving nutrition and medicine through the stomach wall when people cannot take food or medicines).The MAR charts contained confusing information such as some medicine having instructions relating to medicine being crushed and given down the PEG and some instructed to be given orally. The nurse in charge explained that staff knew the people that had their medicines this way but it was not clear how the information was clear for agency staff.

A number of people had a 'consent to covert (without the person's knowledge) medication form' in place. These documented this as being in the person's best interest and stated the person did not have mental capacity to make decisions about taking their medicine however, a formal assessment of capacity in relation to this decision could not be provided. We asked staff how they prepared medicines for a person that had them covertly. The nurses explained that sometimes medicines were added to tea or juice, when asked if they had considered that a hot drink may affect the stability of the medicine they confirmed they had not.

On one unit we found that three people's medicines had been dispensed into pots which presented an increased risk of errors as staff were unable to check the medicine, strength and dose at the time they administered people's medicines. For two people we saw that the nursing staff had not followed Nursing and Midwifery standards for medicines management in relation to transcribing. For example, for one person there was no signature and for a controlled drug only one person had signed the entry. This meant that people were at risk because the record had not been checked for accuracy and signed by two skilled and trained staff to ensure people's safety.

Medicines were not stored safely. The provider's medicines policy and current guidance stated that the temperature of the medicine fridge should be between 2 degrees centigrade and 8 degrees centigrade. On Oaks unit we saw that the medicine fridge temperatures had been recorded on multiple occasions as minus 4 degrees centigrade for 12 days. We viewed previous records and saw entries as far back as December 2014 recording a minus temperature.This meant that people had been placed at risk as some medicines had not been stored at the correct temperature.

Medicines were not disposed of safely. We saw that pharmaceutical waste had been discarded into the yellow sharps bin on one unit, instead of the blue bins for collection by a licensed waste disposal contractor.

The manager confirmed that medicine audits were undertaken. We looked at the last two completed audits

and found them to be superficial and not robust enough to identify issues, record findings, plan actions and then to ensure process and staff practices were reviewed to ensure positive outcomes for people in relation to their medicines management.

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

We could not be assured that people were protected from the risk of unsafe or inappropriate care as accurate records were not kept. We viewed records relating to the care and treatment people received. We found gaps in the recording of information, for example no entries had been made for two days in the daily records for a person about the care they had received. For another person we saw that their weight recorded indicated they had lost 8 kilograms in one month. When we asked the nurse about this they told us this was incorrect and the person was eating and drinking well. The wound dressing regime for a person had changed to daily dressings from the 13 November 2015. The records we viewed for this person showed that the dressings had not been changed in line with the instructions. Where people received nutrition via a Percutaneous Endoscopic Gastrostomy (PEG) we saw that records of the rotation of the PEG tubes were not consistently made. For example, the care plans stated that people were to have their PEG tube rotated weekly, records we viewed did not demonstrate this. Staff had not transferred information about a person's needs in relation to their nutrition from the person's hospital discharge summary, into the person's care plan. This showed us that accurate and complete records of care and treatment were not being maintained, which put people at risk of unsafe and inappropriate care.

The above evidence demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were identified and steps were taken to mitigate risks. We saw examples of good risk management and assessments in relation to people's health and safety. Risks including those relating to falls, pressure care, moving and malnutrition were assessed and management plans put in place as necessary. Assessments we viewed had been completed and risks had been accurately rated and recorded. People's care records outlined the potential risks to their safety and the plans that had been put in place to support them to keep safe. For example, where people were at risk of developing pressure sores, we saw that pressure relieving equipment was identified and provided to reduce the risk. Daily checks were carried out of the air mattresses to ensure they were at the correct setting in relation to the person's weight. A person had been referred and seen at the falls clinic and the provider had worked with the commissioners to ensure that additional staff were available to reduce the risk of falls for this person.

All the staff we spoke with had been trained in safeguarding adults. We spoke with staff about their knowledge and understanding of forms of abuse. Comments from staff included "I would report anything that worried me, I would not let it go. Many of the people here cannot speak up for themselves" and "Of course I would report, it is my duty to do so to the people here."

Staff had a good understanding of what safeguarding adults entailed and of their safeguarding responsibilities, could identify types of abuse and knew what to do if they witnessed incidents of abuse. They knew how to raise their concerns and felt confident that if they did raise concerns they would be listened to and action taken. All staff told us they had access to the safeguarding and whistleblowing procedures, which were available on each unit. We saw that safeguarding training was regularly updated for all staff. Records of safeguarding concerns showed that the provider had worked with the local authority and other agencies to investigate these.

