College Care Limited

College House

Inspection report

20 College Road
Fishponds
Bristol
Avon
BS16 2HN

Tel: 01179651144

Date of inspection visit:
28 April 2016

Date of publication:
27 June 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

We carried out a comprehensive inspection of College House on 20 November 2014. Breaches of the legal requirements were found. The breaches related to medicine management, cleanliness, staff training, consent, record keeping and the running of the home.

We carried out another comprehensive inspection of College House on 28 April2016. This was the first inspection of the home since it was registered under a new provider in March 2016.

College House is a 20 bedded home that provides accommodation for persons who require personal care. At the time of our inspection there were 18 people living in the care home.

There was a registered manager in post at the time of our inspection. 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. The registered manager had remained in post following the change of provider.

At our comprehensive inspection on 28 April 2016 we found breaches relating to the care and safety of people using the service, as well as matters relating to record keeping, staff training, medicine management and the running of the home.

Some risks to people were assessed, however other risks had not been identified. Where risks had been identified, insufficient actions were taken to keep people safe. Hazards and risks were identified in the management of the environment and these posed a significant risk of harm to people using the service.

There were shortcomings with the management and security of people's medicines. Medicines were not stored, recorded or administered safely. Whilst the provider had a policy and procedure in place, this did not provide instruction and guidance in some of the areas where shortcomings were identified.

The service provided sufficient numbers of staff. However, the staff did not receive adequate and sufficient training to enable them to meet people's needs effectively.

We found the service was caring. People spoke positively about the staff and how well they were supported in the home. Staff enjoyed their roles and spoke with kindness about the people they provided care and support to.

Whilst efforts were made to address people's needs, people's care records did not accurately reflect all their support needs. Records were not always up to date and complete. This placed people at risk of unsafe or inappropriate care.

People were not fully protected when they were unable to provide consent to care and treatment. The Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. This is to make sure people are not deprived of their liberty unless authorisations are in place.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking enforcement action against the provider. We will report further on this when it is completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments were not always completed. Risk management processes were not effective and actions were not always taken to minimise the risks of harm to people.

People's medicines were not safely managed. The standard of recording, storing and administering of medicines was poor. This placed people at risk of not receiving their medicines when they needed them and in a safe way.

Robust recruitment practices were not consistently followed. Appropriate references were not always obtained before new staff started in post.

Staff demonstrated awareness of safeguarding procedures and knew how to report concerns about people's safety.

Is the service effective?

Requires Improvement

The service was not effective.

People were protected against the risks of malnutrition and dehydration. However, the supporting records were not always accurately maintained.

Staff did not receive sufficient training to support them to effectively care for people.

Is the service caring?

Good

The service was caring. People felt respected and well cared for by staff.

Staff provided care to people that was kind and attentive.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider completed care plans that demonstrated a personalised care approach. However, the supporting records were not always in place.

People were not fully and accurately informed about their right to complain about the service.

Is the service well-led?

Requires Improvement

The service was not well-led.

Governance systems to monitor the safety and quality of the service were not in place

People's records were not always accurate and up to date.

Policies and procedures were in place, but some of these were inaccurate and incomplete.

College House

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.

We undertook a comprehensive inspection of College House on 28 April 2016.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by one inspector. Before carrying out the inspection we reviewed the information we held about the care home.

During our inspection we spoke with four people who lived at the home and with one visitor. We also spoke with the registered manager, the home manager, four staff and two health professionals. The registered manager was in charge of the overall running of the care home and the home manager reported directly to them. The day to day arrangements were that the home manager managed the care home during the week and the registered manager provided support to the staff teams at weekends.

We made observations of staff interactions with people during the day and we observed medicines being given to people.

We looked at four people's care records. We also looked at medicine records and records relating to the monitoring and management of the care home.

Inadequate

Is the service safe?

Our findings

We spoke with people who told us they felt safe. Comments included, "Yes, I feel safe and I can always call for help using my buzzer", and "I always feel safe and looked after here." A relative said, "When I leave, I always feel that Mum is safe here." However, we found risks to people's safety were not always assessed or sufficiently managed. Safe care was not always delivered.

One person used a pressure relieving mattress and bed side rails. The pressure relieving mattress, supplied and fitted by external health professionals, was not a suitable fit. The person had received an injury as a direct result. The registered manager had taken action which they believed would reduce the risk. However, the actions taken were not sufficient and adequate to mitigate the risk of further injury. We brought this to the attention of a health professional who was visiting on the day of the inspection. The following day the home manager contacted us to confirm a health professional had reviewed the situation. Whilst an acceptable solution had not yet been agreed, the home manager told us they had taken action to make sure the person was safe.

