Colin Limited

Colin Care Home

Inspection report

19 Garlies Road
Forest Hill
London
SE23 2RU

Tel: 02086995151
Website: www.colincarehome.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this unannounced inspection on 12 and 20 July 2018. At our last inspection in March 2016 we rated this service 'good'. At this inspection we found several breaches of regulations and have rated this service 'requires improvement'.

Colin Care Home is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The service provides residential home care for four men with mental health needs who may also have an associated brain injury or alcohol dependency. The care home consists of four bedrooms and a communal lounge, dining room and kitchen.

The service did not have a registered manager following the resignation of the manager in December 2017. The provider told us they were advertising to recruit a new manager. A registered manager is a person who has registered with CQC 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 provider was recruiting a manager from the existing staff team and told us they intended to appoint a new manager in August 2018.

At the time of our inspection two key posts were not covered and staffing levels were too low to safely meet people's needs. Most care workers were part time which meant the service was not able to provide a consistent staff team. Safer recruitment measures were not consistently followed to ensure that care workers were suitable for their roles.

Care workers did not receive regular supervision and lacked training in key areas such as mental health awareness and managing behaviour which may challenge. People did not have personalised plans to manage and de-escalate such behaviour. Risk assessments were in place but were not reviewed regularly or in response to changes in people's needs. The provider worked with the local authority to review people's care and manage risks to people.

People told us that they were treated with respect by care workers, but there were limited meaningful activities in place. Keyworking and residents' meetings were not taking place frequently and consistently and plans lacked clear goals for people to gain independence and engage in meaningful lifestyles. People were safeguarded from abuse. People were supported to make choices about what they ate and people's nutritional needs were assessed and met.

The building was kept clean and was a pleasant environment. There were systems of health and safety checks to ensure the premises were safe for people who used the service. Medicines were managed and stored safely by care workers who had the competence to do so. There were systems of weekly audits in place to ensure that this continued. However, a lack of consistent management at the service meant there

were not robust systems to ensure that other regulations were met and that care plans and risk assessments were kept up to date.

The provider was not meeting requirements to display their ratings of the previous inspection or to notify CQC of serious incidents that had occurred in the service.

We have made a recommendation about how the service manages and records complaints. We found breaches of regulations relating to staffing levels, supervision and training, display of ratings, notifications of serious events and good governance. You can see what action we told the provider to take at the back of the full version of this report.

In response to our inspection feedback, the provider sent us a plan stating how they would address our concerns, which included appointing a new manager. We will carry out a further inspection in due course to ensure these requirements have been 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 not safe in all respects.

Staffing levels were too low to safely meet people's needs and recruitment measures were not always effectively followed to ensure people were suitable for their roles.

Risk management plans were in place but were not always updated regularly and in response to changes in people's needs. There were not personalised plans for responding to behaviour which may challenge.

Medicines were safely managed and there were audits in place to ensure medicines and health and safety procedures were followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People received good support to access healthcare services and to eat and drink well. There were detailed assessments carried out of people's needs and evidence people had consented to their care.

Staff did not receive regular supervision and lacked training in several key areas.

Is the service caring?

Requires Improvement

The service was not caring in all respects.

People told us they were treated with respect by care workers but staff teams were not always consistent.

Systems such as keyworking and residents' meetings were not effectively carried out to ensure people were empowered to speak up about their care.

Activities timetables were in place, but there were limited meaningful activities for people who used the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's plans were not always up to date and lacked clear goals and outcomes for people to develop independent living skills and move on from the service.

Care workers did not always record the support people had received to maintain personal hygiene.

People were able to complain, however we found complaints were not always fully recorded and it was not clear what actions had taken place as a result or what the outcome was.

Is the service well-led?

Requires Improvement

The service was not well-led.

The service lacked a full-time manager and consequently some audit and monitoring systems were not operating effectively, which had affected the performance of the service.

The provider was not displaying their ratings or notifying the Care Quality Commission (CQC) of significant events that had taken place in the service.

Colin 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.

Why we inspected- this was a routine inspection as we last rated this service 'good' in March 2016.

This inspection took place on 12 July 2018 and was unannounced. We returned announced for a second day on 20 July 2018 as the provider was on holiday and we were unable to access certain key documents. The inspection was carried out by a single adult social care inspector.

