HC-One Limited

Callands Care Home

Inspection report

Callands Road
Callands
Warrington
Cheshire
WA5 9TS

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20 July 2016

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Ratings

Overall rating for this service	Good
Is the service responsive?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of Callands Care Home on the 7th, 8th and 17th March 2016. Following our inspection we recommended that the activities programme and staffing resources be reviewed to develop and enhance the provision and range of activities on offer for people using the service.
This was because a number of people highlighted concerns regarding the range of activities available in the home. People told us that they felt there were insufficient activities on offer to meet their diverse needs and the number of people living in the home.

Since our last inspection in March 2016, we have received information of concern regarding the standard of care provided to people with complex support needs.
We therefore 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.

This report only covers our findings in relation to this topic. 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

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 focussed inspection the service was accommodating 114 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.

A peripatetic manager had been assigned to oversee the management of Callands Care Home and was present during the day of the inspection. We were informed that a new manager had been appointed and that this person intended to apply to register with CQC.

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. We found that people had not always received care that was person centred and responsive to their individual needs and that some call bells were not operating and / or being responded to effectively.

Since our last inspection the provider had increased activity coordinator hours by ten additional hours per week to enable the provision of activities over a seven day period. A sensory garden had also been developed for the Grasmere unit to include an arbour area and sensory items and a newsletter produced. Despite this action, people spoken with were still of the view that the range of activities on offer was limited and that this issue remained in need of review.

Systems were in place to record and respond to complaints.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records showed people using the service had not always had their needs adequately assessed and planned for.

People using the service did not always receive care that was person centred and responsive to their needs.

Systems were in place to receive and act upon complaints.

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.

We undertook a focussed inspection of Callands Care Home on 20 July 2016. This inspection was completed because the Commission had received information of concern regarding the standard of care provided to people with complex support needs. We inspected the service against one of the five questions we ask about services: is the service responsive? This is because the concerns we received related primarily to the responsiveness of the service.

The inspection was undertaken by one adult social care inspector and an inspection manager.

Before the inspection we reviewed the information we held about the home, this included speaking with the local authority's safeguarding and contracts monitoring team.

During the site visit we spoke with the peripatetic manager of Callands Care Home, deputy manager, three nurses, three staff; eight people who used the service and one relative.

We looked at a range of records including four files 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; complaint logs, activity records and rotas.

Requires Improvement

Is the service responsive?

Our findings

During the inspection we asked people about their experience of living in the home. Comments from some people indicated that there was a lack of person centred care.

Since our last inspection the provider had increased activity coordinator hours by ten additional hours per week and employed two full time and one part time activity coordinators who were responsible for the development and provision of a range of activities for people using the service over a seven day period. A sensory garden had also been developed for the Grasmere unit to include an arbour area and sensory items.

A programme of activities had been produced which was displayed in reception for people to view. The manager informed us that changes had been made to ensure a rolling programme of activities was provided to people on different units, to ensure people had access to activities geared towards their needs. A newsletter had also been produced to provide information on the home and activities on offer.

However, one person told us that she usually got up about 7am. When asked if she had preferred getting up at that time when she lived in her own home she said she hadn't and had always stayed in bed later. She went on to say that she got up "when they come for me". This person told us she spent all day in the small lounge she was sitting in.

We asked if there were any activities that she enjoyed participating in but she said they all took place in another lounge and because she needed to use the hoist to be moved she wasn't able to access that lounge. We looked at this person's care records and although there were some brief details about interests that she had, there was no record that she had been enabled or encouraged to carry on enjoying them.

We observed the same person sitting in the lounge on her own for several hours. Over the course of the morning carers came into the room on a couple of occasions but did not engage in any conversation with the person. After two hours one carer came and asked her if she wanted the TV on and at 11.35am another carer came in with a drink and biscuit. Other than these minimal interactions this person was left alone. We asked this person if she would be going to the dining room for lunch but she told us she was always served her meal where she was. She went on to say that because she needed the hoist to move she wasn't able to go to the dining room.

Although there was a range of activities that were listed as on offer, it wasn't clear how people were encouraged and enabled to participate. We looked at the activity records for several people and found that there were very few, or no entries for some people about any social events they had engaged in.

