

Colbury Care Limited

Colbury House Nursing and Residential Home

Inspection report

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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?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on the 27, 28 and 30 November 2017 and was unannounced.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected this service on 31 October, 1 and 2 November 2016 and found the provider was in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued requirement notices in respect of these breaches. Following our inspection the provider sent us an action plan on 29 December 2016 to tell us about the actions they were going to take to meet these regulations.

During this inspection, we found that insufficient action had been taken to meet the requirements of three regulations the service had breached at the inspection in October / November 2016. In addition to this, we found a further two breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to ensure that staff had received such appropriate support, training, supervision or appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Where risks to people had been identified, steps to reduce or mitigate these risks had not always been completed placing people at risk of unsafe care.

Whilst there were some systems in place in the home to monitor the quality of the service provided via audits these were not effective at identifying the areas of concern that we found during this inspection.

People received their medicines safely, accurately, and in accordance with the prescriber's instructions. Medicines were stored safely.

People were protected against abuse because staff understood their responsibility to safeguard people and the action to take if they were concerned about a person's safety. People's rights were protected because staff were aware of their responsibilities under the Mental Capacity Act 2005.

People had access to and were supported with their healthcare needs, including receiving attention from GPs and routine healthcare checks.

People were involved in their day to day care. People's relatives were invited to participate each time a review of people's care was planned.

People were comfortable and relaxed in the company of the staff supporting them.

Staff treated people with dignity, respect and kindness. They knew people's needs, likes, interests and preferences. People were supported to maintain relationships with their friends and relatives.

We recommend that the service seek advice and guidance from a reputable source about supporting people with communication needs or with sensory loss to have access to information in a format they can understand.

We found one continuing breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and identified a further four breaches. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. Where risks to people had been identified, steps to reduce or mitigate these risks had not always been completed placing people at risk of unsafe care.

People received their medicines safely, accurately, and in accordance with the prescriber's instructions. Medicines were stored safely.

People were protected against abuse because staff understood their responsibility to safeguard people and the action to take if they were concerned about a person's safety.

Requires Improvement ●

Is the service effective?

The service was not always effective. Staff had not received appropriate support, supervision and training that would promote good practice to enable them to support people to live their lives fully.

People's rights were protected because staff were aware of their responsibilities under the Mental Capacity Act 2005.

People had access to and were supported with their healthcare needs, including receiving attention from GPs and routine healthcare checks.

Requires Improvement ●

Is the service caring?

? The service was caring. People were involved in their day to day care. People's relatives were invited to participate each time a review of people's care was planned.

People were comfortable and relaxed in the company of the staff supporting them.

Staff treated people with dignity, respect and kindness. They knew people's needs, likes, interests and preferences.

Good ●

Is the service responsive?

The service was not always responsive. The provider did not

Requires Improvement ●

always follow nationally recognised evidence-based guidance when designing, delivering and reviewing care.

People did not have access to information in a format they could understand.

People were supported to maintain relationships with their friends and relatives.

Is the service well-led?

The service was not well led. Staff told us they did not have confidence in the registered manager and did not feel they were supportive or approachable.

Staff meetings took place regularly and although they were encouraged to share their views some staff felt unable too

Whilst there were some systems in place in the home to monitor the quality of the service provided via audits these were not effective at identifying the areas of concern that we found during this inspection.

Requires Improvement 

Colbury House Nursing and Residential 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 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.

Colbury House Nursing and Residential 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.

Colbury House Nursing and Residential Home accommodates 58 people in one adapted building. There were 44 people living at the home at the time of our inspection.

This inspection site visit took place on 27 November 2017 and was unannounced. The inspection was carried out by two adult social care inspector, one specialist advisor and two Experts 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

Inspection site visit activity took place over three days starting on 27 November 2017 and ended on 30 November 2017.

Before our inspection we contacted two health and social care professionals in relation to the care and support being provided at Colbury House. We reviewed the information we held about the home, including previous reports and notifications of incidents the registered provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law.