We were aware of a single allegation of abuse against a person who used the service and had seen the outcome of the independent investigation the provider had commissioned to examine this. We were not aware of any further serious incidents, complaints or concerns about this service at the time of this inspection.

We looked at records of care and support of four people using the service. We spoke with three people who used the service and two family members of people who used the service. We spoke with the director and three care workers and a contracts and quality officer with the local authority.

Requires Improvement

Is the service safe?

Our findings

People were not always supported by an adequate number of staff to ensure their individual needs and preferences were met. The manager's post had been vacant since December 2017 and the deputy manager had been on sick leave for over a month. Neither of these key posts had been covered by the provider. The company director was directly overseeing the service, but was on holiday at the start of our unannounced inspection. The service was staffed 24 hours a day. Care workers typically worked alone in the service, but told us they could access support from an on call system of senior staff who would attend the service to support them if there were any problems. There were clear guidelines displayed for care workers to access the on call service. A staff member told us, "They can get here in 10 minutes." However, this was not sufficient to ensure that people's preferences were met in terms of how they spent their time.

There was a single member of staff on duty at the time of our arrival. One person using the service was subject to a Deprivation of Liberty Safeguard (DoLS) order and was unable to leave the house without staff support. The provider told us that people could access the community or attend appointments with the support of either a manager or an additional member of staff. The staffing rota showed that only one staff was rostered to work in the house each day and that managers were rostered to cover five days per week. The staff signing in book showed that a manager had visited the premises on 14 days of the last 31. On one occasion the manager had only stayed for 40 minutes, and on two occasions had arrived after 3pm.

The signing in book showed that on 10 days in the past month only a single member of staff had been on duty throughout the day time without support from a manager or another care worker. On a further three occasions the additional member of staff had been on duty for fewer than three hours. This meant that people were not able to access the community without giving notice should they wish to do so. A care worker told us, "It's not enough, if someone wants to go out they can't." A person using the service said, "You're subject to sitting in your room looking at the ceiling." A relative told us, "He has to wait for someone to be available. That could be two hours or two days." However, people who used the service with lower needs told us they felt there were enough staff on duty. Comments from people included, "there's enough staff" and, "I go out on my own, I'm OK." Therefore people who required staff support to access the community were restricted from doing so because staffing levels were insufficient.

This constituted a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Following our inspection the provider told us that they had changed the staffing rota in order to put a member of staff on duty from 10:30am to 5:30pm three days a week in order to better meet people's needs. They also showed us that they had been advertising for care workers and a manager.

The provider did not always operate safer recruitment measures to ensure that care workers were suitable for their roles. The provider had systems in place to obtain references, proof of the right to work in the UK and a full work history. All care workers had had a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer

recruitment decisions. However, some people's records were incomplete. One care worker did not have references on their file despite having previously worked in health and social care; this had been noted on an audit but not addressed. The provider determined that these had been requested but could not be certain it was received, and after our inspection obtained this information.

One person's work history was incomplete in that it gave roles but not dates. Another care worker had only personal references and had stated on their application form that they had not previously worked in health and social care, however they had attached a CV and stated in their interview that they had previous employment in this field. Managers had not noted this anomaly or obtained proof of satisfactory conduct in this employment.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People who used the service told us they felt safe. One person said, "People know us round here" and another said, "Yes it's safe, I'm OK". Where people were supported by staff to manage their finances care workers kept accurate records of this including regular checks of the balances which were signed off by two care workers. This protected people from loss or theft.

Staff received training in safeguarding adults and understood their responsibilities to report suspected abuse. We were aware of one instance where abuse was alleged against a staff member. The provider had reported this appropriately and arranged for an independent person to investigate this due to being a small service. Records showed that the investigator had spoken to all parties involved but that the allegation was not substantiated.

The provider had systems in place for assessing and managing risk. This included assessing risks relating to the person's living environment, falls and smoking. The provider's policy stated that these should be reviewed monthly, however in practice some had not been reviewed in seven months and had not been reviewed in response to incidents and changes in people's needs. For example, one person had become intoxicated on several occasions in one month; there was a specific risk assessment to cover this but this was 10 months old, and did not mention strategies staff had in place for limiting the person's drinking, recent behaviour that challenged relating to alcohol intake and how a recent injury had affected the risks. A person had been identified as being at increased risk of falls, but their assessment had not been reviewed for 12 months, even though there had been further significant changes to their mobility.