Risk assessments were completed, for example, for falling, nutrition and moving and handling. We saw some risk management plans were fully completed and provided detail of the care people needed to keep them safe. They also provided detail of where advice and guidance had been sought from other health professionals. However, in two assessments we saw the level of risk had not been correctly recorded. For another person, they were at risk of injury and the care plan stated they needed to be checked every 30 minutes when they were in bed. There was no evidence this was completed. We spoke with staff about the frequency this person was checked and they were not sure. One member of staff told us, "I think we check her every hour when she is in bed." This meant people were at risk of not receiving the care they needed to be safe.

Accidents and incidents were recorded and the care plans provided detail of actions taken at the time. One person had repeated falls and was referred to a falls clinic. Actions had been taken, the person had been supplied with a wheelchair safety belt, and they had not fallen since December 2015. The manager told us an occupational therapist had initiated the use of the safety belt for the person. Whilst it was clear the safety belt was being used for safety reasons and not as a means of restraint, this was not recorded in the person's care plan.

People accessed the first floor either by the staircase or a stair lift. A further staircase on the ground floor led down a steep staircase to the manager's office and storeroom. The door to this staircase, located next to the kitchen, was not locked. The home manager told us people sometimes opened the door to call down to them when they were in their office. They had not recognised the risks this posed to those people who were unsteady, used walking aids or who were confused. The risks to people had not been identified. This meant people were at risk of falling down the stairs.

People had a 'pull cord' or a buzzer on the wall in their bedroom so they could call for assistance. They were answered by being turned off at a central call bell point in the main corridor before the staff answered the

person's call for help. Most call bell systems are cancelled at the point of the call, which means staff have to attend where the person is calling from before the call is switched off. A recent meeting with people who used the service was held on 31 March 2016.
The notes from the meeting included the following, "All present were told if they cannot reach a call bell then all they need to do is shout or bang something." There was no suitable or sufficient system in place to make sure call bells were accessible or other actions taken to support people unable to use or access their call bells. This meant people were at risk of not being able to summon help when they needed it. The home manager told us they recognised the call bell system required upgrading and they were obtaining replacement quotes.

The home manager told us thermostatic mixer valves in place to control the temperature of water from sinks and baths. However, they had no system in place to routinely monitor the effectiveness of the valves. They had no system in place to assess, monitor or control the risks associated with legionella bacteria. This meant people were at risk of harm because the provider did not make sure facilities within the home were safe.

The lack of systems in place to assess, monitor and mitigate risks to the health, safety and welfare of people were breaches of Regulation 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home manager contacted us after the inspection and told us they had contacted a company who would visit the care home on 5 May 2016 to discuss legionella testing.

The systems for storing, administering, recording and disposing of medicines were not safe. The provider had a policy and procedure, but this was not detailed and was incomplete. For example, it did not provide guidance with regard to covert medicines or medicines to be given when required. In addition we found the legal requirement for storage of medicines that required additional controls was not being met.

Records were not maintained for the amounts of medicines received into the home, or for those returned to the pharmacy, with the exception of medicines that required additional controls. This meant staff were unable to check the stock levels to safely monitor people's medicines.

Records were maintained for medicines that required additional controls. However, we found one occasion where the amount received was not recorded. In addition, we found these medicines were not stored safely or in accordance with the legal requirements of the Misuse of Drugs (Safe Custody) Regulations 1973. The administration of these medicines was not being recorded using an appropriate format. This meant that important information about people's medicines could be mislaid.

People were asked if they needed any medicines that were prescribed 'when required', for example pain relief. The records did not provide information about the types of pain people experienced. The records did not confirm the effectiveness of the pain relief. However, the home manager clearly knew and explained to us the types of pain people experienced for those people they gave pain relieving medicines to.

The home manager signed the medicine administration charts (MARs) before they saw that people had actually taken their medicines. We also saw they gave medicines to other members of staff to give to people. This meant people's records may not be accurately maintained and people were at risk of not taking their prescribed medicines when they were needed.

The home manager told us one person had one of their medicines administered to them covertly by staff.

This meant the person received their medicines in a disguised way. However, although the manager told us there had been discussions and it had been agreed this was appropriate for the person, this was not recorded. This meant the person may not have received the medicine lawfully and in their best interests.