People and relatives we spoke with told us there were enough staff to care for them safely. We observed staff attending to people in an unhurried manner and call bells were answered promptly. Care records we viewed detailed the number of staff that were required to carry out the care and support people required. For example, a person required one to one support to minimise the risk of them falling. For another person we saw that they required the assistance of two staff when they had a bath. There was a calm atmosphere throughout the service and we saw various staff members taking their time and speaking with people. For example, we saw the catering manager visiting each unit and speaking with people and checking they were happy with the meal provision. The team included staff that supported people to take part in activities, domestic staff who maintained the cleanliness of the service, administration staff and catering staff who prepared all food and beverages.

Requires improvement

Is the service safe?

People's safety was promoted because staff recruitment procedures were robust. We looked at three staff recruitment records. Recruitment records contained all necessary documents, such as checks for criminal convictions and written references. Staff were only confirmed in post once all checks had been completed and were satisfactory. This showed us that staff were recruited safely to make sure they were suitable to work with people who needed care and support.

We looked at records relating to fire safety. We saw that weekly tests of fire safety equipment were taking place to make sure it was in good working order. Regular fire drills were taking place to ensure that people using the service and staff knew what action to take in the event of a fire. Procedures to be followed in the event of a fire were clearly displayed throughout the service. The facilities team carried out regular health and safety checks to ensure that the service was safe for people, staff and visitors. For example, hot water outlets were checked so that bath and shower temperatures were safe. There were environmental risk assessments in place and the environment was clean and well maintained. We looked at certificates relating to health and safety. We saw that gas, electrical and fire safety certificates were in place and renewed as required to ensure the premises remained safe for staff and people using the service

All accidents and incidents were recorded and there was evidence that the general manager checked these records to identify any actions needed to prevent recurrence and any emerging themes.

Requires improvement

Is the service effective?

Our findings

People, were able to tell us that staff looked after them well, knew what they were doing and cared for them in a professional way. One person told us that staff were good, used the hoist correctly when moving them and were very well trained. A relative told us "They have been really good with my [family member]. They didn't want personal care, they don't bully or anything but they did manage to gentle persuade [family member] to accept help with the shower and [family member] has been happy with the care here."

We observed people making choices about what they wanted for breakfast and lunch, what time they got up and where they wanted to spend their time. Some people chose to spend time in their bedrooms and others in the communal areas. Staff sought people's consent before they carried out any care. For example, we saw two staff seek consent from a person before they used a hoist to move them. For another person we saw staff asking them where they wanted to have their lunch.

However, we found that staff had not always assessed people's capacity to consent to care and treatment. Staff lacked understanding in how the Mental Capacity Act 2005 (MCA) was to be applied in everyday practice so that people's consent to care and treatment was sought in line with legislation and guidance. The service was using a standard form for assessing capacity and assessments we saw were not decision specific as required by the Mental Capacity Act. The assessment tool did not allow for individual decisions to be assessed and staff were applying it in a global way. For example, the capacity assessment for a person detailed that the person had dementia and therefore lacked capacity to make decisions.

We saw that consent to care in people's care records had been signed by people's next of kin. We did not find any evidence of next of kin having lawful authority to give consent. Where people had their medicines administered covertly we saw that there was no assessment or care plan to explain why this was taking place. There was no evidence of a multidisciplinary decision to do this in the person's best interest. Although there was a very general system for every day decisions, there was no system in place to assess people's ability to make specific decisions, when they needed to be made. The provider did not have processes in place to make sure that care was only provided following the principles of the MCA.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLs). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.The general manager told us that applications had been made to lawfully deprive some people of their liberties. We saw that records of this action included a capacity assessment, meetings about their best interest, an application and authorisation from the local authority.The general manager kept an overview document which detailed when the applications had been made, if the application was granted or not, and when renewal was needed.

People were cared for by staff who had received the training they needed to provide safe and effective care. Staff had a programme of induction, training, supervision and appraisal in place. Staff told us about the various training courses they had undertaken including, manual handling, safeguarding, fire safety, infection control and dementia care. A new member of staff confirmed the induction process they had undertaken which included undertaking in-depth induction training and shadowing another member of staff for two days before being allowed to provide care alone. Most staff confirmed they had regular supervision meetings with their line managers as well as group supervision. They told us this allowed them to discuss their professional development needs, the care and support people received and any concerns they had.