The provider was working with the local authority to manage risks to people from going out and from excessive alcohol consumption. In response to an incident where a person had threatened self - harm the provider arranged to debrief staff members involved and for a referral for the person to see a psychologist. Where a person was identified as at risk from using the stairs, the provider had a strategy in place to limit the person's risk, including reminding them that they did not have to go upstairs to have their medicines.

Logs were maintained of behaviour which may challenge and there were generic guidelines for managing challenging behaviour. However the service also did not operate personalised behavioural support plans, which could support staff to recognise warning signs that a person may become challenging and provide strategies to de-escalate a situation.

The provider maintained missing person's profiles. These included a description and photograph of the person, their known preferred places in the community and a list of their medicines. Night staff carried out regular checks of people's wellbeing in line with their night plans.

There were systems in place to ensure that the building was safe. Knives were kept locked away and food was correctly stored and dated in the refrigerator and freezer which were kept clean. Care workers checked fridge and freezer temperatures daily but lacked clear guideline about what constituted a safe temperature. Health and safety checks were taking place weekly, which included checking that the temperatures in people's rooms were within a safe range and that fire safety equipment was in working order. There were also monthly checks carried out of each room to check for hazards. Fire drills were carried out irregularly but there had been three in the months of April and May to ensure that people using the service were able to evacuate and follow fire safety procedures. There were also up to date checks of gas and electrical safety.

The building was clean throughout and was clear of bad odours. A care worker told us, "We don't have a cleaner, but we all pitch in". There was a clear plan in place for keeping the building clean and staff recorded when tasks were completed.

People's medicines were safely managed. Care plans contained a detailed medicines profile, including the support people needed and what their medicines were for. People's medicines were supplied in blister packs by a pharmacist. Managers carried out observations of people's competency to administer medicines. We looked at three months of medicines records for four people. Medicines administration recording (MAR) charts were in place and correctly completed. Staff carried out a weekly check of blister packs and MAR charts to check that recording was complete and that medicines were given as planned. When medicines were not blistered care workers carried out regular stock checks.

Where medicines were taken 'as needed' there were protocols in place for their use, such as painkillers and other medicines. Medicines and associated records were stored in a locked cupboard in the staff office and temperatures of storage areas were checked daily.

Requires Improvement

Is the service effective?

Our findings

People did not always receive support from care workers who had received adequate training to enable them to carry out their roles. The provider told us that they did not offer the Care Certificate to any new starters, even if they were new to care. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should be covered if a care worker is 'new to care' and should form part of a robust induction programme. A care worker told us, "The training is good, we have first aid and medicines training coming up." Of the nine regular care workers, six had or were working towards a nationally recognised qualification in care, but three did not. Care workers had up to date training in safeguarding and fire safety, but in most other areas of mandatory training staff were either overdue for training or had not had it at all. Three care workers had not had first aid training despite extensive lone working in the service.

There were some significant gaps in training records. Six care workers lacked training in mental health awareness despite this being a specialist service for people with mental health needs. Similarly, although several people using the service had behaviour which may challenge, four care workers lacked training in techniques to manage this behaviour. Two care workers lacked training in administering medicines and six lacked training in the Mental Capacity Act 2005 (MCA), even though one person using the service was subject to restrictions under the MCA and three people lacked epilepsy training despite people using the service being at risk of seizures.

Care workers also did not receive regular supervision. There was a framework for formal supervisions to take place, including discussion of people's responsibilities, timekeeping, personal development and standard of work. When these were completed the recording was of a high standard and showed that care workers had had an opportunity to discuss their roles and concerns, however despite a supervision schedule being displayed in the main office most care workers had only received a single supervision, which included two staff who had been in post for seven and 11 months respectively.

This constituted a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Following our inspection the provider told us they had booked dates for training in epilepsy, mental health and first aid in August 2018. We will check these actions have taken place during our next inspection.

The provider had carried out a detailed assessment of people's needs relating to their health. This included information on people's background and life story, diagnosis, communication needs and identifying key risk factors. Assessments included a detailed breakdown of people's needs and level of independence relating to personal care and daily living skills.
People were supported to access healthcare services. Everyone using the service had a hospital passport. This is a document which summarises a person's health history, support needs and preferences in order to support people to access hospital services. These contained particularly detailed information on people's

likes and dislikes and food preferences. The provider maintained detailed records of people's health appointments which showed people attended routine appointments and that issues of concern regarding people's health were addressed promptly. A person using the service said, "They've done loads with me, and they come to meetings with me."
People's weights were checked every one or two months. The provider assessed people's nutritional needs and the risk of malnutrition or weight loss. This was considered low for everyone using the service. Where significant changes were recorded in people's weights this was noted and raised with managers. Care workers maintained details logs on what people had eaten for their meals and this showed a varied diet. People using the service met weekly to agree a menu.

