HC-One Limited

Callands Care Home

Inspection report

Callands Road
Callands
Warrington
Cheshire
WA5 9TS

Tel: 01925244233
Website: www.hc-one.co.uk/homes/callands

Date of inspection visit:
12 September 2023
18 September 2023
20 September 2023

Date of publication:
21 November 2023

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Callands is a 'care home' providing accommodation, nursing and personal care for up to 120 younger and older adults; some of whom live with dementia or physical disabilities. At the time of the inspection 109 people were living at the home across four separate units.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

People's experience of using this service and what we found
Right Support:
People were not involved in their care planning. Care plans were not reflective of people's needs and lacked person centred details. Risks were not always assessed. There was only 1 activity coordinator available to provide support to 109 people, there was limited activities available. The environment was not supportive of people living with dementia there was limited signage to promote independence.
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Right Care:
The service had an inconsistent staff team and high agency use. This meant staff were not always aware of people needs. People's communications needs were not always recorded and there was a lack of awareness of how to apply national best practice supporting people with a learning disability and autistic people.
Some inappropriate language was used when referring to people who used the service.
Although some people had individual ways of communicating, using body language, Makaton (a form of sign language), pictures and symbols, this was not documented which meant staff were not aware of how best to communicate with people to provide effective support and encourage independence.

Right Culture:
Staffing levels and shift patterns were insufficient to enable all people to access the community to pursue their leisure interests and form meaningful relationships within their local community.
Staff did not always have the training and skill needed to support people effectively.
Some staff had poor relationships with each other and management. Staff did not always feel management were approachable and supportive.

Governance processes were not always effective in the monitoring of the service. Whilst some of the

concerns were identified through the service's own provider audits, they had failed to rectify the concerns raised.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The service has been rated requires improvement for the previous 4 inspections, the last inspection was published on 21 March 2021. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to the management of the service, medication, and people's nursing care needs. As a result, we undertook a focused inspection to review the key questions safe and well-led only. During the inspection other concerns were identified and as a result we opened the inspection to include the responsive domain. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.
We have found evidence that the provider needs to make improvements. Please see the Safe, Responsive and Well led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Callands Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified continued breaches in relation to lack of risk assessment, medicines management and governance systems in managing and monitoring the service. There were also breaches identified in relation to the lack of person-centred care, safeguarding people from abuse, clinical practice and staffing, at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

Callands Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection team consisted of 6 inspectors, a medicines inspector, a specialist nurse advisor 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.

Service and service type
Callands Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Callands is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for 4 months and had submitted an application to register. We are currently assessing this application.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed all the information we had received since the previous inspection. We sought feedback from the Local Authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service. We used all this information to plan our inspection.

During the inspection
During the inspection we spoke to 12 people who lived at the service and 4 family members. We spoke with 17 members of staff including, area director, clinical lead, deputy manager, nurses, nursing assistants and carers, to gain their views and experience of the service.

We spoke to external professionals. We reviewed 15 care records, multiple medication administration records, and 3 staff personnel files and 4 agency profiles in relation to recruitment. We also viewed various records, policies, and procedures in relation to the governance of the service and management.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection we found the assessment of risk, safety monitoring and management processes were not effectively established. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- People's current needs and risks were not always clearly assessed and managed. Care plans did not always contain enough information to guide staff on how to support people safely.
- Not all risk were assessed for people who had specific conditions, such as epilepsy, or were at risk of falls. This meant staff did not have guidance on how to support people safely and people were at risk of avoidable harm. One person care plan review identified they utilised a continuous positive airway pressure machine which they kept removing. There was no risk assessment in place to guide staff on what to do if this is removed or how to encourage the use of this. Another person was at risk from placing things in their mouth, this was not risk assessed therefore no plans were in place to mitigate this risk.
- Equipment was in place to reduce risk such as sensor mats and call bells. However, call bells were not always accessible for people to use and were not always responded to effectively by staff. This meant people could not always call for help in an emergency or get their needs met in a timely manner.
- The safety of the premises was not consistently monitored. We found the provider was operating the lift without a valid LOLER and service inspection. The provider immediately responded to this, and work was carried out during day 1 of the inspection.
- People's dietary needs were not always updated. One persons modified diet had been changed following a review from SALT (Speech and language team) however, their care plan reflected previous dietary requirements. This placed people at risk of receiving the wrong modified diet.