The provider completed a Provider Information Return (PIR). 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 our inspection we spoke with the registered manager, deputy manager, three registered nurses, 11 care staff, activities co-ordinator, a member of the maintenance team, 17 people living at the home, nine visiting relatives and a visiting GP. Following our inspection we spoke with the provider's nominated individual and one company director.

We looked at the provider's records. These included four people's care records, eight staff files, training and supervision records, a sample of audits, satisfaction surveys, staff attendance rosters, and policies and procedures. We also pathway tracked four people. This is when we follow a person's experience through the service and get their views on the care they receive. This allows us to gather and evaluate detailed information about the quality of care.

Some people were not able to verbally communicate their views with us or answer our direct questions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

At our inspection in October / November 2016, we identified that the provider had not ensured that they were able to respond to and manage major incidents and emergency situations which occurred in the home. Following our inspection the provider sent us an action plan detailing the improvements they would make. During this inspection, we found that sufficient action had been taken to manage these events.

Fire alarm testing and fire drills had been carried out routinely since our last inspection and personal emergency evacuation plans (PEEP) folder located at the entrance to the home contained evacuation details for all except one person who had lived at the service since August 2016. The deputy manager was able to show us a copy of the missing PEEP which was stored electronically and this was immediately placed into the evacuation folder.

At our inspection in October / November 2016 the provider had not ensured medicines were stored, administered or recorded accurately. Following our inspection the provider sent us an action plan detailing the improvements they would make. During this inspection, we found that sufficient action had been taken to manage medicines safely.

There was a clear medication policy and procedure in place to guide staff on obtaining, recording, handling, using, safe-keeping, dispensing, safe administration and disposal of medicines. People's medicine was stored securely in medicine cabinets that were secured to the wall. Only staff who had received the appropriate training for handling medicines were responsible for the safe administration and security of medicines. Medicines that were required to be kept cool were stored in an appropriate locked refrigerator and temperatures were monitored and recorded daily.

Regular checks and audits had been carried out by nursing staff to make sure that medicines were given and recorded correctly. External audits had also been carried out by a visiting pharmacist in March and October 2017. An action point from the March visit had prompted the home to carry out more 'regular' checks of controlled drugs and this action was being followed. Medication administration records were appropriately completed and staff had signed to show that people had been given their medicines. We checked the quantity of medicines held against quantities administered for eight people and found these to be correct. The home used a monitored dosage system with names, medicine details and details of each person with their photograph. Each person had a record of homely remedies that could be given. The list had been authorised by the GP and was reviewed annually or as needs changed. This ensured that medicines were handled and given to people safely.

Where risks to people had been identified, steps to reduce or mitigate these risks had not always been completed placing people at risk of unsafe care. For example, on the 11th July 2017 the registered manager contacted Public Health England (PHE) to seek guidance following an outbreak of gastro-enteritis in the home. Documentation and guidance supplied by PHE, titled, 'Information for Staff', 'Should the home be closed?' states, 'The home should be closed to admissions and transfers until a deep clean has been carried out (not less than 48 hours after the last episode of diarrhoea and vomiting)'. We could find no record of a

deep clean of the premises having been undertaken and in addition the home admitted one person during the outbreak on the 13 July 2017. The registered manager was unable to provide cleaning schedules to evidence that the home had undergone deep cleaning and was unable to provide a rationale for not following the guidance from PHE in respect of admissions. The failure to carry out a thorough cleaning process did not protect people from the risk of infection and therefore put people at risk. The admission by the registered manager of one person against the advice and guidance from PHE also put that person at risk.

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

Incidents were not investigated to make sure that any causes were identified and action was taken to minimise any risk of reoccurrence. For example, during the night visit of 15 June 2017 between 3am and 5am the registered manager had recorded in the managers night visit report that the night nurse on duty had 'signed' the Medicine Administration Records, (MAR's) indicating that everyone had received their prescribed medicine although this was not due until 8am. The night report states that the nurse apologised and said, 'It had been a mistake' and confirmed that these medicines had not been given but would be given in the morning. The nurse did not follow the providers Medications Policy and Procedure section (11) which states, "Record what you do and when you do it. As medicines are given they should be recorded immediately and signed for by the person responsible immediately. We asked the registered manager what actions had been taken in respect of an investigation and a re-assessment of the nurse's competency in relation to the administration of medication and the registered manager told us the nurse was offered 'counselling'. We asked for a copy of the actions taken to mitigate any further risk relating to the health, safety and welfare of people and the registered manager told us, "Sorry it wasn't recorded". Where risks to health, safety and or welfare of people had been identified the provider did not escalate such matters within the organisation or to a relevant external body as appropriate.

