Crimson Care Limited

Colne Valley Residential Home

Inspection report

185 Scar Lane
Milnesbridge
Tel: 01484 659176
Website:

Date of inspection visit: 17 July 2015
Date of publication: 24/09/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

We carried out this inspection on 17 July 2015. The inspection was unannounced.

The service provides accommodation for up to 20 older people, some of whom may be living with dementia. On the day of our visit there were 10 people living at the home. Accommodation at the home was provided in single ensuite bedrooms set over three floors.

The registered provider is also registered with the Care Quality Commission as the registered manager of the service. 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 found there had been a number of improvements at the home since our last inspection and did not identify any breaches in regulation.

People told us that they felt safe and well cared for; they told us they enjoyed the food and were enjoying the new activities programme.

Summary of findings

There were some issues in relation to cleanliness and infection control.

Systems for managing medicines were safe.

Staff training was up to date. Systems for supporting staff were in place.

Staff were not always working in line with the requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Staff treated people with kindness and demonstrated a good understanding of the need to treat people with respect and dignity.

None of the people we spoke with raised any issues in relation to staffing, however we noted there were not always staff visible.

Some good care plans were in place but one of the ones we saw lacked the required detail.

People had access to meaningful activities.

People felt able to tell staff if there was something they were not happy with and we saw that concerns and complaints were managed well.

A programme of refurbishment was in place but we found that staff did not have a good understanding of how the environment could be adapted to support the orientation of people living with dementia.

Processes were in place for auditing the quality of service provision but these were not always robust. New systems were under development.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was safe but some improvements were still needed.

People told us they felt safe and staff knew how to maintain people's safety.

Accidents were not always looked into thoroughly.

Systems for managing medicines were safe.

Some improvements were needed in relation to infection control.

Is the service effective?

Requires improvement

The service was effective but some improvements were still needed.

Staff training was up to date. Systems for supporting staff were in place.

Staff were not always working in line with the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Refurbishment was in process but the environment was not dementia friendly.

People enjoyed the food at the home.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and demonstrated a good understanding of the need to treat people with respect and dignity.

People felt well cared for.

Is the service responsive?

Good

The service was responsive

Person centred care was being practised but this was not always reflected in care records.

People enjoyed meaningful activities.

Complaints and concerns were managed well.

Is the service well-led?

Requires improvement

The service was well led but some improvements were still needed.

Processes were in place for auditing the quality of service provision but these were not always robust. New systems were under development.

Lines of responsibility were not clear.

Colne Valley 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.

We had previously inspected this service in January 2015. Due to concerns identified at that time, the Care Quality Commission started enforcement proceedings against the provider. The provider made appeal against these proceedings. This inspection was completed to assess if the provider had made sufficient improvement for enforcement proceedings to be withdrawn.

This inspection took place on 17 July 2015 and was unannounced.

The inspection team consisted of two Adult Social Care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The area of expertise of the expert-by-experience was caring for older people and those living with dementia.

Before the inspection we reviewed the information we held about the service. This included looking at any concerns we had received about the service and any statutory notifications we had received from the service. We usually send the provider a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. On this occasion a PIR had not been sent to the provider.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with nine people who were living in the home and one visiting relative. We also spoke with seven members of staff including the care manager, the activities co-ordinator, the cook and the registered provider/ manager.

We looked in detail at three people's care records and observed care in the communal areas of the home. We looked at two staff recruitment files and staff training records. We also looked at records relating to the management of the service including policies and procedures. We looked round the building and saw people's bedrooms, bathrooms and communal areas. We also looked in the laundry room.

Requires improvement

Is the service safe?

Our findings

We asked people if they felt safe in the home. One person said "Yes and the carers are really good. I've seen them deal with really awkward people; I don't know how they keep patient". In regard to bathing they added "They get me in and keep an eye on you". When asked, another person said "Safe? Yes".

We asked a visitor if they felt their relative was safe in the home. They said "Yes, they put precautions in."

