HC-One Limited

Callands Care Home

Inspection report

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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

This inspection was unannounced and took place on the 10 March 2017. A second day of the inspection took place on 13 March 2017 in order to gather additional information.

Callands Care Home was previously inspected in March 2016 when it was found to be meeting all the regulatory requirements which were inspected at that time. We also undertook a focussed inspection on the 20th July 2016 to review action taken since our last inspection and to check that people were receiving appropriate care and support as we had received information of concern. During that inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person centred care and safe care and treatment. We found that people using the service had not always had their needs adequately assessed and planned for. Furthermore we found that people did not always receive care that was person centred and responsive to their needs.

During this inspection we found that the provider had taken action to address one of the breaches identified at the last inspection in respect of person centred care. We found that improvements had been made in regard to the breaches however further work was needed in both areas.

Callands Care Home is owned by HC-One Ltd (the provider) and provides personal and nursing care for a maximum of 120 people. At the time of our inspection the service was accommodating 110 people.

The home is a two storey building which has five units equipped with individual lounges and dining areas set in its own grounds within the Callands area of Warrington. There is a car park provided for visitors at the front of the home.

The units include: Coniston (which accommodates 30 older people with nursing care needs); Windermere (for 10 people living with dementia); Grasmere (for 30 people living with dementia who also have nursing needs); Ullswater (for 20 people with nursing care needs) and Lakeside (for 10 older people and 20 younger adults).

At the time of our inspection there was no registered manager at Callands Care Home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The deputy manager had been assigned to oversee the management of Callands Care Home pending a newly appointed manager commencing in post and was present during the two days of the inspection.

Whilst many of the people spoken with and their representatives told us that they were well cared for and

happy in Callands Care Home, we observed and identified breaches of the relevant regulations in respect of staffing, safe care and treatment, person centred care and good governance. You can see what action we told the provider to take at the back of the full version of the report.

Systems were in place to safeguard people from abuse and to respond to complaints. Staff spoken with confirmed they had received training in this key area and were confident that any allegations of abuse made would be reported and fully investigated to safeguard people's welfare.

Some people who used the service did not have the ability to make decisions about some parts of their care and support. There were systems in place to protect people who could not make decisions which followed the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Staff also had access to training in this protective legislation.

Staff recruitment systems were in place and information about prospective employees had been obtained to make sure staff did not pose a risk to people using the service.

Staff were had access to induction, regular on-going training and periodic supervision to develop the necessary skills and competence for their roles.

People using the service had access to a choice of menu and received wholesome and nutritious meals that were well presented and took into consideration each person's dietary needs.

Records showed that people also had access to a range of health care professionals (subject to individual need).

The home employed three activity coordinators who supported people to take part in activities either individually or in groups, which included going out to places of interest. Since our last inspection changes had been made to how activities were planned and organised, however we identified areas where there was still scope for further improvement.

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 completely safe.

People were not adequately protected from the risks associated with unsafe medicines management.

Staffing levels were not always adequate to ensure people received appropriate levels of care and support

Staff knew how to recognise and respond to abuse. We found that safeguarding procedures were robust and staff understood how to safeguard the people they supported.

Recruitment procedures provided appropriate safeguards for people using the service and helped to ensure people were being cared for by staff that were suitable to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective.

Some parts of the building were in need of maintenance and refurbishment.

Staff had access to induction, mandatory and other training that was relevant to their roles and responsibilities.

Policies and procedures relating to the Mental Capacity Act and Deprivation of Liberty Safeguards had been developed. Staff understood how this protective legislation impacted upon their work and the need to protect the rights of people who may lack capacity.

People's nutritional needs had been assessed and meals planned accordingly.

Systems were in place to involve GPs and other health care professionals when necessary.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people did not consistently receive care and treatment that was appropriate for their needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provision of activities for people required further improvement to ensure people had regular access to activities that were geared towards their individual needs.

Some care records were not secure, up-to-date or accurate

Systems were in place to receive and act upon complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager in place and the home had not benefitted from consistent leadership and direction.

Quality assurance systems had been established so that the service could be monitored and developed. There were arrangements for people who lived in the home and their relatives to be consulted about their opinions of the service however this process was in need of review.

Callands 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 checked whether the provider was 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.

The inspection took place on 10 March 2017 and was unannounced. A second day of the inspection took place on 13 March 2017 in order to gather additional information.

