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Colindale Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This comprehensive inspection took place on 17 and 19 December 2018. The first day was unannounced.

Colindale Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Colindale Care Home specialises in providing care to people living with dementia. It accommodates up to 14 people in an adapted house. Individual bedrooms are located on all four floors, and there is a stairlift between the ground and first floors. There were 13 people living there when we inspected.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe and Well Led to at least good. At this inspection, we found that action had been taken to meet the regulations for both of these key questions, although further improvements were required in relation to Safe.

At our last inspection in November 2017 we asked the provider to make improvements to how medicines were stored and managed. This action has now been completed. Medicines were stored securely and managed safely. We have made a recommendation about the recording of variable doses of medicines.

At our last inspection in November 2017 we also asked the provider to make improvements to how they monitored and managed the quality of the service. This action has now been completed. There were arrangements in place to monitor and improve the quality of the service.

The provider acknowledged that refurbishment of paintwork, tiling and carpets was needed in various parts of the home. The provider had already identified and planned to address most of the issues we found.

The premises were kept as clean as they could be, given the maintenance improvements that were necessary, and most areas smelt fresh. Routine infection control measures, such as hand cleansing and staff use of personal protective equipment, were in operation.

Care and support was planned and delivered to promote a good quality of life. People's needs and choices were assessed holistically and their care was personalised according to their individual needs. Assessments and support plans flagged people's sensory and communication impairments and how staff should assist them to communicate. A range of activities was provided, and people were supported to access the local community. People had the support they needed to eat and drink enough. Medical attention was sought promptly if people became unwell or to address unplanned weight loss.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Risks were

assessed and managed with the fewest possible restrictions. Records were up to date, securely stored and readily accessible. Staff understood their responsibilities for safeguarding people from abuse and discrimination. Recruitment procedures protected people from staff who were known to be unsuitable to work in care.

Staff were motivated and proud of their work and there was a strong sense of teamwork. There were sufficient staff to provide the care people needed. Staff had the necessary skills and knowledge. They were supported through training, supervision and appraisal.

People were treated with kindness and compassion. Staff knew and cared about the people they were supporting. They noticed when people looked upset and were quick to support them. They maintained people's dignity and as far as possible promoted their independence.

People were supported at the end of their lives to have a dignified, comfortable death when the time came.

Lessons were learned, and improvements made when things went wrong. Complaints were taken seriously and used to improve the quality of care.

The service had a friendly, homely feel. The provider and staff had informal, open communication with people and their families and friends. Staff reported they were starting to have more communication with the provider and business manager. We have made a recommendation regarding the ongoing development of communication between the management and staff teams.

The provider had developed working relationships with the local authority safeguarding and contracts teams, and this had supported them to plan for and bring about improvements. Legal requirements were understood and met.

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 safe, although further improvements to safety were needed.

Maintenance had fallen behind, and refurbishments were required. The provider had started to address this.

Staff managed medicines consistently and safely.

There were enough competent staff on duty.

Is the service effective?

Good

The service was effective.

Staff applied their learning effectively and in line with best practice, leading to good outcomes for people's care and support.

Staff understood and met their responsibilities under the Mental Capacity Act 2005.

People had enough to eat and drink and got the support they needed with this.

Is the service caring?

Good

The service was caring.

People were treated with dignity, respect and kindness.

Staff took time to get to know people and involved them and where appropriate their families in decisions about care.

Is the service responsive?

Good

The service was responsive.

People received care and support that met their individual needs.

People were supported to keep busy with things that were

meaningful to them.

Complaints were taken seriously.

Is the service well-led?

Good

The service was well led.

Staff understood the need to provide a quality, person-centred service.

There was an open and positive culture. Staff were motivated and worked well as a team.

Quality monitoring and improvement arrangements were in place.