The provider was working in line with the Mental Capacity Act 2005 (MCA). The Act 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. Everyone using the service was considered to have capacity to consent to their care plans and there was evidence of people having done so.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service had applied to deprive one person of their liberty, as there were concerns that the person lacked capacity when they had been drinking. They had not carried out an assessment of capacity but had discussed this with the local authority as part of a risk management plan. However, care workers were clear that they would not prevent the person from leaving the premises and people were free to come and go as they pleased. One person said, "The door is locked by nine o'clock with my agreement for safety…I can go out anytime I like."

Requires Improvement

Is the service caring?

Our findings

Keyworking was limited in its scope and inconsistent. People had assigned keyworkers in place, and keyworking was used to discuss significant news and achievements, activities, finances and the person's support plan. However, keyworking sessions had not taken place regularly and one person had not had a keyworking session since February 2018. One person had had two keyworking sessions in April and May but no other sessions during this year. The provider said that these took place more frequently than this, but no records were available. Only one person had more consistent keyworking sessions recorded, which had taken place four times in the last seven months. There was a rota in place for these sessions but this was not being followed. The provider told us after the inspection, "Staff did not comply with the planned rota due to high levels of staff sickness but a new [manager] will commence duty and ensure that all the target dates are met."

People did not receive a person-centred service as the staff team did not provide continuity of care. The staff team lacked the consistency required to deliver a person-centred service. A person using the service told us "They don't have any full-time staff". Typically, eight care workers would work in the service in the course of a week. Two care workers worked one day per week and most other staff only worked two days per week. This often led to poor communication. For example, members of the staff team passed us contact details of a relative of a person using the service but were unaware that this person had not spoken to their relative in several years. A family member told us "Sometimes they get some really good staff there and they are brilliant. But the staff turnover is so vast we don't really know who is who anymore. We had a [social worker] there once [for a review meeting], which was prearranged. [The manager] wasn't there and a temporary member of staff sat in, we said that was totally unacceptable."

Residents' meetings were used to obtain people's views of the running of the service. In June a meeting had taken place where people agreed to meet weekly to draw up a menu, with one person using the service leading on this. This was also used to discuss shopping and activities. People had asked for an aromatherapist and foot massage session which was taking place. However, these meetings did not appear to be happening regularly, as we could only identify one other set of minutes which were not dated. One person told us "Once every three months we all have a meeting on what we feel and what we would like to see happen". The provider told us that they had since put a timetable in place for these meetings to ensure everyone who used the service had an opportunity to speak up.

People told us that staff protected their privacy. One person said "Yes, they knock on my door before they come in." There were systems in place to protect people's confidentiality. For example, files and confidential information were kept in locked storage, and staff had a policy of locking the office when it was unattended. People told us that this was always taking place.

Requires Improvement

Is the service responsive?

Our findings

People had personal profiles in place which were reviewed six monthly. These contained a summary of their physical and mental health needs, and their preferred names. Plans were detailed about the level of support people required with personal care, including what people could do for themselves and had limited but clear strategies for offering support. People were positive about the support they had received from care workers to develop. One person told us, "I cook for myself twice a week now…They have tried their hardest and they have worked wonders in taking me away from alcohol and drugs". Several people told us they hoped to move on from the service. However, plans lacked clear goals for people to promote recovery and develop independent living skills to be empowered to move on in future. A relative told us, "[my family member] has not progressed."

Where people were due for placement reviews with the local authority these had either taken place or the provider had requested these.

The provider had strategies in place to support people to manage their money and limit their drinking. These were detailed with regards to money but did not always contain clear written strategies to manage people's alcohol intake. Sometimes plans of care contained out of date information. For example, a nutritional plan of care was 12 months old and stated that a person had a nutritional supplement drink, but this was no longer given.