The inspection was undertaken by three adult social care inspectors and two experts 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, in this case of younger adults and older people requiring residential or nursing care.

The provider was not requested to complete a provider information return (PIR) prior to the inspection. A PIR 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.

We looked at all the information which the Care Quality Commission already held on the provider. This included previous inspections and any information the provider had to notify us about. We invited the local authority and Clinical Commissioning Group to provide us with any information they held about Callands Care Home. We took any information provided to us into account.

During the site visit we spoke with the deputy manager of Callands Care Home. We also spoke with the area finance administrator, a visiting community psychiatric nurse, five registered nurses, one nursing assistant, one trainee nursing assistant, four care assistants, one activity coordinator, a maintenance person, the head cook and member of the domestic team. Furthermore, we spoke with 37 people who used the service, nine visitors and contacted five family members by telephone to obtain additional feedback.

We encouraged people using the service to communicate with us using their preferred methods of communication. We also undertook a Short Observational Framework for Inspection (SOFI) observation in one unit of Callands Care Home in addition to other observations we made. SOFI is a specific way of

observing care to help us understand the experience of people who could not talk with us.

We looked at a range of records including 10 care plans belonging to people who used the service. This process is called pathway tracking and enables us to judge how well the service understand and plan to meet people's care needs and manage any risks to people's health and well-being. Examples of other records viewed included: policies and procedures; four staff files; minutes of meetings; complaint and safeguarding logs; rotas; staff training; activity records; maintenance and audit documentation.

Requires Improvement

Is the service safe?

Our findings

We asked people who used the service if they found the service provided at Callands Care Home to be safe. We received mixed feedback from people using the service and relatives.

For example, one person reported: "They are sometimes short of staff due to sickness and things so they call in other staff or sometimes agency." Likewise another resident reported: "I just hope they know what they are doing."

We received mixed feedback from relatives. For example, three relatives reported: "I feel it is very safe"; "I am happy that there are no risks to his safety and "I am sure that there is no bullying or harassment." Conversely, another three relatives reported: "They always seem to be short staffed"; "I don't think it is perfect here" and "Her needs are only met when the manager [deputy manager] is on duty."

At the time of our inspection there were 110 people were being accommodated at Callands Care Home who required different levels of care and support. We checked staff rotas with the deputy manager in order to review the numbers of staff on duty. We noted that there were vacancies for four nurses which the provider was in the process of trying to recruit to.

Examination of the rotas on each unit showed occasional variations in the staffing levels when more or less staff than was average for that unit had been rostered to work.

Resident dependency assessments were in place to monitor the dependency levels of the people using the service on each unit however the deputy manager was not aware of the existence or whereabouts of a staffing tool. Likewise, there was no evidence available in the home to demonstrate how the dependency needs of people using the service were being taken into consideration in the planning of rotas and the deployment of staff.

We spoke with the area finance administrator who informed us that a staffing tool had been circulated however this could not be located in the home at the time of our inspection. We were informed that a 'colleague deployment team' based in Darlington had been established in February 2017 and was now responsible for dealing with staffing 'grids' and staff deployment tools. The deputy manager reported that she had received no contact from this team at the time of our inspection but had provided the previous registered manager with dependency information prior to her departure.

We noted that the needs of some people using the service were not being met. For example, on one unit, we observed people to look unkempt and not dressed appropriately; people not receiving appropriate personal care, interaction or support at meal times or when displaying inappropriate behaviour and an unclean toilet (soiled tissues in the sink, stained flooring and a malodorous smell). Thick and Easy products (an instant food and beverage thickener used for people with swallowing impairments) were also not being safely or securely managed and records were not being completed contemporaneously.

It was evident that a few people on the unit required more intensive levels of support and monitoring to ensure their basic needs were met. Staff spoken with also stated that they felt they needed a review of staffing and made comments such as "I don't think there's enough staff. You need eyes in the back of your head" and "It would be beneficial for more staff." Staff also reported that they were often asked to go and help on other units and that they would benefit from a twilight shift to help with assisting people to bed.

This is a breach of Regulation 18(1) and 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, sufficient numbers of suitably qualified, competent skilled and experienced persons were not being deployed effectively.

The service employed a deputy manager on a full time basis who worked flexibly subject to the needs of the service. Ancillary staff were also employed for activities, domestic, laundry, catering and maintenance tasks.