Colindale Care Home

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 was a routine comprehensive inspection. We were aware of concerns about people's safety that had been referred to the local authority safeguarding team. Prior to the inspection, we heard that these concerns had been resolved. However, we took this into account in how we planned the inspection.

The inspection took place on 17 and 19 November 2018. The first day was unannounced. An inspection manager and inspector were present on the first day, with the inspector returning alone for the second day.

Before the inspection we reviewed the information we held about the service. This included statutory notifications about significant incidents such as deaths and serious injuries. We obtained feedback from the local authority safeguarding and contracts professionals. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we met all of the people living at Colindale Care Home and spoke with three of them who were willing to speak with us. However, they were not able to describe their experiences in depth. We also spoke with four visitors, the provider, the business manager and three care staff. We observed how people were supported and examined two people's care records. We reviewed the medicines administration records, staff rotas, recruitment records for two staff, supervision and training records for two staff, premises maintenance records, accident and incident records, minutes of staff meetings and audits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in November 2017 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Medicines. This was in relation to the storage and management of medicines. At this inspection, we found the Regulation was now met as there had been improvements in the way medicines were stored and managed.

Medicines were stored securely and managed safely. There were checks at least daily to ensure medicines were stored at a suitable temperature to maintain their efficacy, both in the medicines cupboard and in the refrigerator. Temperatures had remained within the correct ranges, despite the hot summer. Several people sometimes needed their medicines administered covertly because they refused medicines but lacked the capacity to understand the effects this might have. There were records showing the prescriber had considered covert administration of each medicine to be in the person's best interests. Advice had been obtained from a pharmacist about how the medicines should be mixed with food and drink, so that they remained effective. There were clear instructions for staff about how to administer covert medicines. There were also clear instructions for the administration of as required, otherwise known as PRN, medicines. Protocols for individual PRN medicines were signed off by the GP. Some PRN protocols were not available on file; the provider explained this was because the protocols were with the GP for signature.

Staff who handled medicines had training to do this and their competence was assessed annually. Most medicine administration records (MAR) were pre-printed by the pharmacy and staff checked them for accuracy before they came into use. One handwritten MAR did not have details of the person's allergies; when we highlighted this, staff wrote in that the person had no known allergies. The current MAR started on the first day of the inspection; MAR from the previous month had staff initials each time a medicine had been given and any omissions were explained. There were checks to ensure the quantity of each medicine held could be accounted for. The service avoided carrying large surplus stocks of medicines and ensured that medicines no longer required were returned to the pharmacy each month. Where medicines were prescribed in variable doses, staff had not always recorded the dose given, for example whether they had given one or two tablets. This is an area for improvement.

We recommend the provider prompts staff to record the amount of a medicine given where it is prescribed as a variable dose, and that medicines audits check this has been done.

The provider acknowledged that further premises maintenance was needed. They had started to address this as funds became available, although this is an ongoing area for improvement and will be monitored through future inspections. Bedrooms were being redecorated as they became vacant. Hot water on the top floor ran too hot when we checked it; the temperature restricting valves on these taps were adjusted during the inspection to correct this. The provider thought this was to do with a recent boiler repair. There were areas of scuffed paint in some bedrooms and communal areas. In a bedroom the carpet by the door had snagged, which presented a trip hazard, and the seal around the sink was not intact, making it difficult to clean effectively. There were missing tiles by the door in the kitchen. The provider had already identified these issues and had plans for refurbishment. A radiator in the shared first floor shower room was not

guarded, although it was switched off, and was not fixed to the wall. There was a broken shower chair in the shower. The provider explained that this room was not currently used for showers. They were due to refurbish the room and would be installing a cool-touch radiator. On the first day of the inspection, some old furniture stood on a landing outside someone's bedroom. This was removed by the second day. Some fire extinguishers were not secured to the wall, presenting the risk that they might fall over and hurt someone. The provider agreed to attend to this.