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

People and their relatives told us they were felt safe living at Colbury House. One person told us, "On the whole it's very good, there's a nice atmosphere, there's good staff and I have a good relationship with them which is nice". Another told us, "Yes, because of the staff and people can't get in without ringing the bell". A relative told us, "Mum has lived here for a while and is very safe. The staff do call me if they have concerns. I have no worries. One health and social care professional told us, "We do not have any concerns about the home", whilst another told us, "We do not have any concerns at this moment in time about the safety of people living at Colbury House".

The provider had taken appropriate steps to protect people from the risk of abuse, neglect or harassment. Staff were aware of their responsibilities in relation to safeguarding. They were able to describe the different types of abuse and what might indicate that abuse was taking place. Staff told us there were safeguarding policies and procedures in place, which provided them with guidance on the actions to take if they identified any abuse. They told us the process that they would follow for reporting any concerns and the outside agencies they could contact if they needed to.

Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Application forms had been completed and recorded the applicant's employment history, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any

criminal convictions that might make them unsuitable for the post. A Disclosure and Barring Service (DBS) check had been obtained by the provider before people commenced work at the home. The Disclosure and Barring Service carry out checks on individuals who intend to work with vulnerable children and adults, to help employers make safer recruitment decisions. Checks to confirm qualified nursing staff were correctly registered with the Nursing and Midwifery Council (NMC) were also held on file. All nurses and midwives who practice in the UK must be on the NMC register.

There were enough staff deployed to support people and meet their needs. During the day we observed staff providing care and one-to-one support at different times. Staff were not rushed when providing personal care and people's care needs and their planned daily activities were attended to in a timely manner. Staffing levels were kept under review and adjusted based on people's changing needs. Staff told us there were enough of them to meet peoples' needs however the service relied on agency staff to cover many shifts. The provider generally used one agency and the deputy manager told us, "We do have problems recruiting our own staff because we are set in the country with no real links to public transport. We use as far as is possible one agency for consistency of staff and I don't think this has a negative effect on people or the running of the home".

Staff provided care in a timely manner to people throughout our inspection. Staff responded to call bells quickly. People said call bells were answered promptly and staff responded quickly when they rang for help. People who were unable to use this system were checked by staff at regular intervals to ensure their safety but also monitor their needs.

The environment and equipment used within the service was maintained to ensure it was safe. The provider had dedicated staff at the service that monitored all aspects of the environment and the equipment. We reviewed information that detailed the regular maintenance and servicing of mobility equipment undertaken. Environmental aspects such as the fire alarm, fire extinguishers and emergency lighting were tested. Records showed that there were also systems that ensured the nurse call bell, gas appliances and portable appliances were serviced and checked. Mobility equipment used within the service, for example hoists, was also serviced. Equipment such as weighing scales also underwent a programme of recalibration.

Is the service effective?

Our findings

At our inspection in October / November 2016, we identified staff had not received such appropriate support, training, supervision or appraisal as was necessary to enable them to carry out the duties they were employed to perform. Following our inspection the provider sent us an action plan detailing the improvements they would make. During this inspection, we found that insufficient action had been taken to address these concerns and the service remained in breach of the regulations.

Staff had not received appropriate support, supervision and training. All staff had received "mandatory training" updates since our last inspection however some staff had not received all of the training relevant to their role. The service supports people living with dementia, older people and people with physical disabilities however not all staff had received training in these specialisms. For example, only 35% of staff had received training in dementia, dignity and person centred care. Only 8% of staff received training in nutrition and hydration, 9% in End of Life Care, 23% in continence care and 23% in dysphagia. Dysphagia is the medical term for swallowing difficulties.