One person showed us they had hurt their arm and we saw this was bruised and cut. They showed us they had done this on the fitting within the patio doors and we saw there were two sharp protruding metal corners. We asked the care manager and senior staff to make sure this was made safe so no other person was injured. We looked at the accident record for this person and we saw the injury had been recorded but the cause of this had not been investigated, even though the record stated the person thought they had hurt their arm on the door.

We looked at the record of accidents and incidents and we saw these were summarised monthly. However, there was no analysis of these to identify when incidents may need further investigation or identify what action had been taken. For example, we noted there had been three accidents to one person involving a wheelchair, yet there had been no action taken to ascertain whether there was a fault with the wheelchair or to determine how a further accident may be avoided.

We looked at the person's wheelchair and the person told us it may have been any of the home's wheelchairs that caused their injury as 'one of them had a sharp bit'. We could see no protruding part on the person's wheelchair. We looked at wheelchair checks and one of the wheelchairs was recorded as 'seatbelt' and 'seat base back' in need of maintenance from January to May, but it was not clear what action was taken about this, whether any of the chairs had caused injury to the person or if there was a correlation between the accident records and the wheelchair maintenance records.

We spoke with two staff who told us they would be confident to report any concerns if they were worried about a person's well-being. One member of staff knew the signs of abuse and said they would always report to their manager, or to other relevant agencies if necessary. Staff said they would always report any poor practice if they witnessed this, to ensure people in the home were safe. However when we gave examples of verbal abuse to two members of staff they did not recognise this as an issue that would need reporting.

The Care Quality Commission had received notification from the manager of safeguarding referrals they had made. This demonstrated that policies and procedures were in place for reporting safeguarding issues.

Staff we spoke with told us what they would do in the event of an emergency, such as if a person fell. Staff were confident that management support for emergencies would be available at all times.

We had an accompanied tour of the home. We saw evidence of some refurbishments taking place and the manager told us of their plans for continuation of the refurbishment programme.

We found some concerns in relation to cleanliness and infection control in some people's bedrooms. For example, in one room there was a used continence pad in the corner. In another room there was a pair of dirty slippers with something stuck to the sole in a drawer and the drawer was dirty on the inside. One person's room had a stained headboard and another person's bedding was visibly dirty. The manager told us it was the care staff's responsibility to make sure people had clean bedding and whoever assisted each person to get up should check this was in place.

Some people had disposable razors in their rooms which were visibly clogged up with dirt and hairs. In some ensuite toilets we saw the seats were dirty and stained. We saw the underside of the bath seat in the communal bathroom was dirty and rusty. The manager said she knew about this.

We saw that the laundry room had been refurbished since our last inspection and that systems had been put in place to maintain good infection control procedures.

In one bathroom we found the hot water was very hot to touch. We tested this with our temperature probe and found it to be 44.9˚c above the safe limits of 43˚c. There was no bath thermometer available and staff told us they used their judgement to determine whether the bath water was a safe temperature for people. We were told monthly testing of water temperatures took place and we saw these were completed up to date.

Requires improvement

Is the service safe?

We looked at the systems that were in place for the receipt, storage and administration of medicines. We saw that the temperature of the room and the medicines fridge were recorded on a daily basis to make sure that medicines were stored at an appropriate temperature. We found medicines were stored safely and only administered by staff that had been appropriately trained. We observed some people being given their medicine during our visit. On one occasion we saw a member of staff bring medicine to a person the dining room. The staff member knelt down in front of the person and said why they were there, what the medicine was, what it was for and offered a glass of water to take the medicine with. The staff member stayed with the person until they were sure the medicine had been taken. All this was conducted by the staff member in a calm, kindly manner.

We saw care plans for taking medicines were in place with the Medication Administration Record (MAR) charts. They included details of the medicine, what it was for, the dosage and how the medicine should be taken. We also saw that where people were taking a variable dose PRN (as required) medicine for pain, there was a pain chart in place for staff to record how severe the pain the person was experiencing was. However when we asked how the scoring was worked out, neither of the two members of staff we spoke with were able to tell us.

We checked a sample of the medicines available against the amounts recorded as received and administered. We found these to be correct.