The provider informed us that testing of the fixed wiring, portable electric appliances, fire alarm system and fire extinguishers had been undertaken within the past year. They had been unable to get certificates from the contractor because of the contractor's own issues. However, invoices reflected that this work had been undertaken as the provider said. The most recent gas safety certificate was from February 2017. This should be renewed annually. The provider had relied on the contractor to contact them. They said they would contact the contractor and arrange for the gas safety check to be undertaken as soon as possible. There was a legionella risk assessment in place and precautions, such as checking water temperatures and flushing infrequently used taps, were in place to reduce the risk of legionella developing (legionella are bacteria that live in water systems and can cause serious illness).

The premises were kept as clean as they could be, given the maintenance improvements that were necessary, and most areas smelt fresh. Care staff did the cleaning as well as care duties, and one of them said it would help if there was a dedicated cleaner and that they thought the provider was considering this. For example, people had left toilets unflushed after using them and staff were busy with other tasks, so had not seen that this needed attention. They attended to this promptly when drawn to their attention. The service had been awarded the highest score of five in a food hygiene inspection in February 2018. Antibacterial hand gel was available at the entrance and around the building. Personal protective equipment, such as disposable gloves and aprons, was available for staff. Staff wore disposable aprons while serving meals. There were monthly infection control audits, which had identified the maintenance issues we noted.

Risks to people were assessed and managed, keeping people safe in the least restrictive way possible. People were not able to tell us about how risks were managed, but relatives expressed confidence that their loved ones were safe. Areas of risk assessed included malnutrition, vulnerability to pressure sores, falls and moving and handling. Where risks were identified, these were addressed in people's support plans. Some people had a history of behaving in a way that challenged. Support plans gave clear information for staff about how to support them. Staff told us with confidence how they helped reduce these behaviours by ensuring people felt comfortable and providing distraction.

Records were up to date and readily accessible. Records were updated at least each shift in relation to people's care and support. Staff were able quickly to find records we needed to see. Files were locked away when not in use, to prevent unauthorised access.

People were protected from abuse and discrimination, and from staff who were known to be unsuitable to work in care. Staff understood what constituted abuse and their responsibility for reporting it. They knew how to report safeguarding concerns to statutory agencies concerned with safeguarding adults. Contact numbers for the local authority safeguarding team were displayed in the office. The service had worked cooperatively with the local authority when there were safeguarding enquiries to ensure people's safety and wellbeing. Staff had equality and diversity training, to help them understand and avoid discrimination. Recruitment checks, including criminal records checks and taking up references, were completed before staff worked unsupervised.

There were sufficient staff to care for people safely, providing the care they needed. Although busy, staff did not rush people as they were supporting them. A relative told us how their family member got more attention from staff at Colindale than they had at their previous home. Another relative commented that some months ago there did not always appear to be enough staff, but that this seemed to have been addressed now. Staff said staffing levels had improved since the summer and were now sufficient for them to do all that was expected of them. Staff took turns to do the cooking, cleaning and laundry as well as providing care.

Lessons were learned, and improvements made when things went wrong. Staff recorded accidents and incidents. The business manager signed these forms off after review for any further action needed, such as a safeguarding referral or notification to CQC. There was a monthly analysis to identify themes, such as people and equipment involved, that might indicate additional preventative action was necessary.

Good

Is the service effective?

Our findings

Care and support was planned and delivered in line with current legislation and good practice, promoting a good quality of life. A relative told us how their family member was happy at Colindale Care Home. Another relative commented that their loved one was "far, far better" since moving in. People's needs and choices were assessed holistically. There was an initial assessment before a person moved into the home, so the provider could be sure the service could provide the necessary care. There was a more thorough assessment when they arrived. Support plans were developed based on these assessments. These were highly personalised and covered people's physical, emotional and social needs. There were processes in place to help ensure there was no discrimination, for example due to people's age, sex, sexuality, disability or religion. Staff had training in equality and diversity. Support plans highlighted any aspects of people's lives that were particularly important to them. For example, a person had a traveller background and their care plan highlighted how they enjoyed being outdoors, which was more difficult for them in poor weather. Staff were aware the person might need additional support and distraction over the winter when they needed to spend more time indoors and supported them sensitively.