The service kept logs on people's daily activities, such as whether they had gone into the community and gone out. Sometimes logs lacked detail on people's mood states and wellbeing and were not always clear about the support people had had to maintain their personal hygiene. In some cases, logs were in place for when people had been prompted to shower, but these contained a small number of entries and had not been continued. One person's record had been completed five times in May and a new record was not in place.

Social activities and life story plans were in place for people. These included a detailed life history, major life events, details on social networks and a list of activities that people could undertake. These were designed to prompt care workers to initiate and arrange activities, but sections relating to making plans were often left blank and some plans were overdue for review. People had activity schedules in place, but in practice these were not being followed. Although logs were kept of people's activities these were quite limited and some activities included going shopping. During the month of May nobody had more than six activities recorded as having taken place. However, people were positive about the cinema trips and foot massages which took place regularly.

The provider told us that they would review people's care plans to make sure they met their current needs and ensure that targets and goals were identified for people.

The provider had discussed the complaints procedure in the recent residents meeting and kept a complaints box by the front door. There had been two complaints received but these dated back to 2016.

There was no system in place for recording what actions had been taken to investigate a complaint or record its outcome. Some people told us they had spoken to managers about their concerns but these did not appear to have been recorded as formal complaints.

We recommend that the provider review their system for managing complaints to ensure there is a clear record of what action has been taken and the outcome.

Requires Improvement

Is the service well-led?

Our findings

The provider did not meet requirements to notify the Care Quality Commission (CQC) of certain events. In June 2018 a person using the service sustained a serious injury, but the provider did not notify CQC of this as required by law. On two occasions people had gone missing from the service and the police were involved, but this was also not notified to CQC.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Providers are required by law to display the ratings of their most recent inspection at their registered location and on any website maintained by the provider. At the time of our inspection the provider's website was not functioning and ratings were not displayed at the registered location. On the first day of the inspection this was rectified at our prompting and on the second day we discussed requirements relating to the display of regulations with the provider. However, on 10 August 2018 we observed the provider's website was now active again but was not displaying their ratings.

This was a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The service was currently overseen by the director of the company who was visible in the service and lived nearby, and people told us they could approach him if there were any concerns. A care worker told us, "I can always talk to him, he's always available". There was a clear checklist in place for duties to be performed by night staff, such as regular checks on people's safety and cleaning tasks. Handover forms were completed each day to verify and inform the next staff member of people's whereabouts, food intake and any issues of concern, although these did not contain information on the activities people had undertaken.

Health and safety checks and checks of medicines were effective, but there was a lack of similarly robust systems for checking staff recruitment and training was taking place. There were not systems to monitor the developing and reviewing of person centred plans. There were not measures in place for ensuring that risk management plans were accurate and reviewed, or whether records relating to the care and support people received were complete and accurate. Managers did not ensure that keyworking and residents meetings were carried out and recorded as planned.

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

The provider told us they would review their service audits in order to identify areas of weakness. The provider had a plan in place to recruit a new manager by August 2018 and told us they expected a new manager to address these areas of concern.

Team meetings were used to communicate with care workers but these were not taking place regularly. There had been meetings the past two months, but prior to this the last meeting had taken place in January.

Some actions were not followed through when these were identified by managers, such as the need to update some risk assessments and care plans. The provider had a set of policies in place with clear procedures for ensuring that they were followed. This included medicines, safeguarding adults and complaints.

Managers operated a system of interview questions and tests to ensure care workers were suitable for their roles, including numeracy, literacy and people's understanding of confidentiality and safeguarding adults.

The provider had carried out surveys of people's satisfaction with the service, but it was not clear what actions had been taken in response to these.

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 18 Registration Regulations 2009 Notifications of other incidents The provider did not notify the Commission without delay of an injury to a service user which had resulted in the service user experiencing prolonged pain or any incident which was reported to or investigated by the police 18(2)(a)(iii)(b)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not establish or operate effectively systems to assess, monitor and improve the quality and safety of the services provided, the risks relating to the health safety and welfare of services users and others, or maintain an accurate, complete and contemporaneous record in respect of each service user. 17(1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were not operated effectively to ensure that the information specified in schedule 3 was available 19(2)(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance

	assessments The website maintained by the service provider did not display the most recent rating by the Commission of the service provider's performance nor was this displayed at the registered location 20A(2)(d)(3)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed; persons employed in the provision of a regulated activity did not receive such appropriate support, training, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform 18(1)(2)(a)