The provider had developed a policy for the administration of medication which included controlled drugs, the disposal and storage of medicines and for PRN (as required medications). The policy was readily available in the medication storage areas in each unit for staff to reference.

We checked and / or observed the arrangements for the management of medicines on 5 units with a registered nurse. We noted that only registered nurses or senior staff administered medication. A list of staff responsible for administering medication, together with sample signatures was available for reference on each. Staff spoken with confirmed they had received medication training.

Photographs of the people using the service had been attached to medication administration records which also detailed people's names and key information. This helped staff to correctly identify people who required medication. Medication was stored in a dedicated area on each unit and medication trolleys were secured to the wall when not in use. Daily stock counts were completed and a 'resident of the day' system was also used to ensure all medication pertaining to an individual was checked each month, together with associated records.

We checked a sample of medicines and medication administration records (MAR) on five units and found that on the whole people were receiving their medications as prescribed. There were two exceptions on different units where we found that prescribed eye drops had not been administered. In one case a service user had not been administered Latanoprost for glaucoma for a period of eight days. Upon examining the reason why, we found that medication had been ordered from the pharmacy but for some reason had not been delivered or put on the MAR. Arrangements were made to contact the pharmacy who agreed to supply the same day. In another unit we found that a MAR had not been signed during the evening on one day for Brinzalomide and Hypromellose eye drops. Latanoprost and Brinzalomide eye drops are essential for people with glaucoma, to prevent raised pressure in the eye that can damage their eyesight. Hypromellose eye drops act as artificial tears and make dry eyes feel more comfortable.

In another instance we noted that a member of staff had signed for medication prior to administering. This is not appropriate as medication administration charts should only be signed following administration to confirm a person has received their medication correctly.

Furthermore, prescribed Thick and Easy products were not being safely or securely managed. For example, on one unit we noticed that one product had been insecurely left on a side table with no lid or label on it. We also noted that lids with people's names on them had been incorrectly placed on products prescribed for other people. This practice has the potential to place the health and safety of people using the service at risk.

This is a breach of Regulation 12(1) and 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that the management of medicines was not completely safe.

We also checked the arrangements for the storage, recording and administration of controlled drugs (drugs subject to tighter legal controls because of the risk of misuse) and found that these were satisfactory.

Systems were also in place to record room and fridge temperatures, medication returns and incidents concerning medication. Additionally, monthly medication audits were undertaken by senior staff as part of a peer review process.

We looked at the personal files of 10 people who were living at Callands Care Home. We noted that each person had a range of care plans together with supporting documentation which included a range of risk assessments. Personal emergency evacuation plans were also in place to ensure an appropriate response in the event of a fire. This information helped staff to be aware of current risks for people using the service and the action they should take to minimise and control potential / actual risks.

Records of any accidents and incidents had been recorded for each individual. The provider continued to use an electronic database known as 'datix' to capture information such as accidents and incidents, complaints, safeguarding incidents and slips, trips or falls. This system enabled management information reports to be generated for analysis and we saw examples of how the data had been used to generate statistical information and summary reports.

The provider had developed a comprehensive range of policies and procedures to ensure safe working practices. Copies of key procedures were stored in the office on each unit for staff to reference. We saw that an Emergency Contingency Procedure had also been developed to ensure an appropriate response in the event of an untoward incident. The copy on file was dated November 2014 and was in need of review as it contained the name of a previous registered manager, deputy manager and people that were no longer living in the home. We recommend that the registered person reviews this document to ensure it is brought up-to-date.

We looked at the personnel files of four staff members to check that effective recruitment procedures had been completed. In all of the files we found that the appropriate checks had been made to ensure that prospective employees were suitable to work with vulnerable adults. Checks had been completed by the Disclosure and Barring Service (DBS). (These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.)

Files also contained interview notes, application forms, two references, health questionnaires and proofs of identity including photographs. All the staff files we reviewed provided evidence that the checks had been completed before people were employed to work at Callands Care Home. In appropriate instances there was also evidence that Nursing and Midwifery Council personal identification numbers had been checked to ensure valid nursing registration.

A corporate safeguarding policy and procedure had been developed by the provider to offer guidance to staff on their duty of care to protect vulnerable people from abuse and how to whistle blow. A copy of the local authority's adult protection procedure was also available for staff to reference.