The care manager showed us monthly audits of medication but told us they intended to change the format as it was too involved for a residential care home setting. This showed that the care manager was keeping the audit process under review. We saw that an incident involving administration of medicines had been recorded and managed well. We also saw that the staff member involved had been managed in line with disciplinary procedures.

We saw that staffing levels at the time of our visit were two members of care staff for each shift over a twenty four hour period. None of the people we spoke with raised any issues in relation to staffing however we noted there were not always staff visible. On one occasion we had to look for staff to assist a person who was asking for help to go to the toilet. When the activities organiser came on duty, they were available to people in the communal area whilst other staff were busy.

Care staff told us that whilst occupancy was low, they also did the cleaning and laundry. Staff said they managed this well.

When we arrived at the home the care manager told us there were no catering staff on duty that day and that people who lived at the home would be having a fish and chip lunch from a local shop. We saw that the staff rota showed no catering staff for the day. However, later in the morning the cook arrived and told us they were on duty but had needed to come in late that day. It is important that staff rotas reflect which staff are on duty and what hours they are working.

We looked at recruitment files for two members of staff. We saw that files contained evidence that checks had been completed prior to employment. However one file contained only telephone references whilst the other showed that the person had not had a criminal record check for six years. Whilst there is no legal requirement in relation to this, it is good practice for checks to be renewed every three years.

We saw that the staff board included a photograph of a child who is a relative of the provider. This person was described on the board as a volunteer. This is not an appropriate title for a young person as it suggests they would have involvement in supporting people who live at the home with aspects of their daily living.

The Care Quality Commission had been contacted about the presence of a large dog in the home. This dog belongs to the provider and is classed as a pet in the home. On this visit we saw that a photograph of the dog was shown on the staffing list as a “volunteer”. The dog was not in the home at the time of the visit. We found a difference in perception as to the health and safety hazard regarding the dog. One person who lived at the home told us the dog “Pinched things” referring to food from the table and when we asked another person if that was the case they said “He has a nibble”. A member of staff said “We’ve asked residents’ if they like having the dog and they say they do”.

A member of the management team said of the dog “He stays out of the way, he doesn’t bother anybody”. However we saw that there was a large dog ‘bed’ in the lounge less than two metres from the dining table. A visiting relative said “Only thing I don’t like is that it’s wandering about when they are eating but apparently its put out now so that has been addressed”.

Requires improvement

Is the service effective?

Our findings

People we spoke with were complimentary of the staff and how they were cared for. One person said "They are very good to me, they are patient and help me." Another person said "Oh yes they know what they are doing."

We observed that staff knew the needs of the people living at the home and they demonstrated this in the way they supported them with their care. For example, staff reminded one person they needed their walking frame as they had left it behind, and staff went to bring it for the person, reminding them why it was important to use it. We checked the person's care plan which showed they should use their walking frame at all times to reduce their risk of falls.

We spoke with one new member of staff who told us this was their second shift. They said they were shadowing other staff on all the different shifts to get a good idea of how the home was run throughout the day and night. This member of staff said they had an induction booklet and they were going to read this in conjunction with people's care records until they felt confident in their role.

Staff we spoke with said training was important and they considered they were supported to undertake any relevant training. We saw the training matrix showed staff had up to date training in moving and handling, infection control, food safety, nutrition and hydration, safeguarding and caring for people living with dementia.

Staff supervisions were listed on a grid and we saw these had taken place at regular intervals. However staff we spoke with were a little unclear about what supervision was and how frequently they received it. All staff did confirm that they received support.

We spoke with a member of night staff who told us the night shift was usually busy with staff involved in a cleaning schedule as well as caring for people through the night. This member of staff said there was a detailed handover between shifts so the staff taking over would know relevant information.

We looked at the handover notes from shift to shift and saw these contained information about each person and any relevant points for staff to note.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS), and to report on what we find.