Staff had the skills and knowledge to provide the care people needed. People and relatives spoke highly of the staff, and staff performed their work confidently. Staff had the training they needed and confirmed this was updated annually. Core training topics included moving and handling, safeguarding, health and safety and fire safety. Different staff told us they had had additional training in managing behaviour that challenges and in dementia care. Some staff had also completed training in managing dysphagia (swallowing difficulties), diabetes awareness and the prevention and management of falls.

Staff were also supported through supervision and appraisal. Staff files contained records of supervision meetings that took place every three or four months. Some staff said their practice was observed but that their supervision meetings were less frequent than this. However, they said they were well supported by senior care staff and were able to talk with them when they needed to.

People had the support they needed to eat and drink enough. There was a two-week rolling menu, which was changed each winter and summer. This reflected a varied menu with vegetables and fruit. A notice on the fridge reminded staff to offer alternatives if people did not like what was presented. Dietary needs were identified and catered for. For example, one person preferred soft food as they disliked the feeling of bits in their mouth, and this was provided. Care staff took it in turns to cook and were aware of people's dietary needs and preferences, also how they liked food to be presented. For example, one person preferred their food to be offered in small portions and this is what they had. Some people presented with desserts while still eating main course, which could be distracting for someone who lives with a cognitive impairment; the provider explained this was usual for these people, reflecting their known preferences. People had snacks and drinks between meals. Staff provided any support people needed in a respectful and unobtrusive way. People's weights were monitored regularly in case of unplanned weight loss, in which case staff would liaise with GPs to request referral to a dietitian.

People were supported to get the healthcare they needed. Relatives confirmed that medical attention was

sought promptly if people became unwell. Care records reflected people's contact with a range of health professionals, such as GPs, district nurses, opticians and chiropodists. Oral health was assessed in line with nationally recognised good practice guidance. People had toothbrushes and toothpaste, although potentially hazardous materials such as denture cleaning tablets were not left out. Support plans specified the assistance they needed with managing this.

There was a system in place to ensure good communication with other services, for example when people were admitted or discharged from hospital or moved to or from another care home. The service participated in the NHS 'red bag scheme' aimed at improving communication between care homes and hospitals. The idea is that when a person needs hospital care, care home staff pack a dedicated red bag that includes the person's standardised paperwork and their medication. Each person had a hospital profile that outlined their health conditions, medicines, any sensory or communication impairments and any other things that care staff must know about them, such as things that could upset them and things they liked and enjoyed. A relative told us they were happy with how their loved one's move from another care home had been handled.

The premises had been adapted so they met people's individual needs, as the building had originally been a private dwelling rather than a care home. There was a stairlift between the ground and first floors for people with restricted mobility. There were toilet and bathroom facilities with mobility adaptations. People chose where to spend their time, whether in their rooms or in communal areas. There was an outside area at the back of the house, which people could access in warmer weather. Where they were able to, people moved freely around the home, for example, spending time in the dining room, which was quieter. Staff supported people who needed assistance to get around safely. There was clear signage, but nonetheless a homely atmosphere remained. Bedrooms were being decorated as they became available, and each room had a criss-cross fabric noticeboard for people to display photographs and letters. People were encouraged to personalise their rooms, for example, with pictures and ornaments.

