TLC Care Management Ltd

Calderdale Retreat

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 9 May 2018 and was unannounced. The last comprehensive inspection was in September 2017, where we found there were 10 breaches of the Health and Social Care Act 2008, (Regulated Activities 2014) regulations. We carried out a further focused inspection in December 2017 and found there were no improvements made.

Following the last inspection, we met with the provider to confirm what they would do and by when to improve the key questions to at least good. At this inspection we found the provider had taken steps to address all of the breaches and significantly improved the quality of the service. We have made two recommendations in relation to ensuring procedures to evidence the robust recording of staff checks and for information about people's consent to be more accurately recorded.

Calderdale Retreat is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates 81 people across three separate units, each of which have separate adapted facilities. One of the units specialises in providing care to people living with dementia, one of the units is for people who need nursing care and the other unit is for people who require residential care. At the time of the inspection there were 25 people living at Calderdale Retreat and the ground floor residential unit was unoccupied.

There was a registered manager who had been in post since January 2018. 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 registered manager had made some significant changes since coming into post and had made real progress to improve the quality of care for people through a clear action plan and targeted approach. All areas of the service provision had improved and actions had been taken to ensure there were no breaches in the regulations.

People were happy and well cared for, with their needs met in a person-centred way. We saw examples where people's health and well being had significantly improved since our last inspection. People's nutritional needs were well met and there was a good understanding of individual risks to people throughout the service. Medicines were well managed and there was good clinical oversight of people's health needs.

Care records were being improved to fully reflect people's needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies

and systems in the service supported this practice.

Systems to recruit and induct new staff were in place although staff checks needed to be evidenced more clearly. Staff had clear direction and they were supported, trained and motivated to carry out their work. Communication had improved throughout the home and staff understood their roles and responsibilities. There were supportive relationships between staff and people in the home and there was a happy atmosphere with kind, caring and respectful interaction.

There was a newly emerging culture of openness and transparency, with good channels of communication between staff at all levels, people who used the service, relatives, visitors and other professionals in support of people's care.

Staff were involved and included in the implementation of new processes and systems to drive improvement in the service and as such they felt valued and respected. The registered manager had an oversight of the strengths of the service and the areas to improve and actively sought feedback from people, relatives, staff and other professionals. There was good evidence of partnership working to secure and embed improvements.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of 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?

Requires Improvement

The service was safe although at this inspection it was too soon to assess if improvements would be sustained.

Improvements had been made to ensure people's safety and minimise risks.

There was a clear oversight of risks in the home, and accidents and incidents were monitored closely.

Staff were deployed effectively to meet people's needs safely.

Is the service effective?

Requires Improvement

The service was effective although at this inspection it was too soon to assess if improvements would be sustained.

Systems were in place for induction, training and supervision of staff.

Staff understood people's individual needs.

People's nutritional needs were well met and there was good access to drinks.

Is the service caring?

Good

The service was caring.

Staff demonstrated a kind, caring and respectful approach to people.

People felt well cared for and they were complimentary about the staff team.

People were consulted and involved in their care and support.

Is the service responsive?

Requires Improvement

The service was responsive although there were still improvements needed.

People were more meaningfully engaged in activities and conversation with staff.

Care was more person-centred and there were improvements being made to the dementia care environment and to care records. This work was in progress and further improvements were still required.

Complaints were responded to in a prompt and professional manner and people felt able to approach the management team.

Is the service well-led?

Requires Improvement

The service was well led although we were unable to assess if improvements would be embedded and sustained.

There had been a significant improvement with the new registered manager in post and well targeted actions were taken to address the concerns raised at previous inspections.

There was improved leadership and clear direction for staff, with staff empowered and supported to carry out their roles and responsibilities.

Systems and processes ensured the quality of the provision was improving and beginning to embed.

Calderdale Retreat

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 is 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.