The registered manager told us, "I started the dementia training but it ran out of steam". Training in these areas would promote good practice and give staff a greater understanding of how to enable and support people to live their lives fully. A number of staff told us that they felt additional training, specifically in dementia awareness, would assist them to understand in more detail how people live with dementia.

Staff had not received regular supervision or appraisals. Supervision and appraisals are important processes which help to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. We looked at the supervision and appraisal records for all staff between January and November 2017. Records indicated that 60% of staff had not received any supervision in that time, 25% of staff had received only one supervision whilst 15% of staff had received between two and three supervisions. One member of staff told us, "We never have them". Another member of staff said, "I had one really early in the year but nothing since". A further member of staff said, "The list he (registered manager) put on the wall last year came down straight after your last visit. I've never had one". Staff did not receive appropriate support or training to enable them to carry out the duties they were employed to do.

This was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

At our inspection in October / November 2016, we identified that the provider had not ensured that staff acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Following our inspection the provider sent us an action plan detailing the improvements they would make. During this inspection, we found that sufficient action had been taken to ensure that staff acted in accordance with this legislation.

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's mental capacity had been assessed and taken into consideration when planning their care needs. The MCA contains five key principles that must be followed when assessing people's capacity to make decisions. Staff were knowledgeable about the Act and its key principles and were able to tell us the times when a best interest decision may be appropriate. Care plans we viewed confirmed people had been assessed as to the level of capacity they had to make certain decisions". For example, one person's medicine was given to them covertly because they did not understand the importance of it and had refused to take it. We reviewed the mental capacity assessment and best interest decision meeting notes that included the person, their relatives, the prescribing GP and other health care professionals.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection 12 people living at the home were subject to a DoLS which had been authorised by supervisory body (local authority). The home was complying with the conditions applied to the authorisations.

People's healthcare needs were considered within the care planning process. Assessments had been completed on people's physical health, medical histories and psychological wellbeing. Arrangements were in place for people's healthcare needs to be monitored through a regular review process. People were supported with their healthcare needs, including receiving attention from GPs and routine healthcare checks. Care records showed people had received visits from health care professionals, such as doctors, chiropodists and opticians. A visiting GP told us, "I visit the service weekly for a ward round and also as required if someone is unwell. In general the residents I feel are supported to maintain good health".

Whilst part of the home was not purpose built, the environment had been adapted as far as was possible to provide a safe environment for people to mobilise around independently. Corridors were narrow in the older part of the home but clear and allowed people to walk in a full circuit around the ground floor of the home. Secure outdoor areas were available during good weather to allow people to walk and sit in the garden. One person told us, "Since I've got this chair I choose what to do and where to go. I got it in the summer and I spent a lot of time outside in the garden. The only problem is getting through that door. I can open the door one way, but not the other. The staff ask if I want to go through and they open it for me".

Fresh drinks were available throughout the day as was fresh fruit and snacks. There were two hydration stations in the main lounge which contained fruit juices. People told us tea and coffee was available when they wanted it and they could have drinks from the machines (hydration stations) whenever they wanted.

Most people we spoke with told us they enjoyed the food served. One person told us, "There's nothing wrong with the food, I don't dislike it. Some of it is very good". Another person said, "It's quite good, there is plenty of choice". Another added, "It's good. My favourite is fish and chips". However one person told us, "Well it was not very inspiring. The food is always lacking in salt, but they do have salt available if you ask for it".

Interactions over lunch period were generally positive. However we did see some less positive experiences for people. For example, people were provided with plastic aprons without explanation or their consent being gained. People were not told what their meal was. Although clean, dinking beakers were heavily stained inside and underneath. There was little conversation between staff and people beyond asking if they

liked the food.

We observed people being supported to eat their meal in the dining room and in their own rooms. In the dining room support was not consistently person-centred. One member of staff was standing up whilst supporting a person with their lunch and there was no interaction with the person. We also observed this lack of person-centred practice for people being supported to eat in their own rooms. However, we also observed instances of positive practice in people's own rooms where the members of staff were sitting down by the bed, talking with the person whilst they supported them with their lunch.