Training records viewed confirmed that 92% of the staff team had completed safeguarding training (11% of which were in need of refresher training). However, the deputy manager and staff spoken with during our inspection demonstrated a satisfactory understanding of how to recognise and respond to suspicion or

evidence of abuse to safeguard the welfare of vulnerable people.

We looked at the electronic safeguarding records for the service. The safeguarding log highlighted that there had been 25 safeguarding incidents in the last 12 months. Records viewed confirmed that safeguarding incidents had been referred to the local authority safeguarding team in accordance with local policies and procedures. One whistle blower concern had also been received by the Care Quality Commission (CQC) in the past twelve months. This was referred to the local authority safeguarding team for investigation.

Staff had access to personal protective equipment such as hand sanitisers, gloves and aprons and policies and procedures for infection control were in place.

We noted that infection control audits were routinely undertaken as part of the home's quality assurance system. The last audit for February 2017 indicated that the overall score was 97.7%.

Requires Improvement

Is the service effective?

Our findings

We asked people who used the service or their representatives if they found the service provided at Callands Care Home to be effective. We received mixed feedback from people using the service and relatives.

For example, comments received from four people living in the home included: "Food very good. First class home"; "You just get what you are given for meals"; "I don't eat fish so I have an alternative" and "The food isn't brilliant."

Likewise, comments received from relatives included: "Place is lovely as care home's go"; "The food is excellent. She was losing weight but is now eating"; "The permanent staff are okay but the agency staff don't know her"; "At times they could do with extra staff" and "The agency staff are different ones all the time and she [a service user] panics when she doesn't know the staff."

Callands Care Home is a two-storey building which has five units equipped with individual lounges and dining areas set in its own grounds within the Callands area. There is a car park provided for visitors at the front of the home.

People using the service were noted to have access to a range of individual aids to assist with their independence and mobility. This included specialist equipment necessary to meet people's needs such as grab rails, toilet aids, hoists and airflow mattresses and cushions to reduce the likelihood of pressure ulcers.

We saw that each unit was decorated with different themes and that some environmental adjustments had been made in the units designated for people living with dementia to help address their specific needs. For example, people's bedroom doors had been painted different colours, names and photographs were displayed within memory boxes on some doors and familiar personal items were on display. These would all help someone to locate their own room and distinguish it from others. Some additional equipment to support activities had also been purchased. Likewise, in one unit we noted that IT equipment had been installed in a room to enable people using the service to access the internet. We noted that although signage was in place for toilets and bathrooms there was no directional signage on the units to further help people find their way round.

Some parts of the home viewed were seen to be in need of maintenance and refurbishment. We observed that some minor refurbishment work was taking place in one unit which consisted of some wires being boxed in and a bedroom being redecorated. However, we also noted that toilets, particularly on two units were in need of refurbishment as several tiles were missing from the walls and some had badly stained flooring. One toilet had been taken out of service because maintenance work was needed. We also saw that some handrails, doors and architraves were chipped and that some fresh paintwork was needed. We discussed these issues with the deputy manager who agreed to raise the issues with the maintenance team.

The provider had a learning and development team in place to support management and staff. A programme of induction, mandatory, qualifications and service specific training was available to staff and

delivered via face to face sessions or online learning modules. Clinical training was also provided for nursing staff.

We spoke to staff during the inspection who confirmed they had accessed induction, mandatory and other training relevant to their roles and responsibilities. The training on offer also included key training in areas such as safeguarding; understanding the Mental Capacity Act and DoLS, introduction to dementia and equality and diversity.

The provider used a computer e-learning package called Touchstone for the majority of staff training and staff were expected to undertake this when required. The electronic 'learning management system' had been developed to assign and monitor each individual's learning based on their role. The system also provided management information and highlighted the outstanding training needs of staff and when refresher training was required. Records viewed detailed that the completion rates for permanent and bank staff ranged from 62.6% (safer people handling) to 90.4% (medicine management awareness). For registered nurses, the completion rates for available training ranged from 44.4% (staff handbook) to 100%)Understanding the Mental Capacity Act and DoLS.

The deputy manager informed us that she was monitoring the learning needs of staff closely to ensure the outstanding learning needs of staff were met.

Staff spoken with confirmed they had attended daily handovers and periodic meetings. Staff also told us that they received on-going support, however some staff gave mixed feedback regarding the frequency of their formal supervisions. We shared this feedback with the deputy manager who agreed to look into the issues raised.

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 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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated DoLS with the deputy manager.