This inspection took place on 9 May 2018 and was unannounced. There were three adult social care inspectors and an inspection manager. We gathered and reviewed information before the inspection, from notifications send to us by the provider and from feedback sent to us by members of the public and staff. We liaised with the local authority partner agencies, such as the commissioning teams and the safeguarding team.

We spoke with eight people using the service, four of their relatives and friends. We spoke with 10 staff directly involved in people's care as well as cleaning, maintenance, laundry and kitchen staff, the registered manager and the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing care and reviewing records. We looked at five care records, three staff files and documentation to show how the service was run.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found people were not cared for safely. This was because risks to individuals were not known, staff were not recruited safely, safeguarding procedures were not known or followed, and there were no safety checks made for individuals or for premises. At this inspection we found there had been significant improvements to address the breaches in regulation and ensure people were safe and any risks to their health were known and planned for. The service was safe although at this inspection it was too soon to assess if improvements would be sustained.

We found risks to people were well managed. For example, where people were at high risk of developing pressure ulcers, records detailed any specialist equipment required, any creams or dressings used and how often the person should be repositioned. Where people required specialist equipment such as pressure relieving cushions and mattresses we saw these were in place. Staff understood who required this level of care and records along with observations showed this was being provided.

People and their relatives said they felt safe. One relative said, "There is continuity of staff now. [Name of person] recognises them" and another relative said "[Name of relative] has always felt safe here, they call it 'my home'." Another relative told us, "Staffing levels have improved. There are enough staff. You almost never hear them say 'just a minute' when people need help, they just get on with it."

Care plans we looked at contained a range of up to date risk assessments, including those for falls, nutritional health, skin integrity, allergies and social isolation. We saw there was a folder available at the nurses' station with summaries of these assessments for quick reference. This meant staff were able to check up to date risk information 'at a glance' as well as accessing more detailed assessments on an electronic document.

Some guidance for staff was detailed and clear, however in one care plan we saw risk minimisation measures were not specific to the person. These were generic prompts which the electronic care system generated. For example, the person's Waterlow (skin integrity) risk assessment indicated a 'Very High' risk, however the guidance for staff stated, "The current Waterlow score for [name of person] is very high, this indicates one or more of the following should be considered." There was then a list of generic actions that had not been adapted to show how the specific risk to that person was being managed.

The registered manager told us they were continuing to revise the care records to ensure these accurately reflected risks and they were mindful some generic documentation was still in place and not necessarily relevant to each person.

Accidents and incidents were recorded in people's care plans, and we saw evidence of review and investigation by either the deputy or registered manager. We saw action was taken to update people's risk assessments and care plans where analysis of any incidents concluded this was appropriate. Lessons learned from these were discussed and shared with the staff team to minimise the risk of reoccurrences.

Staff we spoke with confirmed they had received safeguarding training. They understood the reporting systems and were confident any concerns they raised would be dealt with appropriately.

We observed staff supporting people with their mobility safely and appropriately. When using a hoist staff gave reassurance to people and we saw transfers were safe. Staff used techniques appropriate for each person's abilities and understanding and supported them at their own pace without feeling rushed.

Our observations showed staff were present in sufficient numbers to provide care and support when people needed it. When we arrived people were present in their rooms, dining rooms or communal lounges as they preferred, and we saw staff were unhurried when giving support to people.

People and relatives told us they felt there were enough staff to meet people's needs. We saw staff worked well together as a team making sure there was a staff presence in communal areas as well as regularly checking on people who chose to stay in their bedrooms. When people rang their call bells for assistance we found staff responded promptly. One person said, "If I need someone I just press this (call bell) and they come."

Staff also felt the staffing levels were sufficient. One staff member said, "There's enough of us now. We have someone in the lounge and work together to make sure everyone's okay."

We discussed staffing rotas with the registered manager and we looked at how these were organised. The registered manager explained staffing was worked out several weeks in advance so all staff knew what they were doing and absences could be mitigated. There was use of agency staff and the registered manager told us they were working closely with one particular agency to achieve consistent bookings of the same agency staff. This meant people had continuity of care from staff who knew their needs. Recruitment was ongoing to ensure the home was fully staffed and we saw in addition to care staff there was a supportive ancillary team in place.