Staff spoke positively about the training they had undertaken to ensure people were looked after effectively. Training information showed that all staff received regular training in all relevant aspects of their work. Staff were confident in their work and had a good understanding of the care needs of people, they told us they had training in the areas they needed to support people safely. For example, staff had undertaken training in dementia care, end of life care and spirituality and religion. Records showed that staff had completed at regular intervals a range of training and learning to support them in their work and keep them up to date with current practice. Staff told us they could request any additional or specialist training if

Requires improvement

Is the service effective?

they felt they needed it, such as syringe driver training or tracheostomy training. This showed us that staff were supported to develop the knowledge and skills they needed to perform their roles effectively.

People were appropriately supported by staff with their healthcare needs. Comments we received included "If I have not been well they call the GP". And "The staff arrange for the chiropodist to visit me." We saw timely referrals had been made to other professionals where necessary and accurate records were kept of these appointments and outcomes. For example, we saw that nursing staff had made a referral to a tissue viability nurse about pressure sore prevention and management. We spoke to a visiting therapist who had been called in as a person's hand splints had become too tight due to weight gain. They told us "People here are very well looked after. The staff are good at identifying new needs and what we recommend is always implemented. I would recommend this home." Another visiting health professional told us the staff supported people very well with their complex nursing needs.

Care records showed that staff took appropriate action when a person was not well so that they received the necessary treatment, for example we saw that the GP had been called for a person who was unwell and was sent to the hospital for further investigations. Staff reported that they had good working relationships with other health and social care professionals. They gave an example of how they had worked with the wheelchair service so that a person had a customised wheelchair built so they could be more independent.

People's nutritional needs were assessed and they were supported to eat and drink sufficient amounts and maintain a balanced diet. Where issues had been identified through the assessment, guidance and support had been sought form health professionals. For example, we saw input from the dietician for a person who had lost weight and guidance for staff to follow for a person who had swallowing difficulties. We observed staff following the guidance when supporting people with their food and drink. Where people were unable to take food or drink orally they received nutrition and hydration through a Percutaneous Endoscopic Gastromy (PEG).

The catering team worked with individuals who were receiving end of life care so that they had food that they liked. Relatives spoke highly of the efforts the catering staff had made to ensure their family member had the food they wanted whilst receiving palliative care. They told us that the staff had arranged food for a Diwali family celebration at the service as this is what their family member had wanted. For another person, we saw that they had wanted fish and chips from a chip shop and their request was accommodated. This showed us that people's individual needs and wishes were met.

People told us the food was of a good quality. Feedback we received included "it is always nice and there is a choice", "I prefer to eat in my bedroom" and "I am encouraged to feed myself, but if I need help they are there." Meal choices were available and the menus were displayed in each dining area. Where people had specific dietary and cultural needs such as Halal, Kosher, soft, pureed and diabetic diets information was available on each unit for the staff to refer to. The catering manager met each person and their families so that they could get information on people's likes, dislikes and individual food preferences. Three relatives we spoke with confirmed this. This showed that the service had taken action to ensure people's dietary needs were met.

Good

Is the service caring?

Our findings

People, their relatives and visitors spoke highly of the service. People told us they were at the centre of their care and that staff listened to their personal views and respected them. Comments we received form people included “The place is clean, and I like it. The staff have always been very kind to me and I get the food and drink that I want”, “the staff are very caring”, “I am quite happy”, “the people here are kind and helpful” and “I like everything here really, especially the staff, they are lovely here, it’s like home from home.”

Feedback we received from relatives was positive, Comments included “The ethos of the home is excellent, my [family] member is absolutely safe. If [family member] presses the bell they come quickly, medication is fine, [family] member is always clean and has no bed sores” and “some of the carers are fantastic, they do really care” and “I am happy with the place. The care is good.”

We observed care delivery and watched how staff interacted with people. The majority of interactions we saw were positive when staff were supporting people, for example when assisting them with meals or moving and handling. We saw staff reassuring people and providing them with information before they carried out any care and support. For example, we saw a member of staff discussing a hospital appointment a person was due to attend.