One person was prescribed a variable dosage of pain relieving medicine. The actual amount of medicine given on each occasion was not recorded. This meant the effectiveness of this person's medicine could not be determined.

Some topical creams were stored in the medicine trolley and signed for when they had been given. There were other topical medicines in people's bedrooms. Some of these had not been dated when opened, and one had been dispensed in June 2014. These topical medicines were not recorded as prescribed on the MARs and staff did not record when they applied the creams. This meant people may be receiving treatment that was no longer effective, not in accordance with a prescription and the effectiveness of the treatment was not accurately monitored.

The lack of safe systems for the management of people's medicines was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training and their competency was checked by senior staff, before they were allowed to administer medicines on their own.

Staff were not always safely recruited. We checked the recruitment files for four staff, and found for three staff, appropriate checks had been completed. These included completion of application forms, proof of identity, references and an enhanced Disclosure and Barring System (DBS) obtained. The DBS ensures people who are barred from working with certain groups of people, such as vulnerable adults, would be identified. For one member of staff, references had not been obtained. They had worked in the care home for five months.

For another member of staff, their references were obtained after they started in post. One of the references did not state who completed the reference. The only information on the form was the date and a signature. This meant people were at risk of being cared for by unsuitable staff because appropriate information about their conduct in previous job roles had not been obtained. Interview notes were completed, but these were not signed. A senior member of staff told us they usually attended interviews for staff with the home manager. This was not recorded.

This was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with were complimentary about the staff and told us there were enough staff available to provide support to them. We spoke with staff who told us the staffing levels were sufficient and they were able to meet the needs of the people living in the home. The home manager and registered manager told us of the challenges they had with staff recruitment. They currently had two full time care staff vacancies. A dependency assessment tool was not used to monitor the changing needs and numbers of people living in the home. We looked at the staff rotas and saw there was consistency in the numbers of staff on duty each day.

Staff were able to describe their roles and responsibilities with regard to recognising abuse. They were able to describe how they may recognise if a person was being abused. They told us the actions they would take. One member of staff told us, "I would speak with one of the managers and if they didn't do anything I would

contact CQC." A copy of the local authority guidance with contact details was available for staff.

Requires Improvement

Is the service effective?

Our findings

Mental capacity assessments were completed for people. The assessments stated when a person lacked capacity, and the difficulty they had communicating, understanding or retaining information. Some assessments recorded that people were able to weigh up information and make a decision in response to a clear, short command.

Staff told us they knew they needed to obtain consent from people before they delivered care. One member of staff told us, "We always ask first and if a resident doesn't want help, we leave them and go back later. If we're really concerned we can always ask the manager." Another member of staff told us, "I ask people if they're happy to get up, but it's their choice." The care plans did not provide detail about which decisions people were likely to be able to make for themselves with regard to their day to day care needs. For one person, their care plan stated, "Is not allowed to leave the building without full supervision." There was no guidance for staff to follow to support the person if they did try to leave the building.

Some people had not made the decision and were unable to consent to living in the care home. The home manager told us there were DoLS authorisations in place for seven people. However, we looked at the authorisation documents and found these all expired in June 2015. DoLS provides the legal framework by which a person who lacks the mental capacity to make decisions can lawfully be deprived of their liberty. Further applications had been made for people in June 2015. After the inspection, the provider told us they had followed the requests up with the DoLS assessment team.

We recommend the provider prioritises and follows up DoLS applications in a timely manner to ensure people are not unlawfully deprived of their liberty for long periods of time.

People spoke highly of the staff that supported them. However, we found that staff had not received suitable and sufficient training to ensure they were competent in their respective roles.

Staff told us they received an induction when they started working in the care home. One member of staff told us the training was carried out by senior staff and the home manager. The home manager told us they completed initial induction training with staff. Staff described the regular supervisions they completed with their manager. They said they felt well supported, were provided with feedback, and were able to discuss the progress they were making.

The training records showed that not all staff had received training in health and safety, food hygiene, moving and handling and safeguarding people from harm. This meant people were at risk of not receiving care based on best and up to date practice because staff had not been suitably trained.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were satisfied with the food provided in the home. One person told us, "I think the food

is quite good here" and another person commented, "They ask me what I want and I'm quite happy with what I get." We spoke with the cook on duty. They told us they knew each person's likes and dislikes. We heard them ask people during the morning what they would like for lunch. Choices were offered. The cook told us if people didn't like one of the two main options, they would cook what the person wanted.