We saw recruitment processes were in place, although on occasion were not followed robustly. For example we looked at three staff files and found there was one reference which was not available in one file. The registered manager was able to request the required reference to evidence suitability checks had been done, although they acknowledged this should have been identified at the point of employment. We saw the member of maintenance staff was working in the home but had been contracted by the provider and as such had not completed any suitability checks. We discussed this with the registered manager who took immediate steps to ensure this member of staff was deployed in tasks which did not involve contact with any people living at the home. They immediately commenced the process of completing suitability checks for the maintenance staff. Whilst these matters were dealt with, they had not been identified prior to the inspection. We recommend the procedures are improved for ensuring the robust vetting of staff is clearly evidenced.

Medicines were managed safely. People told us they received their medicines when they needed them. We saw medicine administration records (MARs) were well completed. We watched staff giving people their medicines and saw they did this safely providing support where needed. On the nursing unit we checked two people's medicines and found the number of tablets in stock matched those recorded on the MAR. This indicated medicines were administered in the right way. The opening date was written on eye drops to make sure they were not used beyond their expiry date.

We saw all medicines were stored securely including controlled drugs (medicines subject to tighter controls because they are liable to misuse). We checked a sample of controlled drugs and found stock balances were

correct.

We reviewed the MAR charts for two people on the dementia care unit and saw these were detailed documents that included photographs of people, any known allergies, and clear information about the medicines that people took. Where people took medicines on an 'as and when' (PRN) basis we saw there were clear protocols in place to show when and how the medicine should be given, how often, the maximum daily dose, any contra-indicators or side effects and the expected benefit the person should get from taking the medicine.

Our review of MAR charts showed these were fully completed with no unexplained gaps, and a running stock count was recorded, showing there were processes in place to enable early identification of any stock errors. We observed staff administering medicines on the dementia care unit and saw they gave people assistance and time to understand what they were taking and why. People who said they had pain were given pain relief. The temperature of the medicines rooms were monitored and recorded daily, and we saw this did not exceed a temperature at which the safety of medicines may have been compromised.

We looked around all areas of the home, including toilets and bathrooms, dining rooms, lounges and, by invitation, some people's private rooms. We saw all areas were clean and free of any malodours. Staff had access to and made good use of personal protective equipment (PPE) when needed, and all hand gel and soap dispensers were full. People and relatives told us good standards of cleanliness were maintained. One person said, "My room is kept spotless". We spoke with cleaning and laundry staff who confidently explained the procedures they used to minimise the risk of infection in the home.

Care plans contained personal emergency evacuation plans (PEEPs) which showed clearly the level of assistance the person would need in the event of an emergency. This included information about any cognitive or sensory impairments that would need to be considered, and any equipment staff should use in order to assist the person safely.

We also saw PEEPs were available in people's bedrooms. These clearly showed the support each individual required from staff if they needed to vacate the home in an emergency such as a fire. The registered manager told us they were compiling these into a central file so they could be quickly accessed for the whole home if needed. Staff told us they had received fire training and had taken part in fire drills. They said the drills included how to use fire equipment such as sledges which can be used to evacuate immobile people safely.

We spoke with the maintenance staff who showed us the systems and processes they followed to ensure the safety of the premises and some of the equipment. For specialist equipment, such as for lifting people, there were contracts in place to ensure regular safety checks.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we had concerns staff had not received adequate training and support. People's rights were not protected and staff did not understand the legislation regarding people's mental capacity. People were not supported to have enough to eat and drink. At this inspection we found significant action had been taken to ensure the breaches in the regulations had been addressed.

People and their relatives said staff knew how to do their jobs and they knew people well. A relative told us, "[Name of person] likes a lie in in the morning, that's their choice and it is respected. They listen to what [name of person] says."