We saw that staff had received training in MCA and DoLS. However we were concerned that staff may not have a full understanding of this. For example, we saw in one care file that the person had said they did not wish to be to be checked at night. Records stated that a best interest decision had been made on this person's behalf and that staff would check them every four hours during the night. There was no evidence of who had been involved in the best interests' decision. We asked the manager if the person involved had a mental capacity assessment which indicated they lacked capacity to make a decision about being checked at night. The manager said this had been done but had not been fully recorded.

We saw that people were not able to access the garden or areas outside of the home without asking staff. The manager told us that people could access the garden through the room where medicines were stored or through the patio doors from the dining room. However we saw that both of these doors were locked.

It was not clear from one person's care records whether their mental capacity had been assessed but their needs assessment summary sheet stated 'high risk of getting out' which suggested the person may be vulnerable if they left the home alone. However there was no evidence that this had been thoroughly risk assessed or consideration given to any deprivation of liberty issues.

This meant that staff were not always working in line with the requirements of the MCA and DoLS.

We asked people what the food was like at the home. One person said "They make sure I have plenty to eat – they turn nice things out". Other people said "Breakfast is very nice,", "it's excellent; it is very good food and plenty of it. We get lots of fruit. It's that good I've put a stone and a half on" and "food? It's good."

Another person told us "The cook (name) is good, she tries to please you. There's always two or three choices of lunch and more for tea. The only time we all have the same is Sunday … ".

The cook told us "I discuss the day before what they fancy. I don't just give them a choice. I try and please them all".

Requires improvement

Is the service effective?

A person visiting their relative told us "the cook is really good, talks to them. (My relative) likes their food and even eats things they wouldn't have at home before they came in – I've no concerns". The person added "(Relative) had a bit of a problem with their teeth and they make homemade soup – (relative) loves it".

We saw people were having breakfast on our arrival. One person said "I've had me breakfast but it was a poor do". People we saw at breakfast time had cereal, some of which had fruit on top. Staff told us people could have toast if they wanted, but we did not see anyone choose this.

The menu board was of a cheery, comic design but may not have been suitable for people with any degree of impaired vision or confusion of any sort, the menu being written in blue chalk on a worn and faded black ground.

At lunchtime people were served food from the local fish and chip shop. One person said they did not want fish and chips and they were offered a pie from the shop instead. The cook told us that if people wanted something other than what had come from the shop, they would offer them other alternatives. We saw that staff monitored the amounts people were eating and, where appropriate, asked people if they wanted more, or encouraged people to try to eat a little more.

We saw staff offered people regular drinks throughout the day. One person said they wanted a drink of beer. A new member of staff was not sure if this was 'allowed' but another member of staff said this person had a supply of beer and they agreed to get this for them.

The provider told us that a refurbishment programme was in place at the home and we saw several bedrooms and some corridors were in the process of redecoration. The provider told us that the refurbishments were to continue in the communal areas.

We noticed that there was little within the environment to support and orientate people living with dementia. There were signs with symbols and text on the two toilets we saw and the dining room and lounge had text signs by their doors. Following our visit the provider has informed the Commission that pictorial signs are now in place. However we saw only two people's bedrooms had any signs/photos outside as orientation aids.

There was no distinction between people's bedroom doors and service doors. This was compounded by two bedroom doors and some service doors having the same commercial type "push" signs on them. We also noted that some carpets were patterned which can present visual difficulties and there were no hand rails to aid people's independence and safety whilst walking around the home.

Some of the staff we spoke with demonstrated a better understanding of how the environment can affect people living with dementia. For example, one member of care staff told us they had completed training in caring for people living with dementia and had noticed that one of the people who lived at the home tried to pick the pattern on the carpet up and another person thought the change in pattern was a step. However, one new member of the Management Team said "We're around aren't we, signs make it become more like a hotel don't you think". This member of staff also added "We don't want them wandering around". Asked then about the patterned carpet they said "It's from their era". This response demonstrates a lack of clear understanding of the care of people living with dementia.

We saw from care records that healthcare professionals were contacted as required to support and advise staff in meeting the health care needs of people who lived at the home. This included GPs, district nurses and optician. During our visit we saw a podiatrist visit one of the people living at the home.

