

Pendle Residential Care Limited

Calder View

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Calder View is a residential care home providing personal care to up to 6 people. The service accommodates people who require support with their mental health. At the time of our inspection there were 6 people using the service, who resided in one building which had 2 floors.

People's experience of using this service and what we found

Staffing levels were lower than required on some shifts. The service was in the process of recruiting a new staff member to address this. Recruitment processes needed improving to ensure full employment history was being sought. We made a recommendation about this. Medication pill counts matched records, but some paperwork relating to medicines needed to be put in place, guidelines needed to be followed and medicines audits needed to be more robust. We made a recommendation about this. Although the home was clean and tidy and people were supported to have visitors, on arrival staff were not appropriately wearing face masks, as the provider's policy did not align with national guidance. This was immediately rectified. We made a recommendation about this. Systems and processes were in place to safeguard people from abuse, however we found one example where necessary referrals had not been made. We were able to review some examples of lessons learned and there were appropriate risk assessments in place.

Quality assurance systems required some improvement, the medicines audits did not identify all of the concerns we found and the provider had not completed the provider information return (PIR) when requested. The registered manager spoke about being open and honest when things went wrong, however we did find one incident that had not been appropriately reported, this was before the registered manager's time in post. We received positive feedback about the registered manager and staff knew how to escalate concerns if necessary. Staff worked in partnership with various agencies and the service engaged with people and their relatives to help drive improvement.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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.

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

Rating at last inspection

The last rating for this service was good (published 18 July 2018).

Why we inspected

We made a decision to inspect Calder View after completing a full review of information we hold about this service. We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We undertook a focused inspection to review the key questions of safe and well-led only. 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 to requires improvement. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Calder View on our website at www.cqc.org.uk.

Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to governance at this inspection. We have also made recommendations in relation to medicines, recruitment practices and infection control practices.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Calder View

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

This inspection was carried out by two inspectors.

Service and service type

Calder View 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. Calder View is a care home without 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 a registered manager in post.

Notice of inspection

This inspection was unannounced. Inspection activity started on 29 September 2022 and ended on 04 October 2022 when we provided feedback remotely. We visited the location's office/service on 29 September 2022.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. The provider did not complete the required PIR. This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. Please see the well-led section of this report for further details. We used all this information to plan our inspection.

During the inspection

We spoke with 2 people who used the service and 1 relative about their experience of the care provided. We spoke with 5 members of staff including the registered manager, 3 care workers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. During the inspection, we visited both floors of the home and we reviewed a range of records. This included reviewing 2 people's care records in detail. During the inspection we also looked at various medicines records and the storage of medicines. We looked at 2 staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

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 good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed

Staffing and recruitment

- Staffing levels were at times slightly lower than required. However, the registered manager was in the process of recruiting 1 additional carer to make up the required staffing levels. There was no evidence that this had any negative impact on people.
- Recruitment processes were mostly safe, though the service had not obtained a full employment history for the staff whose recruitment files we reviewed.

We recommend the provider reviews their recruitment processes to ensure new applicants are recruited safely.

Using medicines safely

- Medicines processes required some improvement.
- Information to support staff to safely administer 'when required' medicines was not always available; therefore, people may not have been given their medicines when they needed them.
- For one person the service had not followed national guidance around two staff signing when medicines administration records were updated with hand-written entries.

We recommend the service review their medicines processes to ensure medicines are managed safely.

Following the inspection, the nominated individual told us they had taken action to resolve the issues we identified on the inspection.

- Medicines counts did match stock levels.

Preventing and controlling infection

- IPC practices were not always safe. Staff were not wearing masks on our arrival. When we raised this concern, we were told they were following internal guidance. Internal guidance was not in line with national guidance. The registered manager ensured that staff were appropriately wearing face masks as soon as they were made aware of the issue. The nominated individual assured us that all internal paperwork had been updated to reflect the need to wear face masks.

We recommend the service ensures staff wear PPE in line with Government guidance.

- The home was clean and tidy and we found no other IPC concerns.

- People were supported to have visitors in line with current government guidance.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Systems and processes were in place to safeguard people from the risk of abuse.
- We had seen that a necessary safeguarding referral had been made, however, we also found that an incident from January 2022 had not been notified when needed. This was before the current registered manager was in post.
- A safeguarding policy and procedure was in place and included information on how to escalate concerns.
- Staff told us they had received safeguarding training and were able to provide examples of what they would report.
- We were able to review some examples of lessons learned.

Assessing risk, safety monitoring and management

- Appropriate environmental risk assessments were in place including fire risk assessments and legionella risk assessments.
- People living at the home had their own risk assessments in place relating to their health conditions and requirements.

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 working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

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 good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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

- Quality assurance systems required some improvement to identify the issues we have found in the safe domain, relating to medicines, infection control and staff recruitment.
- Recent medicines audits did not highlight all of the concerns we found. The registered manager told us these were completed by a senior care assistant who is no longer employed by the service and going forward these audits would have management oversight.
- The provider has not completed the PIR which we requested.
- We found one incident that had not been reported to CQC and safeguarding when it should have been, however this incident happened before the registered manager was appointed.

We found no evidence people had been harmed, however, systems were not robust enough to demonstrate records and governance was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager was aware of their responsibility under the duty of candour and spoke about being open and honest when things go wrong.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- The registered manager promoted a positive open culture. A whistleblowing policy was in place and staff knew how to report poor practice.
- Staff told us they enjoyed their roles, staff comments included, "I don't know what my least favourite part is, but my favourite part is making a difference to the service user in their daily living" and "I like helping the chaps out. When you manage to pull something off that you have been working towards for a while, it's good. It's a nice feeling. I like my team, I like to see them and talk to them, it's pretty decent".
- Feedback about the registered manager was positive. One staff member told us, "Yes to be honest with you I think she [registered manager] is a great manager, she's approachable. I do feel that she's given us that support, that we can go to her with our concerns at any time" and one person told us, "She [the registered manager] was here the other day (points to office). I like her, trust her".
- Staff worked in partnership with the local authority, various other agencies and health professionals to ensure people received appropriate support.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- The service engaged with people and staff. Staff and service user meetings were taking place, however, the registered manager had not conducted any recent relative meetings. The registered manager told us relatives were kept up to date via telephone or during visits. People did have contact sheets which detailed how often they would like contact with their loved ones.
- We were able to see some examples of continuous learning from lessons learned and also from actions taken from feedback forms.
- Annual surveys had recently been sent out to and the service was awaiting their responses. We were able to see examples of previous surveys which had been conducted.

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	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not robust, as they did not identify all of the issues we found. This put people at risk of harm. This was a breach of regulation 17(2) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.