Is the service caring?

Our findings

People and relatives told us staff were caring and looked after them well. People were comfortable and relaxed in the company of the staff supporting them. One person said, "On the whole it's very good, there's a nice atmosphere, there's good staff and I have a good relationship with them, which is nice". Another person told us, "Everyone talks to you and they come in and have a chat". Another person added, "The girls are all very nice. Some are better than others but generally they are all ok". One relative told us, "I have no concerns at all about the care my relative receives although I do think the carpets could be cleaner". A second relative added, "Mum is very happy here and that makes me happy. The care is good and I know they do the best they can for her".

People's privacy was promoted and respected. A number of people told us they liked to spend time in their rooms but could choose to sit in the communal areas if they wished. People's bedroom doors were pulled shut unless the person expressed a preference to have the door open. Staff knocked on bedroom doors and waited for permission before entering. People told us staff always did this and that they respected their privacy, one person saying, "They are very good at respecting my privacy. They never come into my room without asking". Another person added, "Yes. If they have a male carer they don't usually come into this room. Well, they will bring you a cup of tea, but that's nothing is it"?

People were supported to make sure they were appropriately dressed and that their clothing was arranged to ensure their dignity. Staff were seen to support people with their personal care, taking them to their bedroom or the toilet/bathroom if chosen. Staff provided clear explanations to people before they intervened, for example when people were helped to move from an armchair to their wheelchair using specialised equipment. Staff checked at each stage of the process that people were comfortable and knew what to expect next. Staff promoted independence and encouraged people to do as much as possible for themselves.

People were able to spend private time in quiet areas when they chose to. Some people preferred to remain in a quieter sitting area when activities took place in the main lounge. This showed that people's choices were respected by staff. There were other areas within the home to allow relatives opportunities to speak with staff privately about the care provided to their loved one.

People's care plans and daily care notes were stored electronically. Each member of staff carried an electronic mobile device that enabled them to input care and support they had given 'as it happened'. One member of staff told us, "I like this system. We log everything as we do it so our notes are always up to date. Nothing gets missed and staff coming on duty can see at a glance how that person is today". A relative told us, "This system is very good. I can go to anyone when I visit and get an update on how mum is, even if that person hasn't actually been involved in her care".

Each person's physical, medical and social needs had been assessed before they moved into the service and communicated to staff. Pre-admission assessment of needs included information about people's likes, dislikes and preferences about how their care was to be provided. Care plans also included a 'life diary'

which documented people's upbringing, early life, education, teenage years, career and work, social and recreational interests and personal achievements. Care plans were developed and maintained about every aspect of people's care and were centred on individual needs and requirements. This ensured that the staff were knowledgeable about the person and their individual needs.

People were involved in their day to day care. People's relatives were invited to participate each time a review of people's care was planned. A relative told us, "We are pretty involved so we get plenty of notice if anything is going to change. I was in two weeks ago for a meeting about her (relative) care".

Is the service responsive?

Our findings

Some people did not receive personalised care that reflected their needs. For example, one person's care plan indicated they were at risk of developing pressure ulcers and should be repositioned every two hours. We looked at the turning charts for this person between 20 and 26 November 2017 and records showed that only half of the prescribed turns and repositioning were carried out in any 24 hour period. Another person's care plan indicated they should be turned and repositioned every four hours. Records were inconsistent with some turns recorded at five and a half hours apart whilst other turns were undertaken within two hours of each other.

We also checked the pressure relieving mattress settings for 13 people who were at risk of developing pressure ulcers. Twelve mattresses were incorrectly inflated and did not take into account the body weights of people. For example, one person's mattress setting was 80kg with a body weight of 49.4kg. Another was set at 95kg with a body weight of 49.kg whilst a third was set at 80kg with a body weight of 47.5kg. The pressure settings for this type of preventative treatment should be set taking into account the person's weight as outlined in The National Institute for Health and Care Excellence (NICE) guidelines for the prevention and management of pressure ulcers: Clinical guideline [CG179] Published date: April 2014 which states; Pressure redistribution devices work by reducing or redistributing pressure, friction or shear forces. Devices include high-specification mattresses, pressure redistribution cushions and equipment that off loads heel pressure. The type of device a person needs will depend on their circumstances, for example, their mobility, the results of the skin assessment, their level of risk, the site that is at risk, the person's weight and the person's general health. Using pressure redistribution devices as soon as possible can prevent pressure ulcers developing and help to treat them if they do arise, ensuring patient safety and improving the experience of people at high risk of pressure ulcers. People were therefore at risk of developing pressure ulcers because the provider had failed to ensure they used nationally recognised evidence-based guidance when designing, delivering and reviewing care.