Staff confirmed they received regular training which was kept up to date. They described the training provided as 'good' and said it was relevant to their job roles. We spoke with an agency member of staff who told us of the induction they had received when they completed their first shift in the home. This included going through the fire procedures and being shown where the fire equipment and fire exits were located. They said they were then introduced to each person by a senior staff member and orientated to the home. They said they worked with a staff member throughout the shift. They described this process as very thorough and said it helped them get to know people.

We saw there was moving and handling 'train the trainer' training taking place on the day of the inspection. We spoke with the external trainer who was delivering the training and they told us they combined detailed theory with practical training to ensure staff were suitably competent to cascade the training to other staff. The trainer also told us they delivered fire marshalling, data protection and risk assessment training.

We saw the training matrix and discussed this with the registered manager who told us staff training was a continuing process and was given high priority following the last inspection.

Staff told us and records confirmed, individual supervision and group supervisions were taking place on a monthly basis. Staff we spoke with said they could approach any of the management team at any time for support and guidance.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

There was clear information in care plans about the status of any DoLS application or authorisation, and this was also included on the daily handover sheet. Where applications had been made we saw evidence the deputy manager had contacted the relevant local authority to query this.

Staff had received training and understood the requirements of the MCA and DoLS. A record was available which showed when DoLS had been applied for, the authorisation date, expiry date and details of any conditions. Four people on the nursing unit had a DoLS authorisation; none had any conditions in place.

Care plans we looked at contained a range of decision specific assessments of people's capacity, including those for receiving support with personal care, administration of medicines, use of sensor mats and residing at Calderdale Retreat. In support of these we saw best interests decisions had been documented, however these did not always involve people other than staff at the home. We fed this back to the deputy manager during the inspection and they told us they would take action.

Consent was inconsistently recorded in the care plans we looked at. For example, the consent to photography in one care plan was not completed, however there were photographs of the person on their care plan and MAR chart. In another care plan we saw a statement that their advocate had given consent to photography, although there was a lack of clear information as to who the advocate was or when they had been consulted. In the same care plan we saw a statement that the person had given consent to regulatory bodies having access to their care plan. There was also a statement, '[Name of person] was not present when their assessment and care plan were completed – [Name] does not wish to have a key to their room'. We recommend information about people's consent is more clearly evidenced.

We saw staff offer people choice, including asking how and where people would like to spend their time and what snacks and refreshments they may like. When providing assistance, such as help to reposition or mobilise we saw people were given encouragement to do as much as possible for themselves, meaning staff were mindful of not over-assisting people in ways which may have been restrictive.

Care plans contained information about nutritional risks and how these were being managed, but we found some variation in the effectiveness of records made, for example in the amount of food or fluid the person had taken each day. The deputy manager showed us they had added a target intake for fluids in response to feedback from our previous inspection. Although this was present, one person's records showed their actual intake had been consistently below this over the week up to our inspection date. On three occasions we saw the person's intake was over a litre less than their target intake, and we did not see any evidence of review or action taken. We brought this to the attention of the deputy manager who told us they would take action.

In another care plan we saw the person was at risk of losing weight and was to have meals fortified, for example with butter or cream, additional high calorie snacks and prescribed fortified drinks. Although we saw staff were recording when the person had their fortified drinks, the food intake records did not always evidence the person's care plan was being followed. For example, on some occasions the record showed the person had 'declined' a meal, due to being asleep. There was no evidence to show staff had returned to offer them a meal when they were awake. Records did not evidence the person was receiving additional high calorie snacks. We checked and saw the person's weight had remained stable, and discussed the importance of staff keeping accurate records with the deputy manager. We saw they actively encouraged staff to record people's intake during lunch.

People told us they liked the food. One person told us they didn't like certain foods and described the chef as wonderful saying they knew what they liked and made meals especially for them. We spoke with the chef who was able to show us how they knew about and catered for people's individual dietary needs and

preferences.

We saw the daily menu was displayed in the dining room in words and pictures showing a choice of meals. Lunch was served by the kitchen staff and we heard people being asked what they would like to eat and drink. Meals were served from a heated trolley onto plates which were covered and taken on a tray to each person. The food was nicely presented. We saw those who needed a soft or pureed diet could distinguish the different components of the meal which were served separately on the plate.