Staff delivered care which promoted and protected people’s dignity and privacy. The people we spoke with said that their privacy and dignity was respected and that staff spoke with them in a calm and professional manner. We observed when staff supported people with their personal care needs the bedroom and bathroom doors were closed to ensure people's privacy.

We observed positive and caring relationships between people, their relatives and staff in the service. We saw staff responding promptly when people needed support. There was a relaxed atmosphere and staff we spoke with told us they enjoyed working at the service and supporting people. They spoke confidently about people’s individual needs, preferences and personal circumstances.

We saw people moving independently on each unit without restriction and they were able to spend time where they wanted to, for example in their bedrooms, communal areas and dining rooms. Visitors and relatives told us they were encouraged to visit at any time and we saw lots of people coming and going throughout our inspection. We observed staff interacting with people and their families in a professional manner, laughing and chatting with people. There was lively banter between staff and people indicating how well staff knew people. For example, we saw a person who was very excited to see a member of staff who had been on leave, they gave the staff member a hug and started chatting to them. This showed that staff had developed positive caring relationships with people who lived at the home.

The service took account of people’s diverse needs. We met the minister from a local church who told us they visited weekly and provided a church service to those people who wanted it. A person told us they enjoyed the weekly church service. The minister said they worked with staff to meet people’s spiritual needs and end of life wishes. The general manager told us they arranged for clergy from all religions to visit and support people if they wanted. Where some people followed the Muslim faith taped Koran readings were available and Arabic speaking staff in the service also read the Koran to them.

People were supported at the end of their life. Family members of a person, who recently passed away, praised the end of life care their relative received. They told us they had been kept well informed by the staff about the different stages of their relative’s condition. One of them said staff “took great care in looking after my [family member], they even arranged a birthday party which all the family came to. The service has been top notch. All the staff have been so helpful – nurses, care staff, cooks and the administrative staff. ” Another relative confirmed they had been involved in the advanced care plan for their family member and told us “”I’m happy for [family member] to be made comfortable here.”

The provider had the ‘Gold Standards Framework’ (GSF) which was an award the service had received and informed people that staff were appropriately trained and competent to care for people nearing the end of their life. People had care plans addressing their end of life care which reflected their wishes, needs and preferences. People were asked for their views on Do Not Attempt Resuscitation orders (DNAR). Where people did not want to be resuscitated their decision had been recorded and staff were aware of people’s wishes. Policies and procedures were in place to guide staff on issues relating to death,

Good

Is the service caring?

dying and bereavement, including dealing sensitively and observing religious and cultural customs. The service worked closely with the palliative care team and GP, records seen confirmed this. A visiting healthcare professional told us the staff were highly skilled and competent in providing palliative nursing care.

Good

Is the service responsive?

Our findings

The care and support people received was responsive to their needs. Prior to using the service, people's health and social care needs were comprehensively assessed to ensure that the service was suitable and could meet their needs. We looked at pre-admission assessments that had been completed for two people that had recently moved to the service. These had been completed with the involvement of the person, their family members and other people involved in their care. For example, relatives told us they were involved in discussions about the care they wanted for their family member and had been asked about their family member's life history, routines and preferences. One relative said "Staff asked me about what jewellery and clothes my [family member] likes to wear."

People and their families were involved in the planning and review of their care needs. We observed staff making an appointment with a relative to discuss how best to support their [family member]. The relative told us "We came here twice before a formal admission. First time we had a look around the place to see if we liked it. Second time we were able to bring pictures, cosmetics and favourite belongings of our [family member] to prepare the bedroom and make it as homely as possible. We are very happy with the home so far". The service held one to one meetings with people and their families to discuss people's care needs. Records we viewed showed us that these meetings took place.

The service was responsive to the people's needs. Care plans and care records were informative and provided guidance to staff on how each person wished to receive their care and support from staff. For example, care records detailed that a person liked to listen to particular music when in their room, when we went to the person's room we saw that staff had followed the guidance for this person.

Some people told us they enjoyed the activities that were on offer such as reflexology, bingo, and games and one to one support. We were unable to meet with the activity co-ordinator during our inspection as they were on leave. The service had two volunteers who were available to read poetry, books and chat with people if they wanted to. We saw staff bringing daily newspapers in for people who wanted them. One person had their magazines on a stand to enable them to read them. We observed one member of staff wheel one person into another person's room as they liked to have a chat. When people were in bed we saw that staff ensured they could reach their personal objects, such as glasses, books or tissues.