We noted that policies and procedures had been developed by the provider to provide guidance for staff on how to safeguard the care and welfare of the people using the service. These included guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). We saw that mental capacity assessments were undertaken if necessary and if applicable DoLS applications were completed. These were only completed if a person was deemed to be at risk and it was in their best interests to restrict an element of liberty. Applications were submitted to the local social services department who were responsible for arranging any best interests meetings or agreeing to any DoLS imposed and for ensuring they were kept under review. The home had a record of people with authorised DoLS in place and the expiry dates.

We talked to staff to ascertain their understanding of who had a DoLS in place and what this meant. Staff spoken with confirmed they had completed training in the MCA and DoLS and demonstrated an awareness of their duty of care in respect of this protective legislation.

A four week rolling menu plan was in operation at Callands Care Home which was reviewed periodically by the provider. The menus included a hot light meal or soup and sandwiches at lunchtime and two choices of main meal in the evening in addition to individual requests. The menu also stated that a minimum of seven hot or chilled drinks would be served each day.

The daily menu was available in each unit for people to view and had been displayed in noticeable positions such as notice boards. We noted that kitchen staff were made aware of any special dietary requirements when people were admitted and information on the dietary needs of people using the service had been obtained as part of the care planning process. We also saw examples of risk assessments and speech and language therapist reports for people considered to be at risk of choking or dysphagia. Dysphagia is a medical term for swallowing difficulties.

Menu choices were obtained the day before a meal was served in order to enable catering staff time to prepare meals. We noted that people's meal choices had been recorded on a menu planner for each unit.

We spoke with the head cook and looked at the kitchen. We saw that information on the dietary needs of people using the service was recorded on a large wipe board in the kitchen. This identified any special dietary needs for people such as: puree (for people with swallowing difficulties); mash; weight loss; allergies and / or special diets so that catering staff were aware of people's needs.

The kitchen area appeared clean and well managed. The cook showed us how she recorded key information relevant to the operation of the kitchen in a corporate catering safety manual which had been developed by the provider. We noted that the most recent food hygiene inspection was completed in April 2016. Callands Care Home was awarded a rating of 5 stars which is the highest award that can be given.

Food was transported in a heated trolley from the central kitchen to each of the five units. We observed that people could eat their meals in the dining area on each unit or in their rooms. Dining areas were appropriately equipped with tablecloths, table mats, decorative flowers, condiments and cutlery subject to the individual needs of people living in the home.

Staff were seen to wear appropriate uniforms and hair covers whilst serving meals and were on hand to offer assistance to people who required support with eating and drinking. Staff were seen to provide appropriate attention and support to some people with a diverse range of needs in an unhurried and relaxed manner. However, we also observed times when some people did not receive the correct level of support they required at mealtimes. For example we observed one person trying to drink out of an empty cup and another person sat in a lounge alone with a chocolate pot upside down. The content of the pot was all over the person's toast.

Portion sizes were seen to be good and meals were attractively presented. We saw that people also had a drink of their choice and additional refreshments and snacks were provided throughout the day.

Staff had developed effective working relationships with a range of social care and health professionals to help ensure positive outcomes for people's health and well-being. We could see from records that staff made referrals to appropriate health professionals where they had concerns about someone's health.

Discussion with people using the service and care plan records viewed also provided evidence that people using the service had accessed a range of health care professionals such as: GPs, opticians and chiropodists subject to individual needs.

Requires Improvement

Is the service caring?

Our findings

We asked people who used the service or their representatives if they found the service provided at Callands Care Home to be caring. We received mixed feedback from people using the service and relatives.

For example, comments received from people living in the home included: "The staff are kind and caring, respectful and look after me"; "The permanent staff are efficient but I don't feel that about the agency staff; "They respect my privacy. They draw my curtains before helping me to dress"; "Sometimes someone helps me" and "Staff look after you on a personal basis."

Comments received from relatives included: "There is nothing the staff could do more and they talk to her when feeding her"; "He is always showered and sat out in a chair when I arrive" and "It is a very caring and understanding home".

However, examination of complaint and safeguarding records and intelligence received by the Care Quality Commission prior to our inspection highlighted ongoing concerns regarding the quality of care sometimes provided to people living at Callands Care Home. Concern was also raised by some relatives spoken with during our inspection regarding the high turnover of staff and management, the subsequent reliance on agency staff and the resultant impact on the quality of care provided.