We made observations of the lunch service. People were able to choose whether they took their lunch in the communal dining rooms or in their private rooms. The dining tables were set with table cloths and matching napkins, condiments and cutlery. There was background music playing and staff were present in sufficient numbers to chat with people and offer drinks before the meal was served. People were offered choice of whether to start their meal with soup, and if they wanted to add any seasoning, and a choice of main courses. When people had finished each course they were asked if they wished to have more, and we saw people provided with second helpings if they asked for them. We saw meals looked appetising and hot, and people we spoke with said they had enjoyed their meal. Some meals were adapted to enable people to eat them safely, for example in a pureed form where people were at risk of choking. We saw these were presented attractively, with each component shaped and distinct from each other. This made the adapted food more appetising for the person.

There was some variation in the support people received when assisting people with their meals on the dementia care unit. For example, we saw two people received focused support and encouragement from staff who were attentive to their needs and mindful of their experience. We saw one person struggled to eat independently was provided with a plate guard to assist them. Two other people who required assistance to eat had a more task-focused experience because staff rarely spoke to them and frequently appeared to lose focus and either look around the room or talk to other people. We fed this back to the deputy manager.

On the nursing unit we saw staff sat with people who needed assistance providing one to one support; chatting and checking people were ready for another mouthful and asking if they were enjoying the food. One person whose care plan showed they liked to eat with their fingers and did not like to eat with others was sat in the same room but on a table by themselves. We saw they had a meal they were able to eat easily with their fingers. The person looked content, they were eating well and we heard them saying 'mmm' after each mouthful. This showed staff had found a way of making sure the person's individual need to eat alone was met while at the same time making sure the person was not isolated.

People told us they enjoyed their lunch. One person said, "It was very nice. The chicken was lovely and tender." A relative told us, "The food is excellent, that's for certain." Another relative said, "They notice more now – [name of person] loves fish and chips, and when [staff] noticed [name] wasn't eating this they knew something was wrong."

We saw people were provided drinks and snacks throughout the day. There were water fountains in the lounges and we saw staff offered people drinks from this as well as juices and hot drinks on regular occasions. A room had been adapted into a café which also included an area set out as a shop and a cut-out post box. There was a drinks station in this room to enable people and their relatives to make drinks if they wished. We did not see people use this room during the inspection, but a visiting relative told us about a time when people had been in there. They said, "[Name of person] liked being able to have a magazine in front of them on a table, as they find it uncomfortable to hold or have on their knee."

There had been some work on the adaptations to the dementia care unit to help provide an appropriate

environment for people living with dementia. For example, there was some additional signage to help people orient themselves, and we saw some rooms had memory boxes at their doors. The registered manager told us, "The photographs of people from earlier in their lives help remind staff of the person, not the condition." We also saw blue crockery was in use. Research shows coloured plates assist people with dementia to identify their food and encourages independent eating.

Care records we reviewed and our discussions with staff, people and relatives showed people were supported to access healthcare services such as GPs, the tissue viability nurse, opticians, chiropodists and community matrons.

Good

Is the service caring?

Our findings

At the last inspection we found concerns around staff's approach to people and people's need for privacy and dignity were not promoted or respected. At this inspection there was considerable improvement; we found staff had a very professional, caring attitude and this was reflected in interactions with people, their families, each other and visitors.

People were very complimentary about the staff. One person said, "All the staff here are very nice." Another person who was unable to verbalise their views gave us a big smile and a thumbs up when we asked them what they thought of the staff. Another person said, "They've got some good staff now, they're kind and they care."

Relatives were equally positive. One relative said, "The care here is very good. They've got a good team of staff who are very caring." Another relative told us, "Staff are just lovely. They're working well together as a team and are so caring and kind."