The system for assessing risk was not robust. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
- Medications were not always safely managed or stored.
- Written guidance was not always suitably robust for staff to follow when medicines were prescribed to be given 'when required'. For example, where there was a choice of dose, insufficient person-centred detail about when, and how to administer and ensure it was effective was not in place.
- Records were not completed accurately for people who required thickening agent. We were sent

information post inspection that showed a new system had been put in place to help make improvements.
● For 1 person who was prescribed 'when necessary' Paracetamol, we found on one occasion that the time interval between doses were given too close together. This placed them at unnecessary risk of side effects.
● Some people were prescribed transdermal patches for support with pain management. Records failed to evidence rotation of the patch as per recommended guidelines.
● Not all staff had been assessed as competent in relation to administration of medication, we were not assured that any observation of practice and competency in the administration medicines placing people at risk of their conditions not being managed or worsening resulting in harm.
● Medication that had been prescribed as time critical were not being administered in keeping with that direction.
● People's medication was not always given on time. One person said, "The staff have on occasion been late with my medication at night by around 3 hours, which isn't ideal when I am in pain."

The provider failed to ensure the safe management of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding policies and procedures were in place but were not always followed. One staff member told us, "I reported a concern to the manager last month, but they haven't done anything about it."
● During the inspection we found concerns in relation to nursing care, as a result CQC raised a safeguarding referral with the local authority.
● Not all staff had received safeguarding training, only 84.0% of all staff had completed this.
● Staff were not aware of their own roles and responsibilities to safeguard people from abuse. CQC identified 4 safeguarding concerns that needed to be raised with the Local Authority that had not been identified by the service.
● People told us they felt safe, one person said, "I like it here, I feel safe."

Safeguarding procedures were not effective. This is a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

Staffing and recruitment
● The service did not deploy enough staff to meet people's needs or in line with the outcome of the providers own dependency tool assessment. A dependency tool collates information about each person in receipt of care and support and calculates how many hours of staff support they need.
● There was a high use of agency staff. One person told us, "There is always agency workers on shift, but I like living here."
● Staff were not always present on the units and did not always respond to people in a timely way. One person told us, "It's a shame that there aren't many staff as they are rushed off their feet." A staff member told us, "I can't do everything, more staff are needed."
● People told us they had to wait for support. One person told us, "The staff have on occasions been late with my medication at night by around 3 hours, which isn't ideal when I am in pain." Another person told us, "I was thirsty waking up when we had the heat. I can wait hours for a drink, or it can be quick, it depends."
● Staff did not always have the skills and experience required to support people; this placed people at risk of harm and not having the health and care needs met. The training record identified diabetes awareness training had only been assigned to and completed by 6 staff members. One person told us, "The place is not catered to meet my needs as a type 1 diabetic, staff do not know how to manage my diabetes they are asking me what to do".
● Staff's competency to deliver safe and care and treatment was not regularly assessed even when things

went wrong. The provider told us they did not complete written competency checks. Therefore, we were not assured all staff were competent to carry out their roles.

We found evidence the service did not deploy enough suitably qualified, competent and experienced staff to enable them to meet people's health and care needs and that the regulated activity was carried out in a safe and effective way. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment processes were in place. This included checks with disclosure and barring service DBS) checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was not working within the principles of the MCA and if needed, appropriate legal authorisations were not in place to deprive a person of their liberty. Some people had restriction in place without the legal authority to do so. MCA processes had not always been followed. There was no evidence best interest decisions had taken placed for some people who had been assessed as lacking capacity.

MCA processes had not always been followed; people who had been assessed as lacking in capacity did not have decisions made following a best interest. Some people who were deemed to lack capacity and had no representation had not been referred for advocate support.

Preventing and controlling infection
● On the first day of the inspection the home was experiencing a COVID outbreak but there was no signage within the home to inform people of this. Therefore, we could not be assured the provider was appropriately managing and preventing the spread of infection to service users and visitors.
● Toiletries were found in shared communal bath and shower rooms. We could not be certain that these were not shared between people. COSHH products are a risk to people and should not be stored in communal areas.