We looked at how staff at the service listened to people's experiences, concerns and complaints. People and relatives told us they felt comfortable raising concerns and complaints about the service. The complaints procedure was displayed in the entrance hall and a copy was given to people who used the service and their representatives when they moved in. A relative confirmed they had made a complaint, and as a result there had been an improvement in a specific aspect of their family member's care. We viewed the complaints log. Where a complaint had been received, this had been appropriately acknowledged, investigated and the outcome communicated to the complainant. People could therefore feel confident that they would be listened to and supported to resolve any concerns.

Requires improvement

Is the service well-led?

Our findings

People, relatives and health professionals spoke positively about the management of the service. Comments we received from relatives included "It is very efficient and available; the ethos of the place, it's very good. They are aware of me, they are absolutely spectacular and it comes from the top and I can't praise it highly enough, it's the way they deal with things." And "There has definitely been an improvement in the service over the past 12 months, the staff team is stable, it is calm here and people are cared for."

The provider had in place systems to assess, monitor and improve the quality and safety of the service. However, these were not always effective. For example, medicine audits had not found the shortfalls we found with medicines management. Clinical audits had not been taking place such as wound care, record keeping, care planning and infection control. We found that people's care records were not always complete and accurate.

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

We saw that other audits were carried out to assess and monitor the quality of the service. These included comprehensive health and safety audits, key performance indicator information gathering, contract monitoring reports required by commissioners and staff training. Where shortfalls had been identified we saw that action had been taken. For example, furniture and equipment such as the hoists were replaced.

The service was being overseen by the general manager with support from the senior staff team. They were not the registered manager. Acton Care Centre is required to have a registered manager. We had received two applications for registration in the past eighteen months, however these had not been fully processed as the applicants had left the service. The manager of the service, who had been recently appointed was also the clinical nursing lead, told us they would be applying to register with the Care Quality Commission. The provider had kept us fully informed about the actions they had taken regarding the registered manager, which included any appointments and applications that had been made to meet the requirement of the registered manager condition.

We found all the staff we spoke with to be very professional in their approach, helpful and committed to providing a good standard of care. Staff told us they felt happy working at Acton Care Centre. The agency staff we spoke with said that they were treated as equal members of the team. Staff described a good team atmosphere and said that they felt supported by the management. They told us they were encouraged to progress and continue their professional development through supervision, staff meetings and additional training. Three of the staff we spoke with commented on the availability of supplies saying that the management took pains to ensure they had all they needed to do their job properly.

Records showed that regular meetings were held with the various departments in the service. Staff confirmed that they attended staff meetings. Meeting minutes showed that the staff were given the opportunity to raise any issues of concern and discussions took place about how to improve people's experience of the service. These meetings also informed staff about relevant issues in the organisation and at a local level.

People and their families were asked for their views about their care and support and they were acted on. Relatives told us they provided regular feedback through meetings with the nursing staff, general manager and by completing a feedback questionnaire sent by the provider. People and their relatives were kept informed of developments in the service. A monthly newsletter was produced and available on each unit and in the main entrance area. This provided information on forthcoming events and developments within the service.

From the records we viewed, speaking with staff and relatives we saw the service worked in partnership with other agencies to ensure people's health and social care needs were met. For example, we saw staff ensured that people had appropriate equipment to meet their needs such as customised wheelchairs and armchairs by working with the occupational and physiotherapist. Monthly meetings were held with the Clinical Commissioning Group (CCG) and records detailed that all aspects of service delivery were discussed. Improvements that were required to the service were also discussed and we saw that the provider was in discussion with the CCG regarding the administration of intravenous fluids to people so that hospital admissions were reduced.

Requires improvement

Is the service well-led?

The provider had implemented recognised good practice approaches for working with people who lived with the experience of dementia. For example on the two units that provided dementia nursing care, a mealtime survey had taken place and people received their main meal in the evening and a light lunch. This had resulted in people having a better night's sleep and therefore feeling less agitated and restless.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment of service users had been provided by the registered person without the consent of the relevant person. Regulation 11(1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 provide care in a safe way for people by not having proper and safe management of medicines. Regulation 12 (1) (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 did not effectively operate systems to assess, monitor and mitigate the risks relating to health, safety and welfare of service users and did not maintain an accurate and complete record in respect of each service user. Regulation 17(1) (2) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.