A service user survey was completed in October 2015. There were positive comments about the food, however from one person the following comment was made, "I enjoy all of the food that is given to me but I would like a nice English breakfast now and again." The cook told us cooked breakfasts were not routinely offered to people. They told us that no one asked for a cooked breakfast, and they were not aware of the feedback in the questionnaire. They told us, "If someone wanted a cooked, our manager would go out and shop for what they wanted, I just know there wouldn't be a problem." This request had not been communicated to the catering staff.

The care home used a nationally recognised screening tool to assess people's risks of malnutrition. Where people had been identified as being at high risk of malnutrition or dehydration, care plans were in place. People were referred to the GP and nutritional supplements were prescribed.

One person had been assessed by the speech and language therapy (SALT) team and needed 'fork mashable food.' This was documented in the care plan. The SALT advice was also to support the person to eat using a teaspoon. The cook described the consistency of the food they prepared for the person. We saw the person being supported to eat their lunch, mashed as recommended, and a teaspoon was used by the staff member supporting the person.

We spoke with two visiting health professionals during the inspection. We received positive feedback. One health professional told us staff responded to changes in people's healthcare needs and followed their instructions and guidance. They told us, "The staff often phone us for advice and to let us know if there are any problems, they are fantastic."

Good

Is the service caring?

Our findings

People told us staff were kind and caring. Comments from people included, "They (the staff) are all pretty good," and "We're well looked after, couldn't ask for anything else." A relative told us they were pleased with how their mother had settled into the home. They said staff made them feel welcome and they were pleased with the progress their mother was making. We spoke with a visiting health professional who had provided equipment for the person. They told us they were really pleased with the staff approach and described them as, "Really good."

Staff spoke and interacted with people in a calm and friendly manner. People were treated with respect. In addition to comments received from people, a quality assurance questionnaire was completed in October 2015. People were asked what the home did well, what could be improved and a final section asked for any other comment or feedback. Most of the comments were positive and included, "I get looked after very well, if I wasn't happy then I wouldn't want to live here" and "I have all my needs catered too and I am very happy."

Staff were approachable and enthusiastic about the roles they had in the home. One member of staff told us, "I think we get to know people well and we are patient and friendly." Another member of staff commented, "If my Mum had to go anywhere (to a care home) I'd be happy with her coming here."

We saw that good relationships had developed between staff and the people they were caring for. Our observations of staff interacting with people showed they understood people's needs. For example, we saw a member of staff gently reminding one person where they usually like to sit when they were in a communal area. Another member of staff provided reassurance to one person and reminded them when their family would be visiting.

Staff were able to tell us how they made sure people were treated with respect and how they maintained privacy and dignity. Staff gave examples of knocking on people's doors and making sure people were sensitively supported when they received personal care. Staff also told us they called people by their preferred names and they recognised how important this was for people. We saw examples of people being treated with respect throughout the inspection.

Staff showed they were caring and they promoted people's independence. One person commented, "I do most things for myself but the staff are lovely and always willing to help me." A member of staff told us, "We are told by our managers about the importance of people having as much freedom as possible". People walked freely around the home on the day of our inspection. They were provided with support and assistance when it was needed.

Requires Improvement

Is the service responsive?

Our findings

The care plans we looked at contained completed 'This is me' documents, which provided detail about the person's history, family, career and what was important to them. However, details from the documents were not always incorporated into the care plans to make the plans person centred. For example, for one person there was detail about their career and lifestyle. The 'This is me' document stated the person worried about the whereabouts of their family. However, this was not referred to in any aspect of their care plan and did not provide guidance about how staff reassured the person if they were worried.

The care plans provided detail about how each person was supported with their personal care, mobility and nutrition. However, some of the additional monitoring charts used for people with an identified risk were not always fully completed. For example, one person had food charts and repositioning charts in place. These had not been completed for the day before our inspection. 'Bowel and bath' charts in the care plans were inconsistently completed. This meant people's care needs were not accurately monitored.

Some people received additional support from district nurses. The care plans did not always reflect the actions taken in the care home. For example, one person had a wound that was dressed by the district nursing team. The care plan stated the person had protective cream applied by the care staff. There were no further details about how often the cream was applied or where it was applied. It was not recorded on the MAR or any other recording sheet. This meant the effectiveness of the treatment could not be accurately assessed.