This was a breach of Regulation 9 (1) of the HSCA 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure that care was provided that met people's needs and reflected their preferences.

On the day of our inspection we observed a group of 16 people participating in a flower arranging and tea /

coffee session with two activity coordinators. During the afternoon we observed one of the activity coordinators leaving the home to support a person to attend a hospital appointment. This resulted in only one activity coordinator remaining in the building.

We could see that important details regarding people's care needs were not recorded. For example, there were no instructions for staff about what time people liked to get up or how people's oral hygiene and nail care was to be provided. We saw that several people had dirty fingernails. We asked one person if staff helped her clean her teeth and she said "no, that may be my fault". We checked this person's toothbrush and found it was bone dry and had certainly not been used that day. We saw that one person had a hearing aid but no mention of this was made in their care records to advise staff about its use.

We looked at a seven day care plan for one person who had recently been admitted and found no evidence of twice daily evaluation as required by the provider. Furthermore, care plans viewed were brief and some were difficult to decipher.

We looked at a sample of care plans to see how issues with people's diet and fluid intake were being managed. We saw that generally people were being weighed within the timescales stated in their care plans. Where people had lost weight, this had been acted on and people had been referred to the dietician or to the Speech and Language Therapist (SALT) appropriately.

We also looked to see how people who were at risk of pressure ulcers were being cared for. Whilst risk assessments had been carried out and reviewed we could not always see that the required care was being delivered. For example, several people were assessed at high risk of skin breakdown and according to their care plans required help to change position every 2-4 hours. However, when we asked to see the monitoring charts there were gaps and longer periods where it appeared people had not been helped to move as frequently as they should. We were furthermore concerned that the person sat in the lounge for long periods of time was not assisted to move at all for the time we observed and her charts indicated that she was sat in the lounge from early morning until at least mid- afternoon and sometimes as late as 6pm.

We had concerns about the system in place to monitor the care being provided. When we asked at 11.10am to see the monitoring charts for that day the carers showed us a file that they were just about to start completing. All the charts in the file were at that stage blank. We saw later that staff had written specific times when food or drink was given and quantities but all the information had been written retrospectively. If charts are not maintained contemporaneously there is a risk that they will not be accurate as they rely on individual staff to remember over a period of time which people had what care. Some of the charts from previous days recorded low levels of fluid intake. For example the chart for one person on 19/7/16 recorded only 800 mls of fluids taken. The temperature on that day was extremely hot (28°C+) so if the record was correct, the person would not have had sufficient to drink.

This was a breach of Regulation 12 (1) of the HSCA 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure that risks to the health and safety of people using the service were fully assessed and that all action was taken to mitigate risks.

We spoke with one person that wanted help to go to the toilet. A nurse call pendant was close at hand and we asked if he could use it. He was able to ring the pendant for assistance. We waited for 15 minutes but no staff arrived to assist the person. We asked the nurse if the nurse call bell was working. The nurse showed us a pager that all staff had. The person's room number was showing on the pager but no staff had attended. We asked the nurse what the system was for ensuring the nurse call bells were responded to but she seemed unsure. We checked the nurse call in another person's bedroom, where the person was in bed. When we

pressed the pendant the buzzer didn't activate. We found that we could only activate the buzzer by pressing another button on the box on the wall, but this was out of reach for the person in bed. We looked to see if there was a nurse call pendant in the lounge. We saw that although there was, it had not been made available to the person sitting on their own in the lounge and when we tested it, it was not working properly. This person's care records stated that she was able to use the nurse call system and she should have it at hand.

This was a further breach of Regulation 12 (1) of the HSCA 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure that equipment used by the service provider for providing care or treatment to a service user was safe for such use and was used in a safe way.

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.

A complaints log had been established to record any concerns or complaints. This outlined the complaint reference number; date of complaint; details of the complaint; action taken and date closed.

Records detailed that there had been 16 complaints in the last seven months. Records confirmed that issues had been investigated and acted upon by the service.

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 The registered provider had failed to ensure that care was provided that met people's needs and reflected their preferences.

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 registered provider had failed to ensure that equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way.