Visiting in care homes
At the time of our inspection there were no restrictions on visiting within the home.

Learning lessons when things go wrong
● There was a lessons' learnt log in place. However not all identified incidents were recorded therefore we were not assured lessons were learnt following concerns.
● Safeguarding concerns were not always acted upon. Concerns had been raised in relation to care within the home. This was shared with staff during a staff meeting. Actions had been identified however, there was no evidence of any learning as these areas of concern were still an issue during this inspection.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans were not personalised. They failed to take account of people's needs including health, emotional, spiritual, and cultural needs. This meant peoples quality of life was reduced, were at increased risk of poor health outcomes and being supported by staff that did not know them or their beliefs which can impact on peoples mental and physical health. One person told us, "Since being here my mental health has declined, my independence has reduced."

- There was no evidence of future planning, or consideration for the longer-term aspirations of each person. One person on the young person unit, care plan stated under 'Hope and Aspiration' 'unable to express hopes and aspirations.' This meant people were not encouraged to reach their own goals and achievements and plan for their future.
- People were not actively involved in the decisions or planning of their care; effective communication methods were not utilised to ensure people with nonverbal skills could participate in their own care planning. This meant people were at risk of not being supported in their preferred way.
- The environment did not support people to remain independent. There was limited signage to help people living with dementia. One of the toilets had a male and female symbol on the door but only had a urinal in place.
- Daily notes were task centred and lacked personal detail. There were gaps in recording which meant we were not assured that people's needs were being met.

People were not always supported to make choices about their care and they, or their representative were not always involved in decision-making or reviews. This placed people at risk of harm. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Communication care plans were not effective and did not guide staff on how to support people to communicate. Staff were not aware of communication aids that were in place to support people.

● People's preferred way of communication was not clearly documented or understood; for example, one person was able to use Makaton to communicate, but there was no reference to this within the care plan; another person needed written communication this was not identified within their care plan. This meant people were not supported effectively. Staff did not know peoples means of communication or always have the skill? to be able to understand or include them in day to day activities to ensure their needs were met and to prevent social isolation.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were not always provided the opportunity to engage in meaningful activities. One person told us, "I am not offered activities, I was offered when I first came here and I said no, since then they just don't bother to ask me."

● Some people's care plans were not personalised; they did not identify people's social and leisure activities therefore staff did not encourage people to participate in activities of their choice.

● People were not always supported in meaningful activities; we observed one person sitting in the same chair with the same colouring page open for the duration of the first inspection day.

● Activity support was organised around the service's needs, rather than the person. Staffing hours within the service did not allow for evening activities due to a reduction in staffing levels overnight. No staff were able to support and promote young people's social activities and engagement after 7pm when staffing hours reduced. One person told us, "The place is not suitable for people like me, if I want to go out I have to wait for staff to open the door as all of the doors are locked for other peoples safety."

● People who are cared for in bed received limited interaction with people and staff. Inspectors observed people remaining in their room throughout the day.

Improving care quality in response to complaints or concerns

● There was a complaints policy in place however, some people told us their complaints were not responded too. One person said, "I have raised it [concern] with the care staff and they don't do anything, I raised it with the managers and they said it's the first time they're hearing of this but didn't do anything about it, so I involved my social worker". Another person informed us, "I have told them [managers] about this and they haven't done anything."

● Some complaints were responded too however, the tracker used to monitor complaints was not effective as it did not demonstrate any actions taken following on from a complaint to demonstrate they had responded appropriately.

● Not all people knew how to complain. One person told us, "I wouldn't know how to get the attention of staff or who to talk to if I needed to complain." A family member told us, "If I wanted to complain or raise a concern, I don't know the process although that might be in the paperwork I was given."

End of life care and support

● The service did not consistently engage with people or their advocate in planning end of life care. One person's care plan stated, 'lacks capacity and is unable to discuss wishes.'