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. Staff had received training in understanding the requirements of the MCA and understood their responsibilities. Where there were grounds to doubt people's ability to understand decisions about their care, mental capacity assessments had been recorded. If a mental capacity assessment showed a person lacked mental capacity to consent to a particular aspect of their care, staff recorded how they reached a decision about providing care in the person's best interests. Records of mental capacity assessments and best interests decisions reflected how staff had engaged people in the process, considered their known preferences and consulted with their representatives.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). The DoLS require providers to submit applications to a 'supervisory body' for authority to deprive people of their liberty. The provider had followed the requirements in the DoLS. They had applied for authorisation to deprive people of their liberty; these applications were awaiting assessment by the relevant supervisory body.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion throughout the inspection. They often smiled and confidently interacted with staff. There was a settled, warm, welcoming atmosphere. A regular visitor commented, "The staff are very caring" and said of the provider and staff, "They're all very approachable". Staff noticed when people looked upset and were quick to support them.

Staff knew and cared about the people they were supporting; they spoke about people with affection, respect and understanding. They had a good understanding of people's history, things they liked and the sorts of things that might upset them. A visitor described how they valued staff just spending time chatting with their loved one: "When they get a few minutes, they'll go and sit with her and chat with her." Support plans were person-centred. Each support plan included a summary page setting out the key things that were important to the person, and about their life history.

People were involved in decisions about their care. Where appropriate there was meaningful consultation with their relatives, and relatives were kept informed of any concerns about the person. Relatives said: "They'll consult us before they do anything" and "The staff keep me up to date with everything". There was no restriction on visiting times; a regular visitor told us how they could come in at any time they liked and always got "a nice smile" from the staff. People were encouraged to personalise their rooms with pictures, photographs and personal possessions. We noticed some people had changed into nightclothes by 5pm. The provider and staff explained that this only happened if people were happy to do so, typically after they had had assistance with personal care, and that if they were unwilling to, this was respected. They confirmed people got up and went to bed when they wanted to.

Staff maintained people's dignity and as far as possible promoted their independence. For example, a person who had difficulty mobilising but could walk with encouragement and assistance was supported to do so. Staff quickly noticed where people might need assistance, for example to adjust clothing after using the toilet, and discreetly attended to this. Staff sought permission to enter people's rooms and personal care always took place behind closed doors.

Good

Is the service responsive?

Our findings

People received personalised care that met their needs. Support plans were holistic, reflecting people's physical, mental, emotional and social needs. They had been developed in consultation with people, as far as possible, and their relatives. Areas covered included mental health, medical conditions, mobility, continence, washing and bathing, communication, nutrition and spirituality. Support plans were routinely reviewed most months to ensure they were up to date and were also reviewed and updated if there was a known change in a person's needs. Staff had a good understanding of the care and support people needed and they provided this.

The service met the Accessible Information Standard. This is a legal requirement for providers to ensure people with a disability or sensory loss are given information in a way they can understand and have the communication support they need. Assessments, support plans and support plan summaries flagged people's sensory and communication impairments and how staff should assist them to communicate. For example, a person's support plan and summary stated they were partially sighted and set out the assistance they needed from staff to compensate for this. Staff understood how people communicated and provided any support they needed.

People were supported to follow their interests and a range of activities was provided. Although there were no organised activities during the inspection, people were occupied with things that mattered to them. For example, one person was often busy with their colouring book, which they proudly showed us. Staff painted another person's nails, which relaxed them and made them smile. Some people preferred to spend time in their rooms, watching television or listening to music. There was often music playing in communal areas if the television was not on and people looked as if they enjoyed this, for example shutting their eyes and tapping their feet. One of the care staff had responsibility for organising activities. They told us how they encouraged people to do things they enjoyed and that they often put music on as people responded well to this. They said there were regular visiting singers and armchair exercises. A photo board in the lounge showed people enjoying a range of activities, such as visiting animals, and art and craft activities arranged by staff. The provider and staff told us how in more clement weather they took people out, such as going for walks with them or visiting local facilities such as shops or places of worship.

People were supported at the end of their lives to have a dignified, comfortable death when the time came. The provider had accreditation with a nationally recognised end of life care accreditation scheme. People had advance care plans that outlined their wishes for the end of their life and their death. Staff had a 'coding meeting' each month to assess the status of each person's health and whether their death might be approaching, to plan for any care that was needed. They liaised with GPs and district nurses to ensure people's pain and distress were relieved.