Good

Is the service caring?

Our findings

We asked people if the staff were caring. They said “They are really helpful, without any words of discontent – they just do it”, “They are very nice with us”, “They are fine, I love them all, they treat me well. It isn’t your home here but it is your second home. I’ve never seen anyone treated badly, they are pretty patient” and “It’s decent, found no fault really, I’m quite satisfied”. A visitor told us about a member of staff who they said was very good with their relative.

We asked people if they were aware of care plans. A visiting relative told us “I didn’t have a formal meeting with the manager. I had a little book and questions I ticked off but she (the manager) didn’t write anything down. I typed everything for them, the family tree, hobbies – I just did it I wasn’t asked (relative’s) history. I think last year I went through a plan and crossed things out and put things right but I haven’t seen it since”.

We saw that staff were kind and caring in their approach to people and they spoke with them respectfully. Staff took time to speak with people at an appropriate pace and used friendly faces and tones of voice when chatting with them.

Staff supported people at their own pace and made sure people did not feel rushed or hurried by providing reassurance and a calm attitude to care. We heard one person had difficulty trying to express themselves and we saw staff waited patiently for the person to have their say, listened attentively and responded appropriately.

Staff showed an awareness of people’s change in mood and they noticed when one person was becoming frustrated. We saw staff spent time with the person listening to them and helping them to feel calm. We also observed a member of staff to respond quickly when a person started coughing, the staff member asked them if they were alright and if they needed a drink.

Staff showed a good awareness of people’s talents and spoke with one person, who had enjoyed painting, about their work, some of which was displayed in the home and in the person’s room.

We saw people’s rooms were personalised with their own belongings and items of personal significance.

We asked people if staff treated them with respect and dignity. One person said “every time they come they knock on the door”. Whilst sitting with the person in their room we saw a member of staff bring the person’s medication and although the door was in fact propped open we saw they knocked and asked permission before coming fully into the room.

One member of staff told us they felt they could deliver care in person centred manner.

We asked a visiting relative if an End of Life Plan had been discussed and agreed for their relative. They said “No end of life plan, no, but I did ask when (relative) came if they had to be moved if that happened. They said no (relative) could stay at the home”.

Good

Is the service responsive?

Our findings

We asked people about how they spent their time. People told us that activities were picking up again and they enjoyed them. The manager told us a new activities co-ordinator had just started work at the home. A visiting relative said they had met the activities co-ordinator and said they were "really enthusiastic."

On the board in the hallway we saw that the "Daily Activity Programme" comprised 10-10.30 Exercise Session, 2.30 to 3 Quiz and 3.30 – 4.30 Group Games/Singing. Additionally on Tuesday 11.30 there were Bible Stories. Wednesday 5.30 Movie night and Sunday 5.30 Movie night.

We asked people about the "Bible Stories" sessions. One person said "We have the Jehovah Witnesses every Tuesday morning, it's alright every now and again but not every week. A Catholic priest comes to see (name) and a parson comes every now and then and we sing hymns. That's alright but it's every now and again".

We saw the activities coordinator arrived mid-morning. This person was very animated and enthusiastic and encouraged people to join in with group exercises. They showed us a book with ideas to enable people to keep busy and said they were using activities to engage people's cognitive skills and stimulate memory. We saw people willingly joined in with the group activities and copied the exercises; people chatted and laughed with one another as they attempted to join in. People moved their bodies in time to action songs, such as the 'hokey cokey' and joined in with group games, such as throwing balls and bean bags. We heard one person say: "I'm shattered now, that was good".

We spoke with the activities co-ordinator who demonstrated enthusiasm and knowledge/research in regards to Dementia.

Referring to a programme, Making a Difference (An evidence-based group programme to offer cognitive stimulation therapy (CST) to people with dementia) they told us the previous activity co-ordinator "gave them enjoyment I think but I want to help them too with their illness." They went on to tell about plans they had for developing the activities provision at the home.

We saw one person had their fingernails painted in a colour of their choice. They told us they always used to like having their nails painted and it made them 'feel dressed right'.