● End of life care plans did not contain information required by the home, one person end of life care plan did not reference they had a DNACPR. This could mean people are resuscitated against their wishes.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection, we identified that quality assurance measures were not effectively in place. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Not enough improvement had been made at this inspection and the provider continued to be in breach of Regulation 17. This was the fourth consecutive inspection that the provider had been in breach of Regulation 17.

● The service had a home improvement plan however the identified time frames were not being met. This included care plan review and staff competencies, which meant we were not assured people were receiving the right care from experienced and competent staff.
● The procedures for monitoring the health and safety of the service was not robust. We identified failings in checks and actions required.
● The providers monitoring systems had identified some of the shortfalls found during the inspection, but the provider had not taken action to address these concerns. This included the management of risks and medication.
● Support plans did not contain enough specific person-centred detail to guide staff on how to support the person's needs. This meant staff did not know how to communicate effectively with people or support them when they became upset.
● Daily records were not being suitably maintained to ensure people's care needs were being met. We observed several examples where people were not receiving the care, they needed including positional changes and sufficient fluids.
● We identified night checks were not updated at the time of support being provided. These were completed at a later time; we therefore could not be assured of the accuracy of any records held regarding people's daily care and safety.
● There was no effective system in place to support and monitor staff and their deployment around the service. The deployment of staff did not meet the needs of people living within the service. One staff member told us, "I had too much to do so I rang the office for one of the management team to help me, they never bothered to show up."
● There is no training policy in place to identify how often staff need to attend refresher training courses. It is inputted onto staff members own training log which meant there is no oversight from management. The current compliance rate is only 85.1%. Which meant not all staff had the training and skills to provide safe

care and treatment. Inspectors identified 1 member of staff was carrying out a clinical procedure they were not trained to complete. This placed people at risk of avoidable harm.

The provider's quality assurance systems and processes were not effective and had not enabled them to assess, monitor and improve the quality and safety of the service.' This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff had mixed views in relation to the support from management. One staff member told us, "They [manager] are toxic, no one will speak up to them." Another member of staff told us, "I would speak to my manager if I had a concern to raise, she is approachable."

● The service failed to promote good outcomes for people as people's care was not always planned comprehensively, and it was difficult to tell if people received the support they needed.

●There was a negative culture within the home, staff did not feel valued, one staff member said, "the manager just focuses on the staff and telling them what to do not on the people who live here."

● People did not consistently receive person-centred care and daily records held information that was not person centred.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider responded to some feedback and took action to address some of the concerns we raised. However, feedback from external professionals following on from the inspection still identified concerns had not been actioned. The next inspection will determine the effectiveness of these actions.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The providers engagement with people, staff and relatives was minimal. People were not actively involved in providing feedback to drive improvements within the service. Inspectors viewed one resident survey which was limited in detail and there was no evidence of actions taken following this.

● staff experience of support and supervision varied, 1 staff member told us. "I don't really get supervision, I had to sign one to say I had attended even though I was on leave." However, another staff member told us, "I have regular supervisions."

● There was no consistency in how staff were deployed to ensure a staff team who knew people and had the skills and competencies to meet their needs. The rota were tailored to meet the service rather than people's needs. One staff member told us, "I am moved around to other units which is good for business, but it isn't good for the people on this unit as they then end up with staff they don't know."

Continuous learning and improving care

● Actions plans in place were not always effective. Actions were not carried out in a timely manner and were not always followed up. One action identified within the home improvement plan was to update all care records. Inspectors viewed a care plan that had been audited in May 2023 with updates required, these had still not been completed at the time of the inspection.

● Action plans have been implemented by the provider following on from this inspection. The effectiveness of these will be measured at the next inspection.

Working in partnership with others

● The service has been working with the Local Authority however, safeguarding investigations were

sometimes delayed due to difficulty obtaining information

● Referral to specialist services were not always made in a timely way. One person's catheter had come out a week previously and a referral to the catheter care team had not been made until inspectors brought this to the management teams' attention. This meant this person was at risk of developing infections.

● Informative information had been shared from external professionals including social workers and health profession on how best to support young people with communication difficulties. The provider did not utilise this information to ensure people's needs were met and appropriate support offered,

● The service worked alongside the local GP and the enhanced care home liaison team who visit weekly.