During our inspection we observed that people did not always receive appropriate levels of care and support. For example, on one unit, we saw that people looked unkempt and were not dressed appropriately, were not receiving appropriate personal care and interaction and had inadequate support at meal times and when displaying behaviour that challenged the service.

This is a breach of Regulation 9(1) and 9(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, people did not consistently receive care and treatment that was appropriate for their needs.

We used the Short Observational Framework for inspection (SOFI) tool as a means to assess the standard of care provided on one unit accommodating people living with dementia. We observed a small group of people whilst they were sat in a lounge area during the afternoon.

One member of staff had gone on a break and the other member of staff was sat behind people completing paperwork. The television was on but the people living on the unit showed no interest in watching the television and there was little interaction or stimulation. One person was seen to be reading a magazine. When the other member of staff returned from a break we observed the staff member to interact with people in a warm and positive manner. For example, asking people whether they were okay and engaging in short conversations. The staff member was seen to be kind and responsive and facilitated support when required. For example, one person said they were too warm so the staff member responded by opening a window and suggesting the person remove their cardigan. Overall, people on the unit appeared content and relaxed.

We also observed good practice and positive, relaxed and friendly relationships between service users, staff and visitors during our inspection.

Staff spoken with demonstrated a good understanding of the people they were supporting and their individual needs. Staff were also seen to be diligent, hardworking, responsive and caring and took time to treat people with dignity and respect.

Requires Improvement

Is the service responsive?

Our findings

We asked people who used the service or their representatives if they found the service provided at Callands Care Home to be responsive. We received mixed feedback from people using the service and relatives.

For example, comments received from four people living in the home included: "There are no activities"; "Plenty of activities if you want them"; "I don't see much going on" and "Activities generally very good."

Likewise, comments received from relatives included: "Gets well looked after" and "Totally happy with care and support."

One person using the service and a visitor reported that staff sometimes took a long time to answer the call bells. We spoke to a member of staff about this and were told that sometimes the batteries on the pagers could go flat. We raised this issue with the deputy manager and senior staff during a meeting and noted that some staff had set their pagers to vibrate only. This could result in a call for help being missed. We received assurance from the deputy manager that all staff would be requested to set their pagers to sound an audible alarm in the future so that there was no chance that if someone pressed their alarm it could be missed. We also received assurance that the batteries would be checked frequently.

We looked at the records of 10 people living at Callands Care home during our inspection and noted that a corporate care planning system was in use.

Pre-admission assessments of need were in place which confirmed people's needs had been assessed before they moved into the home. The assessments identified key information such as the person's needs, their family details and medical history prior to admission to the home.
Care plans had also been produced which contained personalised information on the needs of people and took into account the level of support required, each person's views, abilities, level of understanding and other key considerations.

Supporting documentation was also in place such as updated assessments of need; risk assessments; resident profiles; weight records; malnutrition universal screening tools (used to identify whether people were at nutritional risk); observation records (used to monitor for example position changes or food and fluid intake); personal hygiene; daily records; consent forms; care reviews and other miscellaneous information.

Records viewed provided evidence that people using the service or their representatives had been involved in care planning wherever possible and that plans had generally been kept under regular monthly review.

However, we identified some issues with records and records management. For example, some records viewed were difficult to decipher and had not been updated contemporaneously. On one unit we asked to look at a sample of one person's recent position change forms and they could not be located. We also noted that confidential records relating to people using the service were being stored in boxes in a communal

lounge area.

Furthermore, although we found that reviews of risk assessments and care plans had been completed monthly, they had not always been updated following significant changes.

For example, one person's needs had changed since the last review as their health had improved. The person had been reassessed by a Speech and Language Therapist and no longer required thickened fluids and a soft diet. The person had also had a catheter removed. The person's care plan had not been updated to reflect this.

Furthermore, some handover sheets contained varying degrees of information for each person – some were very detailed about such things as diet, mobility, continence, but some contained no information. We also looked at wound care plans and saw that wounds were not recorded as being dressed as frequently as the plan required and there was no system in place to remind staff when dressings were due.

This is a breach of Regulation 17(1) and 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, accurate, complete and contemporaneous records were not being maintained securely in respect of each service user, including a record of the care and treatment provided.

The registered provider had developed a 'Compliments, Concerns and Complaints' policy to provide guidance to people using the service and / or their representatives on how to make a complaint.

