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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Calderdale Retreat is a residential care home providing personal care to up to 89 people. The service provides support to older people some of whom are living with dementia. At the time of our inspection there were 50 people using the service. The care home accommodates people across three separate wings, each of which has separate adapted facilities.

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

Medicines records were not always completed accurately which meant we could not be assured they had been handled safely. People were at risk of harm as the provider had not always identified, assessed or mitigated risks.

Quality audits were not always effective in identifying or securing improvements. The provider had identified some issues and started to address these through their action plan. People's care records were not always accurate and up to date.

There were enough staff to meet people's needs. Recruitment processes were robust. People said they felt safe in the home and safeguarding incidents were recognised and reported. The environment was clean and well maintained. Infection prevention and control measures were implemented. However, some concerns were raised by 2 relatives about visiting arrangements during a recent COVID-19 outbreak.

People and relatives spoke positively about the staff and the care and support provided. 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.

The registered manager took action during and after the inspection to address the issues we raised.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 12 August 2021) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they

would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended the provider should seek feedback from staff about staffing levels throughout the home. At this inspection we found the provider had acted on this recommendation and made improvements.

The service remains rated requires improvement. This service has been rated inadequate or requires improvement for the last seven consecutive inspections.

Why we inspected
We carried out an unannounced focused inspection of this service on 17 and 23 May 2022. Breaches of legal requirements were found. We served a warning notice regarding medicines in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

This inspection was carried out to follow up on action we told the provider to take at the last inspection. This report only covers our findings in relation to the Key Questions Safe and Well-led.

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.

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 not changed and remains requires improvement based on the findings of this inspection.

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

Enforcement
We have identified breaches in relation to safe care and treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Calderdale Retreat

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
Two inspectors, a medicine inspector and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Calderdale Retreat 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. Calderdale Retreat 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 6 April 2023 and ended on 21 April 2023. We visited the location's service on 6,12 and 19 April 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spent time with people in the communal areas observing the care and support provided by staff. We spoke with 27 people who used the service and four relatives about their experience of the care provided. We spoke with 10 staff including the nominated individual, the registered manager, the general manager, senior care workers and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with 2 visiting healthcare professionals.

We reviewed a range of records. This included 10 people's care records and 14 people's medicine records. We looked at 3 staff recruitment files. A variety of records relating to the management of the service were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained 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.

Using medicines safely

At our last inspection the provider had failed to ensure safe medicine management systems were in place. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Medicines records were not always accurately completed, so there was a risk medicines would not be handled safely.
- For 1 person prescribed medicine for anxiety, the rationale for administering the medicine had not always been recorded.
- For 1 person who was prescribed a thickening agent (powder added to people's drinks when at risk of choking,) records were not completed when thickener was added to their drinks.
- Information about how to give PRN (when required) medicines was in place. However, these were not person centred about how and when the person needed to take their medicine.
- Topical charts were in place for recording when creams were to be applied but body maps to show where to apply were not completed for 2 people. A process was in place for patch administration, but this was not completed for 1 person.
- Medicines audits had been completed but some actions had not been completed in a timely manner.
- Medicines were stored securely in a clean and tidy environment and controlled drugs (medicines liable to misuse) were handled safely.

Medicine records were not always accurate which placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They said action had and was being taken to address these issues.

Assessing risk, safety monitoring and management

- Risks to people were not always assessed, placing people at risk of harm or injury.
- Risk assessments were not always updated or included full information about the risks posed. One person had experienced 12 falls in a 10 month period. The falls risk assessment showed only 4 falls. Sensor equipment was in place. However, known risks relating to the person's eyesight and footwear had not been

fully recorded or mitigated.
● Risks were not always identified and acted upon. Food and fluid charts were not always completed correctly, monitored or acted on when intake was low.
● One person had been moved into a bedroom on a different wing. The registered manager told us this was due to 2 incidents that had occurred with another person living in the home. No incident reports had been completed and there was no reference to these events in the person's daily records.
● Safety checks of the premises and equipment were mostly up to date. An electrical installation inspection in October 2022 identified works to be completed. An action plan showed these were due to start in June 2023. Safety checks of hoists were being arranged by the registered manager.
● On the first day of the inspection we saw some people in their rooms did not have call bells to hand. One person said, "I really could do with a buzzer, sometimes I need the toilet and I can make it on my own but I can't wipe myself." The registered manager said some people were unable to use a call bell and assured us people were checked regularly and had sensor equipment in place to alert staff.

The lack of robust risk management processes meant people were not always protected from harm or injury. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They said action had and was being taken to address these issues.

Staffing and recruitment

At our last inspection we recommended the provider sought feedback from staff about staffing levels and considered this along with people's level of need and the size and layout of the building, when working out appropriate staffing levels. The provider had made improvements.

