Crimson Care Limited

Colne Valley Residential Home

Inspection report

185 Scar Lane
Milnesbridge
Tel: 01484 842652
Website:

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Overall summary

We carried out an unannounced comprehensive inspection of this service on 29 October and 8 November 2014. We identified a number of breaches of regulation and, in line with our enforcement process issued the provider with a notice of proposal to cancel their registration. The provider has made representations against this proposal which, at the time of this report, are being considered by the Care Quality Commission.

We undertook a focused inspection on the 24 March 2015 because we had received information of concern. This related to people who lived at the home being put at risk because there were not enough staff available to meet their support needs safely and that accidents had occurred as a result of this. We had also received concerns about the presence of the provider's dog in the home and the conduct of the registered provider/ manager.

This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Colne Valley Residential Home' on our website at www.cqc.org.uk'

This inspection did not change any of the ratings made as a result of our comprehensive inspection in October/ November 2014.

Colne Valley Residential Home provides accommodation for up to 20 people who require support with their personal care. The home mainly provides support for older people and people living with dementia.

The registered provider of Colne Valley 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 and associated Regulations about how the service is run.

When we arrived, we were met by a member of staff who introduced themselves as the manager. They told us they had previously worked at the home as a senior care assistant but had been asked by the provider to take on the role of manager. This person said they would be making application to the Care Quality Commission for registered manager and if successful, the provider would de-register as the manager.

When we conduct comprehensive inspections, we report our findings under the five domains: Safe, Effective, Caring, Responsive and Well Led. All our findings from this inspection come within the 'Safe' domain.

None of the people we spoke with raised concerns about staffing levels, however we were concerned that they were not always appropriate to the needs of the people living at the home. We saw that one accident had

Summary of findings

occurred because a staff member worked alone to support a person to use moving and handling equipment and this had resulted in the person falling. We also saw that a person had been taken to hospital following a fall in the lounge when no staff were present. Neither person sustained injury.

Most of the people we spoke with about the presence of the dog in the home were positive about it. However two people declined to comment. Some staff told us that the dog is locked out of the rooms when food is being served but two staff told us that the dog had pinched biscuits from people who live at the home.

Two members of staff told us they had been shouted at by the registered provider/manager in a communal area of the home; however there was no evidence that people who lived at the home had been affected by this.

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?

The service was not safe

Staffing levels were not sufficient to meet the needs of people living at the home.

The registered provider had failed to take the action identified as needed by themselves to safeguard people.

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 was to look into some information of concern received by the Care Quality Commission about the service.

This inspection was undertaken by 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.

During our visit we spoke with six people who lived at the home, one visiting relative and eight members of staff.

We also reviewed staff rotas, looked at accident/incident reports and three people's care records.

Is the service safe?

Our findings

The Care Quality Commission had received information that people who lived at the home were not being supported safely due to insufficient levels of staff being available to meet their needs safely. We were told this had resulted in accidents and incidents occurring at the home.

During our visit we spoke with people who lived at the home and staff about staffing levels. None of the people we spoke with raised any concerns. We looked at staffing rotas for the week of our visit and saw that on weekdays, daytime staffing was organised at three staff from 7.45am until 3pm and two staff from 3pm until 9.45pm. At weekend there were 2 staff on duty from 7.45am until 9.45pm. Night time staffing was one care assistant with one 'sleeping' night care assistant. Staff told us that the person doing the sleeping night could be called upon for assistance if needed.

At the time of our visit there were nine people living at the home. The manager told us that three of these people needed two staff to support them with mobility. This meant that when any of these people needed support with personal care at a time when only two staff were on duty, there would not be any staff available to ensure the safety of, or to support the other eight people living at the home. This also meant that, during the night, there were not enough staff available to support these people to access the toilet without using the person designated for 'sleeping' night duty. We saw from the rota that on three occasions of the week of our visit, the person designated for 'sleeping' night had this sandwiched between a late and an early shift. If this person was disturbed to assist with attending to people's personal care needs, there was a risk that they would be too tired to safely and effectively fulfil their duties on the following morning shift. This would be particularly relevant when they were designated as in charge of the shift and the designated person to administer medication.

Staff told us about a person who lived at the home who displayed aggressive behaviour towards other people living at the home. We saw record of an incident which had occurred seven days prior to our visit when this person had hit another person who lived at the home. The Care Quality Commission had not been notified of this incident until the day before our inspection. The manager stated in the notification 'since the incident the home has taken extra safeguarding measures where both clients are not left unsupported in the same area without a member a staff, this is to protect both clients from an further altercation from happening again with in the home.'

This arrangement had not been put in place at the time of our visit. When we queried this, the day after our inspection, the manager told us they had arranged extra staffing between the hours of 3pm and 7pm from the day of our visit.

This meant that the registered provider had failed to take the action they had identified themselves as being needed, and as reported to the Care Quality Commission, to protect people who lived at the home.

We looked at documentation and spoke with people who lived at the home and staff to find out if people who lived at the home had been involved in accidents because there were not enough staff to support them. We were told of one accident which had occurred because one member of staff had worked alone in supporting a person to use moving and handling equipment. The instruction in the person's care plan at the time of the accident was for one to two staff to support the person. We noted that the person's moving and handling assessment had not been updated, on the advice of the physiotherapist, to say two staff were required at all times. We saw this accident had been recorded and reported appropriately. The member of staff involved told us they had been 'spoken to' about the incident by the provider and manager. Other staff also told us they had been reminded about the need for two staff to support.

Staff also told us about a person who lived at the home who had been taken to hospital the week before our visit because they had fallen. Staff told us there were not any staff present in the lounge when the person fell. The person was taken to hospital but had not sustained any injury.

The Care Quality Commission had also received information of concern about the presence of the registered provider/manager's dog in the home. This related particularly to the dog pinching food from the people who lived at the home.

When we spoke to people who lived at the home about the dog they were mostly positive in their responses although two people declined to comment. Most of the staff we spoke with said the dog was liked by the people who lived

Is the service safe?

at the home and said it was locked away during meal times. Two staff however told us that the dog did pinch biscuits from people. One person who worked at the home told us they were frightened of the dog.