We sat with one person when a staff member came in to see them. The person said to us, "She's a lovely girl that one. She's very good, knows what I like." Another person pointed out a different staff member and said, "She's my favourite. She's just lovely."

During our inspection we made formal and informal observations of staff practice which showed they engaged with people in a positive, caring way which evidenced they knew people well. Staff chatted with people and offered to find things for them to do, for example offering magazines to read, and putting on music to listen to or sing along with. Some interactions were not sustained, however, and at one point we saw the staff created an environment which may not have been appropriate for people living with dementia; the television was on, there was also music playing at a higher volume, and one person vocalised repeatedly without receiving any response or reassurance from staff.

There was a calm and friendly atmosphere on the nursing unit. We saw staff had developed good relationships with people and clearly knew them well. Staff took every opportunity to engage with people, crouching down so they were at the same level and listening to what people had to say.

Staff were kind, caring and compassionate in their interactions with people. We saw one person held out their arms to hug one of the staff who hugged them back. We saw other staff sitting with people and holding their hands as they talked with them. Staff were cheerful and happy and complimented people. For example, we heard staff telling one person how nice they looked in the clothes they were wearing and saw the person smiled in response.

Care plans we looked at contained information about people's preferences, likes and dislikes, for example preferences for gender of staff providing personal care, preferred routines and food and drinks. We found an inconsistent level of detail about people's families, friends and life histories, however, there was clearly work in progress to improve this.

We saw people looked well presented, in clean pressed clothes, with combed or styled hair that evidenced personal care had been attended to. Gentlemen who did not have beards were clean shaven. Staff offered clothing protectors to people when they ate. Staff paid attention to detail such as noticing when someone's beard needed a wipe and making sure people had things that were important to them. For example, one person had on their favourite jewellery, another person had special blankets over their legs which their family had made for them. We saw subtle symbols were used to make staff aware if people were living with dementia or had a DoLS authorisation in place.

We saw people's rooms were personalised with pictures, ornaments, photographs and other treasured possessions, and noted considerable improvement in consideration of people's dignity in this respect; at an earlier inspection we had seen continence products left in people's rooms which showed a lack of respect for people's dignity. At this inspection there was no evidence this practice had continued. One person said, "It's lovely having all my things around me." One relative told us, "Staff do respect people's privacy – I have been in here helping [name of person] use their bathroom. A member of staff knocked on the door and gave me the chance to ask them to wait a moment."

We did not see any evidence of information being available in alternative formats, such as large print or in languages other than English. Care plans contained an assessment relating to the Accessible Information Standard, which covered people's eyesight, hearing and first or preferred language. People's religious and spiritual identity was documented although this information did not always show how any needs were being met.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found the service was not responsive to people's needs. Care was not person-centred and complaints were continuous, with poor response to those who complained. At this inspection we found all areas of concern had been addressed and there was work ongoing to bring about further improvements.

At our previous inspection we found some people were being nursed in bed all day and there had been no action taken to explore different options so people could spend some time out of bed. At this inspection we found staff had been pro-active in contacting other agencies such as occupational therapists to see if they could provide suitable seating. Staff told us and we saw that this had had a dramatic impact on one person who had previously been confined to bed. We saw this person was up and dressed and sat in the lounge listening to music and engaged in what was happening around them. Staff also told us this person had begun to speak which they had not done previously.

On the dementia care unit we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Our observations showed people's experience to be highly positive.

People and their relatives said care was now responsive to individual needs. "They have a 'resident of the day', there is more focus on [name of person]." Another relative said, "[Name of person] has never wanted to join in with activities much, but they do have things going on. They had people outside recently, then they all went in to the café for a bit of a chat. The staff take more of an interest in people now."

Staff had a good understanding and knowledge of people's current needs due to effective communication systems. Staff told us they received a handover at each shift change which they said was thorough and informed them of any changes. There was also a daily 'flash meeting' which heads of each department attended. This provided an opportunity for staff to provide an update from their area and discuss any issues that needed addressing such as additional resources that may be required.