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

We asked the registered manager how they ensured that all people had access to the information they need in a way they can understand it and are complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The registered manager was unable to tell us or provide evidence that the service had taken any steps to comply with the Accessible Information Standard to identify, record, flag, share and meet the information and communication needs of people with a disability or sensory loss.

We recommend that the provider seek advice and guidance from a reputable source about supporting people with communication needs or with sensory loss to have access to information in a format they can understand.

Relatives told us they had shared information about their family member when they first went to live at Colbury House such as their medical history and previous lifestyle, to help develop their care plan. They said that staff seemed interested to know about their family member. One relative added, "Yes they wanted to know everything about (person) it was all very positive. I spent a long time with them so they had all the information they needed". A second relative told us, "He (registered manager) came to the hospital to speak with us before (person) came here. It was to make sure they could look after them I suppose. I remember the staff at the hospital were also involved and I think a social worker. It seems to be going ok".

Care records included care needs assessments, risk assessments and care plans. Initial assessments included the person's medical history and a life history these contained details of the person's education, employment, marital status, holidays / interests and pets. There was a photograph of the person, details of any known allergies and of their family relationships. Risks that were identified during the assessment process were not always recorded in risk assessments that detailed the identified risk and the action that needed to be taken to minimise the risk.

Assessment and risk assessment information had been incorporated into an individual plan of care. Topics covered in care plans included eating and drinking, continence, mobility, personal hygiene / dressing, skin care / pressure relief, health needs (including medication), breathing, communication, pain, end of life care and social activities. People and relatives told us that the service they received was flexible and based on the care and support they wanted. Comments from people for example were, "I'm satisfied with them, the food and how they treat you. They will do your shopping if you want anything special and they don't have to do that", "I'm very satisfied. All my family know I'm happy here. I would recommend it to a friend", "It's alright. It's as good as any other home" and "I'm satisfied generally and very satisfied". One relative said, "I am pretty much always here so I know they do a good job". Other comments from relatives were, "It's very good", "The staff are very helpful" and "We're very happy".

People's individual assessments and care plans were reviewed with their participation or their representatives' involvement. Care plans had been updated to reflect any changes to ensure continuity of their care and support. Updates had been made when people's medicines or health needs had changed. One relative told us, "The home reviews the care plans regularly and we are always invited to attend". Another relative told us how their family member's general wellbeing had improved since they had moved to the home because staff had worked with them to ensure the care and support they received was tailored to meet their individual needs.

The provider employed a full time activity co-ordinator and a variety of activities took place throughout the day. For example, arts and craft, exercise groups, board games and cooking and baking. There were also weekly church services and visiting entertainers. The activities co-ordinator told us, "I work hand in hand with the staff. Sometimes I notice changes in people, for example if someone's mood is low and I tell the nurse who will check all is alright". During the morning of our first day of inspection eighteen people were involved / participated in the morning activity. The activity coordinator greeted each person as they came for the activity before moving on to a quiz. Throughout the activity people were offered snacks such as fresh fruit, biscuits and drinks. People who lived at the home told us that there were activities available, but some of the people who we spoke with told us they chose not to take part. One person told us, "There is a list on the wall of what we are doing. It's not always my cup of tea so I may stay in my room and watch TV". Activity records showed what people had participated in, how their engagement had been agreed, whether people had enjoyed the activity and an observation of their mood. The activities co-ordinator told us, "This helps to identify people who are at risk of social isolation. If that happens we try to get them more involved or I go to see them in their room and we have a chat about what they would like to do and we try something different".