People told us what was important to them. One person said their faith was important and they had visits from a priest from their local church. Another person said they enjoyed having visitors and we saw their visitors arrive to spend time with them. We saw people had access to books, newspapers and magazines, although some newspapers in the paper rack were out of date. In one dining area, people told us they enjoyed looking at the fish tank and one person said they liked the view out of the window.

We looked at three people's care records and saw files were organised well so that information was easy to locate. In one file we saw, the assessment was person centred with a completed life story and monthly reviews. There was clear information as to how the person wished to be supported and what their needs were. We saw a personal emergency evacuation plan and clear risk assessments for aspects of the person's care. There was clear recording where other professionals had been involved in the person's care and the person had signed a record of their care review. A second file contained similar detailed information.

Another file we looked at was for a person who had recently come to live in the home. The information in the care plan was sparse. The assessment document was hand written, partially completed and not dated. Some risk assessments were in place but there were blank forms in place for the person's consents and preferences.

We asked people if they had ever made any complaints against the home or what they would do if they had a problem or compliant.

A visitor told us "Not officially no, nothing in writing". They told us how staff had responded well to concerns they had raised previously regarding the care of their relative.

One person who lived at the home said "Well I'd tell the girls first and if it's still a problem I should speak to (the provider)." Another person said "I've never tried or needed to do but I think I'd be listened to reasonably".

We saw that there was a "Complaints, Compliments, Suggestions" form prominently available in the hallway with a closed "post box" for receipt of these.

Good

Is the service responsive?

We saw that complaints made to the home were clearly recorded with an analysis and investigation of what had happened.

Requires improvement

Is the service well-led?

Our findings

Since our last inspection of the home, the person who was acting as manager has left the service. The registered manager of the service is also the owner or provider.

On arrival at the home we were met by a person who introduced themselves as the care manager. They told us that the management team was being developed and that another care manager was due to start work at the home shortly. They also introduced us to another member of staff who had started work at the home the previous day who was to take on the role of quality assurance manager. Later in the morning the registered manager and another member of the management team arrived at the home.

This meant that there were 2 carers on duty and 4 managers. The carers themselves appeared to be unsure of who exactly was responsible for care at that time and lines of responsibility were unclear. One member of staff said her line manager was the "senior" but then said "but today it would be Tina (registered manager) I suppose". Another said that responsibility lay with "The manager, but if a senior and no manager, the senior".

When we spoke with the members of the management team they agreed that the arrangement did appear somewhat top heavy but that it was in the early stages of development.

We looked at the systems in place for assessing and monitoring the quality of the provision. The care manager told us they were responsible along with the registered manager for completing quality audits and were in the process of developing new documentation for this.

We saw there were audits in place in relation to health and safety, including window restrictors, nurse call system, lift call system, water temperatures, cleaning and infection prevention. We saw monthly audits of mattresses but records showed these only until May 2015. These audits showed what action was taken if a mattress failed the checks. We saw the cleaning audits identified some of the areas we had seen on our tour of the premises, such as high to reach areas in the lounge. However, on the bathroom cleaning audit the bath seat had been recently ticked as clean, yet we saw it was not. The registered manager told us there were new systems being developed for quality assurance of the cleaning and premises and said a new member of staff was being inducted into this role.

We saw there was a file for premises and equipment maintenance and this was kept up to date, along with a refurbishment plan.

We saw the relatives' survey dated January 2015, the results of which were positive. We saw recorded evidence the manager had weekly residents check in discussions to find out people's views and a recent satisfaction survey had been carried out with people in relation to Scooby the dog.

We saw evidence of resident and relatives and staff meetings. Staff we spoke with said they could have their say in these meetings. As part of the inspection process we had spoken with the relative of a person who lived at the home. This person had told us that they sometimes found communication difficult and they were not always responded to when they wanted to communicate with the manager.

Prior to our inspection we had received concerns about the manner in which the registered manager spoke with staff. None of the staff we spoke with raised this as a concern. However we did observe a new member of the management team interrupt the handover process and speak to a member of the care staff in a brusque manner.