We looked at the electronic concerns and complaints records for the service. This outlined the type of incident; name of complainant; date received; subject; brief description; date of reply; actions taken and lessons learnt and date closed.

Records detailed that there had been 36 concerns / complaints raised in the last twelve months which covered a range of issues such as: standards of personal care provided; catering; conduct and attitude of staff; cleanliness of the home; response to call bells; accuracy of care records; staffing levels; lack of activities; standard of the environment and missing belongings. Records confirmed that issues had been investigated and acted upon by the service however we identified similar issues during our inspection.

People spoken with confirmed they were aware of how to raise a complaint and that they were confident that in the event they raised a complaint they would be listened to.

The provider employed one full time and two part time activity coordinators who were responsible for the development, planning and provision of a range of social and other events for people, either on an individual basis in someone's bedroom if needed, or in groups.

During our inspection, one of the activity coordinators was on annual leave.

On the first day of our inspection, we were informed that a group of people participated in an art and craft session in the main (Kendal) lounge which involved painting. In the afternoon, we observed the two activity coordinators in the lounge supporting three service users who were undertaking colouring and knitting activities.

On the second day of our inspection, we observed the two activity coordinators supporting 10 people to undertake their preferred chosen activity such as arts and craft, manicures, puzzles and jigsaws. We were told that people from each unit except Windermere (a unit for people living with dementia) were present.

A programme of activities was displayed on a large noticeboard in the home which advertised the range of activities on offer to people. We reviewed the provision of activities with one of the activity coordinators and noted that people using the service had continued to access a range of activities such as: one to one time; word games; flower arranging; gardening; chair exercises; arts and crafts; board games; parachute and target games and film shows. There were also signs around the home advertising that the Alzheimer's Society was due to host entertainment in the main lounge on the Saturday following our inspection. A hairdresser and ministers from the Church of England and Roman Catholic faith also visited the home. A sign was on display informing people to let the staff know if they wanted help to practise any other religions.

Since our last inspection staff responsible for activities had started to introduce centralised records to provide an overview of activities and participants. We were also informed that activity staff had started to allocate time on each unit and this was evidenced via a unit allocation matrix. However, upon viewing the record, it became clear that activity staff had spent a limited period of time on each unit.

We raised this observation with the deputy manager and discussed the benefit of activity staff planning more daily time (such as a full morning or afternoon) on each unit. The deputy manager assured us that she would undertake a further review of the provision of activities at Callands Care Home so that people using the service benefitted from meaningful daily activities that were more geared towards their individual needs and preferences.

The home also had a room designated and equipped as a bar. The bar was open for two hours on a Monday and Tuesday, four hours Wednesday to Friday and six hours at the weekend. The bar had a full licence so people who used the home and visitors could have an alcoholic or soft drink in casual surroundings in the evenings and at weekends. We saw people using the bar area during our inspection.

Requires Improvement

Is the service well-led?

Our findings

We asked people who used the service or their representatives if they found the service provided at Callands Care Home to be well led.

No direct comments were received however some people spoken with expressed concern regarding the leadership and direction of the home.

The provider (HC-One Limited) had developed a 'Quality Assurance Policy and Framework'. The quality assurance framework had four tiers of interrelated processes which included: a home based system known as 'Cornerstones'; a regional support team quality assurance process; quality assurance process following external scrutiny and a quality assurance overview by the provider.

The policy indicated that surveys of key groups were an essential part of the quality assurance framework. We noted that people were encouraged to share their feedback via the carehome.co.uk website and information on how to use this facility was displayed in the reception area of the home. We asked for a print off of the reviews submitted to the website and noted that the score was 4.3 out of five from seven positive reviews in the last 12 months.

The provider had also installed a 'Have Your Say' electronic tablet in the reception to enable people using the service, professionals and visitors to provide feedback on the service provided. We were informed that the tablet had been out of use for approximately two months at the time of our inspection as it required a replacement battery pack.

We asked to view all surveys and feedback received from people using the service and their representatives in the last 12 months. The deputy manager provided us with four reports dated June 2016. Two were for feedback from relatives and their comments and two were for feedback from residents and their comments.

The feedback results indicated that only 23 relatives and two residents had completed the surveys which contained questions relating to: the overall impression of the care home; environment; lifestyle; décor and maintenance; staffing; dignity and respect; complaints and management and communication. The responses were ranked into four areas - outstanding, good, requires improvement and inadequate.