People's rooms were personalised and furnished with their belongings, such as their own furniture, photographs and ornaments. The home worked with people and their relatives to ensure they felt at home as much as possible.

People told us that their relatives could visit at any time and that their relatives and friends were made welcome. One person said, "My daughter comes every week, she's always in contact. The reception lady gets in touch if needed". Another added, "You're allowed to have visitors. They have to buzz to come in and they can stay as long as they like. My daughter stays 'til 9.00". A third person added, "My son lives local. Staff help if I want to contact him. They do it for me". A relative told us they felt reassured that they were able to visit whenever they wanted. They also felt supported in making decisions regarding the care and treatment of their relative. They added staff were very caring and thoughtful. Staff told us that they helped people to keep in touch with their family and that they would take a telephone to people so they could speak to members of their family and friends if they wanted to.

The provider kept a complaints and compliments record. People and relatives told us they knew how and who to raise a concern or complaint with. The complaints procedure gave people timescales for action and who in the organisation to contact. People told us that if they were unhappy they would not hesitate in speaking with the manager or staff. Relatives were familiar with the provider's complaints procedure which was on display at the entrance to the home and said they would speak to the registered manager directly. One person told us, "I would go to one of the nurses if I had complaint. I feel comfortable speaking to her and she gets things done. There are ways of doing a written complaint. I've not done that, I've not had to. I was satisfied with the nurse's response".

People's wishes and decisions they had made about their end of life care were recorded in their care plans when they came into the service. A GP told us, "I am impressed by the delivery of end of life care. People pass with dignity and I have had no adverse feedback from relatives. Indeed quite the opposite".

Is the service well-led?

Our findings

At our last inspection in October / November 2016 we found that the provider did not always maintain an accurate, complete and contemporaneous records in respect of some service users, including a record of care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The provider sent us an action plan detailing the improvements they would make to people's care records and we saw that these had been completed.

Whilst the provider had some systems in place in the home to monitor the quality of the service provided via audits on areas such as health and safety, infection control, medicines, and care plans, these had not been effective at identifying the areas of concern that we found during this inspection. We found for some audits they did not detail clearly what areas were required for improvement, giving only yes and no answers. Where issues had been identified not all the audits undertaken had resulted in an action plan. This meant that the provider was unable to demonstrate whether any actions had been taken to address the issues raised. In other cases where audits had generated action plans we saw these actions had not been followed up to ensure that the improvements required had been made.

Records relating to night spot check visits by the registered manager did not fully reflect or report on the findings of those visits. For example, on 30 January 2017 and 15 June 2017 the registered manager made unannounced night visits to the service. The manager's night visit inspection reports contained information that was identical to a previous night visit report we viewed dated 15 June 2016. We were unable to establish that reporting on these two occasions was reliable and factually correct. We raised our concerns with the registered manager and when asked for an explanation he replied, "I'm sorry I made a mistake". The provider did not have systems in place to ensure that their audit and governance systems were effective.

The provider also carried out regular audits of the home. These looked at areas such as, care records, medicines and staffing. We reviewed the provider audit carried out in June 2017 and found this did not reflect our findings at this inspection in respect of staff supervision. For example, to the question 'Do staff supervision's take place three monthly?' the answer was 'Yes'. Monthly regulatory visits to the service were also undertaken by a manager from another service in the provider's portfolio. These started in April 2017 however these were not undertaken monthly as prescribed. The registered manager could only provide records for visits on 27 April, 27 July and 20 September 2017. The inspection visit reports contained little information and areas of concern that were noted did not always contain information that issues had been addressed. The visit report dated 27 July 2017 stated, "A recent gastro-enteritis infection had been dealt with promptly and efficiently. Appropriate advice from governing agencies had been sought". Whilst this inspection found that appropriate advice had been sought the registered manager had not dealt with it promptly and efficiently as reported in the Safe section of this report. The visit report dated 20 September 2017 notes, 'Staff state they do not always feel supported and felt under-valued and not appreciated and two staff expressed a lack of support after reporting issues to other staff'. We could find no evidence and the registered manager was unable to show us any records of how staff who had expressed concerns about the leadership of the home, the lack of support had been investigated and addressed.