During our inspection we saw evidence staff worked to meet people's individual needs. Staff acknowledged people by name and in a meaningful way. When people called out staff were responsive and we saw they attempted to identify why the person may have been vocalising, for example asking if the person was in pain or what the person wished to do.

We saw care was planned and delivered to meet people's individual needs. Care records were documented electronically and although care plans had improved in the level of person-centred detail, we found evidence to show some further improvement was also needed. There was mixed recording as to how care plans reflected people needs and preferences. For example, one person's night care plan described the number and type of pillows they liked and how these should be positioned. Another person's care plan detailed different distraction techniques staff could use to calm the person when assisting them with their personal hygiene needs.

In contrast, one person's 'positive behaviour support' care plan was incomplete. It stated they had very challenging behaviours, but did not state what these were. The description stopped in the middle of a sentence, and the 'assistance' section stated only, 'guidance from one carer'. This meant the person may not receive appropriate support. We saw several instances where generic care plans had not been adapted to make them individual to each person, although the registered manager had identified this through their own audits.

Care plans showed there was still improvement required in the area of end of life planning. There was a lack of detail in some care records as to people's wishes, for example whether they wished to remain at Calderdale Retreat or be nursed in a hospital or hospice setting. We raised this with the registered manager during the inspection, and they told us this had already been identified and action was due to be taken to address this.

One person was receiving end of life care. They were nursed in bed and we saw staff frequently went in to provide care and check the person was comfortable. A detailed end of life care plan was in place describing the person's wishes, which had been drawn up in consultation with the person's relative. Arrangements had been made for the person's relative to have access to an empty bedroom where they could stay overnight if they wanted and have meals and drinks. We saw when there were no relatives present staff went in and sat with the person. We met with the relative who praised the care provided to their family member and also to them. They said, "The staff have been amazing. (Family member) is so well looked after. One staff member rang early one morning to see how (family member) was and came in specially to give (family member) a full body massage. That was so kind and over and above what you'd expect. Another staff member on their way into work saw me waiting for a bus and pulled over in a taxi to give me a lift. (Name of registered manager) organised for staff to take me to a hospital appointment. You can't buy that. It's loving care not just to (family member) but me too."

We saw care plans were regularly reviewed by senior staff, and received feedback about the 'resident of the day' initiative. We did not see records of this activity in care plansor evidence people and their families had been involved in the reviews.

There were no formal activities on the dementia unit on the day of our inspection, although staff spent time with people and helped some people find things to do. There was a television on in the lounge throughout our visit, however we did not observe staff ask people what they wished to watch. We looked at records which showed people did participate in activities, including being supported to spend time outside if they wished. We saw people had been supported to help make their memory boxes, play games and chat with staff, although we did not see evidence that one person, whose care plan stated they should have 30 minutes of one to one time each day, was receiving this. We brought this to the attention of the deputy manager who told us they were confident this was a recording issue as staff did provide this contact.

We met with one of the activity organisers who told us they provided a wide range of one to one support as well as group activities. This member of staff explained their role and told us how the quality of people's care was now much more person-centred, with a holistic approach to engaging with people and families in meaningful ways. In the afternoon on the nursing unit we saw people were involved in planting sunflower seeds. The activity organiser told us people had made bunting for the party they were having to celebrate the Royal wedding. We saw jigsaw and magazines were available in the lounge. We saw some people preferred to spend time in their rooms entertaining themselves. One person told us they enjoyed looking out of their window and watching people go by and got a daily newspaper which they enjoyed reading. Another person spent time watching sport on their television. One person had been out shopping in Halifax.

There were 'smart speaker' devices in use in the home, from which music of any era and choice could be selected and instantly played. Staff used these to play music chosen by individuals. For example, one person liked a particular Shirley Bassey song which was played and on another occasion songs from a musical were put on for another person. The registered manager told us these were effective as a means to evoke memories and reminisce as well as for people's general music enjoyment.