During the morning of our visit, a senior member of staff led a gentle armchair activity session in one of the lounges. A weekly activity plan was displayed on the wall in the lounge and included bingo, exercise and quizzes. People told us they enjoyed the weekly entertainment provided by an external person who sang and played the piano. People told us they were generally satisfied with the activities offered in the home. However, they also told us they were not asked what they would like to have included in the activity programme. One person told us, "If I'm bored in the lounge I go to my room and do my word search." The person told us they didn't really want any more planned activities. Another person told us they like to watch the television with their friends in the lounge. The provider had a minibus which was parked outside the care home. They told us they often asked people if they would like to go out and that people declined most of the time. One person went out with friends on a regular basis. Another person told us they enjoyed the garden in the summer. They told us, "It's lovely, they get the pergola out and we enjoy the sunshine."

One person admitted to the care home four weeks before our inspection did not have a care plan in place. However, staff were knowledgeable about the person's day to day needs, and the person was able to communicate their needs. The person was being supported by external health professionals who told us they were pleased with the progress the person had made during the four weeks since they moved into the home. However, this meant the person's care needs may not be fully recorded.

One person suffered with chronic pain. The documented plan and review for this was incomplete and insufficient. The care monthly reviews described the pain as 'Unbearable when he moves' and 'Still

complaining of pain.' The person's pain score was assessed as severe. There was no review of the effectiveness of the pain relief the person received. The registered manager was able to tell us the actions taken, the health professionals consulted and involved and the probable cause of the person's pain. However, this was not recorded and meant the person was at risk of not receiving the care and treatment they needed.

The lack of accurate record keeping was a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the compliments and complaints folder and saw that no compliments or complaints had been recorded since 2014. The home manager told us they had not received any complaints about the service. However, the complaints procedure was not accurate and did not provide people with the information needed.

Requires Improvement

Is the service well-led?

Our findings

The registered manager and the home manager told us they did not have systems in place to routinely monitor and audit the quality of the service delivery or the record keeping. They told us they completed spot checks, however, these were not recorded. The registered manager did not have systems in place to identify and address the shortcomings and regulatory breaches such as those we found on the day of our inspection. The risks associated with the lack of call bell monitoring, legionella, steep stairs and unsafe equipment had not been recognised or effectively managed by the provider.

Feedback was obtained from people and their families in annual quality assurance surveys. The most recent surveys were completed in October 2015 for people using the service, and in November 2015 for relatives. We saw where areas were identified for improvement some actions had been taken. We were told of improvements that had been made in a person's bedroom in response to the feedback obtained. However, there was no action plan in place. We were not able establish if actions had been taken in response to some of the suggestions in response to 'What we could do better.' Whilst most comments were positive, one person had said they would like a cooked breakfast sometimes and another person had commented they did not wish to be woken by staff. There was no evidence of actions taken.

Resident meetings were held on a monthly basis, and this gave people the opportunity to comment and discuss issues of concern. Staff meetings were also held on a monthly basis. Staff told us they felt able to express their opinions and felt confident their views would be listened to. Staff told us they felt well supported by the management team. They told us College House was a good place to work. All of the staff we spoke with told us they would feel confident to place a loved one in the home and they would recommend the home as a home that provided good care.

We found that staff were kind, caring and compassionate in their approach. However, they had not received adequate and sufficient training from the registered provider. This meant they did not recognise some of the shortcomings in the care and supporting documentation. Their day to day care practices and use of care records was not reviewed, monitored or audited by the provider. This meant people were at risk of receiving care that did not meet their needs because of the lack of good governance systems.

The home manager and the registered person told us they kept up to date with current practice by attending local provider forums. The provider had a range of policies and procedures in place. However, some of the policies, for example the medicines policy and the complaints policy were inaccurate, incomplete and did not provide safe and sufficient guidance and instruction for staff to follow. The policies and procedures had not been reviewed to reflect the change of provider.

The lack of good governance was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a mission statement which was displayed in the care home. Whilst staff were not aware of this statement, they told us they knew the provider wanted people to be as independent as possible and to

have a good quality of life. One member of staff told us, "The manager wants people to have freedom when they live here."

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 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	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Effective recruitment procedures were not in place Regulation 19 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive adequate training to enable them to safely carry out their duties Regulation 18 (2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that medicines were safely managed. Regulation 12 (2) (g)

The enforcement action we took:

We issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place to audit and monitor quality and safety. Systems were not in place to assess and mitigate the risks to the health, safety and welfare of people. Accurate, complete and contemporaneous records in respect of each service user were not maintained. Regulation 17 (2) (a) (b) and (c)

The enforcement action we took:

We issued a Warning Notice