This is a breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

Staff told us they did not have confidence in the registered manager and did not feel he was approachable. Staff we spoke with raised concerns about the registered manager's ability to oversee the service, confidentiality and attendance in the service. They said they would not feel confident raising any concerns with the registered manager.

One member of staff told us, "He is not supporting us. He spends most of his time, when he is here, in his office". Another member of staff told us, "I am scared to report things to the registered manager because I am made to feel like a trouble maker". Other comments from staff included, "The registered manager does not recognise or praise staff and is not supportive", "I don't think we have moved forward since last year. We have some great staff here who care very much but there is no leadership support. He is rarely here and is not managed by head office. Lack of leadership brings this place down" and "There is a blame culture here. If this inspection is good, and I doubt it will be, then it will all be about him (registered manager). If it's bad and I suspect it will be it will be everyone's fault but his (registered manager).

Staff told us that team meetings took place regularly and although they were encouraged to share their views some staff felt unable to. We looked at staff meeting records for May, June and November 2017. Topics covered for example were, medication, nutrition, care plans and staffing. One member of staff said, "Yes we have them. I do attend but I don't feel I am able to have any positive input. It's all a bit classroom like". Another member of staff added, "The meetings we have are really pointless. Once the registered manager said, "We needed to be kinder to each other and more respectful. Respect should be a two way thing but not here it isn't".

At the conclusion of the inspection two inspectors met with the registered manager and deputy manager to share our findings and concerns. In response to some of the comments we received from staff in relation to the registered manager's leadership the registered manager's response was, "Leadership can't change the personalities of people recruited. I struggle with the staff comments. My door is always open. Some staff come in and some don't.

Following our inspection we spoke with the provider's nominated individual who made us aware the registered manager had resigned following our inspection. We forwarded a copy of our feedback record to them at their request. Following our conversation the provider wrote to us to advise us of actions they were putting in place to address the serious concerns we had raised. The provider had recognised in their action plan that these concerns required addressing promptly. However, while we understand the provider was putting some actions into place, these were only as a result of our inspection. Given our concerns identified and the provider's culture for identifying, responding and actioning concerns, we do not have the assurance that the provider would have taken serious and robust action without our input.

Overall, people living at the home and their relatives told us they thought the home was well run. All those we spoke with said they would recommend the home to others. Comments included; "Overall, it is ok. I don't know if I would/would not recommend the home"; "Yes, I would recommend the home to people", "When I first came here it was well run and now it has declined" and "the girls (staff) are all lovely". Relative's comments included, "There are always a lot of staff about. They are quite cheerful. I think they've got to know us now", "(person) looks better than she has for a long time", "The staff are lovely, you can talk to them", "Absolutely fine here, our relative won't come out of her room; they encourage her but it's her wish to stay there, but they do try".

The provider used an annual questionnaire to gain feedback on the quality of the service. These were sent to people living in the home and relatives. The feedback received from the last survey carried out in June 2017 indicated that most people were satisfied with the service being provided. Comments included, "The care at Colbury is amazing, It is a happy place", "I am very pleased with the care my uncle receives" and "Many thanks to all the staff who sometimes have to put up with such a lot".

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	The provider failed to carry out a thorough cleaning process to protect people from the risk of infection and therefore put people at risk.
Treatment of disease, disorder or injury	The admission of one person against the advice and guidance of an appropriate body also put people at risk.
	The provider failed to ensure care and treatment was provided in a safe way for people at risk of developing pressure areas.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	The provider had failed to escalate identified risks to the health, safety and welfare of people within the organisation or to a relevant external body as appropriate.
Treatment of disease, disorder or injury	Quality monitoring systems were not effective enough to ensure compliance with the Regulation's. The provider needed to ensure the systems became embedded into practice.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Diagnostic and screening procedures	Staff did not receive such appropriate support, training, supervision or appraisal as is necessary to enable them to carry out the duties they are employed to perform.
Treatment of disease, disorder or injury	