Given that Callands Care Home is registered to accommodate up to 120 people with a diverse range of needs, the response rate was poor for each survey type. Consequently, this information did not enable the provider to obtain a detailed picture of satisfaction levels within the home. An action plan in response to each service type could also not be located.

We raised concern about the effectiveness of this system with the deputy manager as we had also highlighted a poor response rate for people using the service during our last inspection.

This is a further breach of Regulation 17(1) and 17(2)(a) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014, in that, although there were systems in place for assessing and monitoring the service to improve quality, these were not being operated effectively.

Staff, resident and relative meetings were also coordinated periodically in addition to service reviews with people using the service.

The home based system consisted of various practical tools and audit documentation which had been developed to ensure key aspects of the service were routinely assessed and monitored. For example, we saw that health and safety; accidents and incidents; catering; medicines; falls; care plans and infection control audits had been undertaken periodically. Some of this data had also been inputted on to an electronic database known as 'datix' and analysed by the provider's head office that in turn produced a summary report for the attention of the manager.

Although complaints were investigated and responded to there was a lack of learning as we could see that similar issues were still themes throughout the inspection. This highlights that the provider was not adequately addressing issues of concern in the long term.

This is a further breach of Regulation 17(1) and 17(2)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, although the provider had established a complaints policy and procedure, there was evidence that feedback had not been used effectively to improve their practice.

An example of this was the 'monthly key clinical indicators report' which outlined potential risks for people using the service such as: falls; weight loss; infections data; hospital admissions; bedrail usage and pressure ulcer occurrence.

The completion of the above records provided an on-going account of life within the home that could be audited as part of the company's internal quality assurance system. Actions could also be taken when any risks were identified.

At the time of our inspection the home did not have a registered manager in post. We were notified via a statutory notification from the area director that the previous registered manager had resigned from post during February 2017. We were also informed that the provider had appointed a new manager and was awaiting confirmation of a start date.

The deputy manager informed us that she had been assigned to temporarily oversee the management of Callands Care Home and was present during the two days of our inspection. The deputy manager was consistently helpful and supportive to the inspection team.

The deputy manager was based in an office which was located centrally within the home and this meant that the deputy manager was accessible to staff in all of the units as well as people who lived in the home and their visitors. We observed positive interactions between the deputy manager, staff, people using the service and visitors during the two days of our inspection.

Staff spoken with during the inspection told us that the deputy manager had a visible presence in Callands Care Home and we viewed examples of daily 'home manager walk rounds' records which had been undertaken to monitor standards of care and to ensure that current issues were discussed and briefed.

We also attended and observed the deputy manager facilitate a 'flash meeting' during the inspection. This operated as a head of department meeting and was attended by senior staff in each unit to ensure key

information was shared across a range of operational areas such as: current issues; housekeeping; administration; catering; maintenance; activities and care related issues. We observed that the deputy manager encouraged two-way communication and that she was attentive and supportive to staff.

Periodic monitoring of the standard of care provided to residents funded via the local authority was also undertaken by Warrington Borough Council's Contracts and Commissioning Team. This is an external monitoring process to ensure the service meets its contractual obligations. The contracts monitoring team last undertook a core monitoring visit to Callands Care Home during January 2016. Upon completion of the monitoring visit the service was issued with an improvement plan for areas relating to the safe and well led domains of this report.

Follow up visits were also undertaken during July, September and December 2016. We reviewed the provider's action plan and noted that significant progress had been made in response to the majority of findings.

We sampled a number of test and / or maintenance records with the person responsible for maintenance at Callands Care Home relating to: the fire alarm system; fire extinguishers; portable appliances; gas safety; passenger lift; nurse call and hoisting equipment and found all to be in order.

The registered person is required to notify the CQC of certain significant events that may occur in Callands Care Home. We noted that the acting manager had kept a record of these notifications. Where the Commission had been notified of safeguarding concerns we were satisfied that the appropriate action had been taken.

Information on Callands Care Home had been produced in the form of a Statement of Purpose and a Service User Guide to provide people using the service and their representatives with key information on the service. The information was on display in the reception area of the home for people to view.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not consistently receive safe care and treatment that was appropriate for their needs

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The management of medicines was not completely safe

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not being deployed effectively

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not have effective systems and processes in place to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We served a warning notice under Section 29 of the Health and Social Care Act 2008. We told the provider that they were required to become compliant with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 29 September 2017.