Complaints were taken seriously and used to improve the quality of care. The people we spoke with were not able to tell us about their views regarding complaints management. Relatives told us they would feel comfortable to raise any concerns. Information about how to make a complaint was displayed in communal areas. There had been two complaints in the past year. Both had been followed up and resolved

satisfactorily.

Good

Is the service well-led?

Our findings

At our last inspection in November 2017 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. This was because the provider's quality assurance systems had not identified the shortcomings we found in relation to the management of medicines. At this inspection, we found the Regulation was now met.

There were arrangements in place to monitor and improve the quality of the service. The provider and business manager had oversight through discussion with people, their visitors and staff, informal observation, audits and quality assurance surveys. They had themselves identified that maintenance had fallen behind and had plans to address this over the coming months. Audits covered areas such as medicines, falls, the risk of malnutrition, accidents and incidents, hospital admissions, infection control and maintenance. A quality assurance survey from December 2017 had yielded positive feedback. All respondents felt they were welcomed into the home, that staff had a clear understanding of their or their family member's needs, and that relatives were kept informed of significant change and important matters. The provider kept herself up to date with developments in social care through updates from dementia charities.

The service had a friendly, homely feel, which relatives and staff remarked upon. People were comfortable in their surroundings and with staff. When we asked someone what it was like at Colindale Care Home, they told us emphatically, "I love it." A visitor commented, "Very nice team – you never hear anyone arguing". They said their loved one was happy and benefited from the small, homely environment. Another relative explained their family member had transferred from a larger home and that they felt the person now benefited from more individual attention. The relative said they had felt confident to go on holiday because they were not worried about what might happen in their absence. A member of staff commented, "The atmosphere's very good here". The provider sought to maintain a family atmosphere: "It's a family home, it's people's own home."

Staff were motivated and proud of their work. They valued being able to get to know people who used the service and providing respectful care and support. There was a sense of strong teamwork. Staff felt their colleagues respected them, communicated with them well and treated them fairly. They spoke of having a "great team" and that "everyone does their job". Morale had dropped earlier in the year, when there were empty beds and pressure on staffing levels and a valued colleague had left (this person had subsequently returned).

There was informal, open communication with people and their families and friends. There were no formal meetings for people and their relatives, but relatives told us they spoke regularly with, and felt listened to by, the management team and care staff. The provider commented, "I hope people would feel able to say what they want to say."

Staff reported they were starting to have more communication with the provider and business manager, who based themselves in a garden office behind the main building. There had been a recent big staff

meeting, which staff told us had been useful as they had been able to share their views about the service and hear about developments. The provider envisaged continuing with these meetings every six to eight weeks. Staff commented that from day to day they relied on support from their colleagues and from senior care workers, and one said they were feeling better supported now by management than they had been earlier in the year. Although they did not all perceive they had much contact with the provider and business manager, they felt able to speak with them if they needed to. Staff were aware of the provider's whistleblowing policy and felt comfortable to use it should they have to.

We recommend the provider continues to develop open communication between the management and staff teams.

Legal requirements were understood and met. The previous CQC rating was displayed in a communal area as required in law. Records were stored securely to ensure people's privacy and confidentiality were respected. Statutory notifications of significant incidents such as deaths and serious injuries had been made. CQC uses this information to monitor the service and ensure they respond appropriately to keep people safe.

The provider acknowledged that there was scope to improve community links, although people did use community facilities, such as going out with staff to get newspapers. A religious group came in every three months and did crosswords with people but did not preach or leave literature.

The service worked in partnership with other agencies. The provider had developed working relationships with the local authority safeguarding and contracts teams, and this had supported them to plan for and bring about improvements. Staff routinely liaised with people's health and social care professionals.