People told us they knew how to complain and they found the staff team and new manager to be very approachable and responsive. We saw the record of complaints and there had been one recorded since the last inspection. This had been responded to and resolved very quickly and efficiently with reassurance given to the person and relative along with an offer of a meeting and apology. One relative told us, "I've raised things with [name of registered manager], and something gets done."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we had serious concerns about how the home was managed. The home was being managed by an acting manager on behalf of a management company and there had been a succession of managers in the home, none of whom had stayed enough time to make necessary improvements. Since the last inspection, the provider had employed a registered manager who had been in post since January 2018. We found this registered manager had made significant improvements and taken swift action to address the breaches in the regulations throughout the service.

We spoke with the registered manager who explained the strategic approach they had taken to prioritise the necessary immediate improvements. This meant risks to individuals were identified very quickly and measures taken to reduce the possibility of harm to people and to raise standards of care. The registered manager was very aware of the strengths of the service and the areas still to improve. They acknowledged the needed to embed new practice and ensure they received objective and supportive supervision in their role. The registered manager was working closely with the provider to secure such support. We saw the provider was involved and interested in the inspection findings and they actively participated in the feedback following the inspection.

We found the registered manager had worked closely with the local authority and had welcomed full support from them to ensure improvements were made quickly. We received positive feedback from our partners in the local authority to this effect.

Prior to the inspection we received positive feedback from people's relatives and from staff who wanted to tell us about improvements made at Calderdale Retreat. The registered manager told us they actively encouraged this and we shared the feedback we had received, which in turn was shared with the staff team. We saw a 'you said, we did' information board for people and relatives to know how the registered manager had responded to feedback and suggestions. One relative said, "It feels nice here now. The management have changed. I know [name of registered manager]. They have asked for ideas and suggestions." One relative told us, "I feel confident in the service at this moment in time, my only concern is how they will manage if the service gets busier."

People, relatives and staff all praised the registered manager and improvements they had made. One relative said, "It's improved massively since Christmas. Things are so much better since (registered manager) came. She's the difference. If you tell her something she sorts it out. I wouldn't have recommended the home before, but I would now." Another relative told us, "It's improved greatly. They've got a good team of staff and the care is very good." Another relative said, "They have worked hard to improve here. Morale appears to be better."

Staff told us they loved their jobs and said they would recommend the home as a place to work. They also said the home passed the 'Mum's test' and would recommend the home if a loved one needed care. One staff member said, "It's changed completely since I first started here. It was so disorganised before, there's

was no structure and we didn't know what we were doing. Now we're working together and know what we're doing. (Registered manager) is very good, she's on top of things." Another staff member said, "There's been massive changes since (registered manager) came. When she first started she spoke to staff and asked us what we would like to see improved for the residents. She listened to us and has made those changes. Residents are now getting up and going outside, things are better organised, good communication. She comes round every morning and says hello to residents and staff and checks everything's okay and does the same before going home. I've never seen a manager do that before."

We found staff were empowered to take responsibility for their work, with the assurance of support from a new and clearly defined line management structure. As a result, we found staff were motivated and happy in their work, more responsive to people, deployed effectively and worked well together as team. This helped to create a pleasant atmosphere for people to live in and this was a considerable culture change from previous inspections. One relative commented upon this and said "They have become attached to the residents, that's a real change in the culture." Staff were keen to show the inspection team how they worked and discuss the recent improvements.

We saw systems and processes had been put in place to assess and monitor the quality of the service, with clear action plans where improvements were needed.

Audits were regular and systematic, with clear documentation in place to show the detail and accountability of checks made. We looked at documentation to show how the premises and equipment were maintained as well as policies and procedures. We noted a minor point in that a previous manager was named on the safeguarding policy, but this was rectified immediately when brought to the attention of the registered manager. Staff we spoke with said they knew where to find the policies and procedures in support of their work.

We found the registered manager had taken the necessary steps to address the breaches in the regulations found at previous inspections and there had been a significant improvement in care for people at Calderdale Retreat. However, this inspection was not able to assess the improvements will be sustained as there has been insufficient time so far to evidence this.