● The provider used a dependency tool to calculate staffing levels. These records showed the home was staffing above the required minimum.
● We received mixed feedback from people and relatives. Comments included; "At night times there isn't anyone [staff] around really", "There does seem to be enough staff" and "Yes I do feel [family member] is safe, and there do seem to be enough carers."
● Staff felt the staffing levels were sufficient provided everyone turned up for their shift. They said managers always tried to arrange cover with agency or their own staff. However, sometimes this meant a staff member was on their own until another staff member came in.
● We raised concerns about staff deployment in one area of the home on the first day of the inspection. This had improved when we returned on the second day.
● Recruitment checks were carried out before new staff started work.

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.

Preventing and controlling infection
● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was supporting people living at the service to minimise the spread of infection.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was responding effectively to risks and signs of infection.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes
● During the inspection we saw relatives and friends were able to visit people and they were satisfied with the visiting arrangements.
● However, two relatives said they had not been allowed to visit during a recent COVID-19 outbreak. The registered manager told us visiting had been restricted to one visitor per person during the outbreak. We spoke with the local authority infection control team who clarified the current government guidance for visiting arrangements during an outbreak with the registered manager.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse or harm. One relative said, "I wouldn't have [family member] anywhere else, they care for [family member] really well and I know [family member] is safe."
● The majority of staff had completed up to date safeguarding training and those who still required refresher training were due to complete this by the end of April 2023. Staff knew how to report any concerns and were confident these would be addressed.
● Safeguarding incidents were reported and showed the action taken to ensure people's safety. Referrals had been made to the local authority safeguarding team.

Learning lessons when things go wrong
● Systems were in place to monitor accidents, incidents and safeguarding.
● The registered manager said lessons learnt were discussed at supervisions and staff meetings.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection we found a lack of consistent and effective leadership and robust quality assurance meant people were at risk of receiving poor care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17

● We found shortfalls at this inspection with regulatory breaches relating to medicines and risk management. The provider had identified some of these issues and started to address these through their action plan.
● Care records were not accurate or up to date. Care staff had access to the electronic care record system however care updates were not always scanned onto the system as the provider was looking to implement new software. Care staff relied on paper care records which did not provide an overview of individual needs or the support they required. Some records were incomplete. Staff duty rotas were not always accurate and did not reflect all staff working in the home. For example, the registered manager's hours were not included on the rota.
● Quality assurance systems were not always effective in looking at the wider picture. For example, the monthly accident and incident analysis focused solely on falls. There was good information about how individual risks relating to falls were managed but no overall analysis of themes and trends. We also identified inconsistencies in the records regarding the number of falls people had experienced. Care plan audits identified shortfalls and actions needed but did not include timescales for completion.
● A residents' meeting in February 2023 noted people were unable to go out in the garden area as the surface was very slippery when wet. A health and safety audit in March identified the garden area was not in use as waterlogged, however there was no information to show how this was being addressed. We saw people still had access to this area.
● The nominated individual completed monthly reports which reflected the information found in the audits.

● We identified the provider needed to apply to remove a regulated activity as the service no longer provided nursing care. We also discussed the requirements of the right support, right care, right culture statutory guidance for services providing support to people with a learning disability and/or autistic people. The nominated individual told us they would take action to address these issues.

We found systems to assess, monitor and improve the service were not sufficiently robust. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded promptly to our feedback during and after the inspection. They confirmed action they had taken to make improvements.

● Management and leadership of the service had improved. The registered manager had been in post since December 2021 and was supported by a general manager and nominated individual who worked closely together providing consistency to the staff team.
● People, relatives and staff spoke positively about the management team. One staff member said there had been vast improvements due to the new management team.

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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider understood the duty of candour legislation and fulfilled their responsibility to be open and transparent with people when things went wrong.
● People, relatives and staff were involved in discussions about the running of the service and encouraged to share their views.
● People and relatives gave positive feedback about staff. Comments included; "I am very pleased with the home, the quality of care is excellent" and "I wouldn't have [family member] anywhere else, they care for [family member] really well." We saw some lovely staff interactions and people enjoying activities and entertainment.
● Staff said they enjoyed working at the home and felt listened to and supported in their role. Comments included; "It's a rewarding job, I like helping people and we've got a lovely team" and "People get good care, that's what it's all about. We all work together and support each other."

Working in partnership with others
● Care records showed the service worked in partnership with health and social care professionals to meet people's needs. Healthcare professionals visiting the home told us communication was good and staff sought advice appropriately and acted upon it.
● Some people were admitted to the home from hospital through the Discharge to Assess (D2A) pathway. In these circumstances people are ready to leave hospital but not well enough to return to their previous place of residence. One person told us how well this had worked for them. They said, "When I came in, I couldn't do anything. I was in a wheelchair. They've been fantastic here and got me back on my feet. They all worked together to get me right – physios and occupational therapists and I'm going home today."
● The registered manager told us of difficulties they had experienced with the D2A pathway as some people were not fit for discharge to the home and had to be readmitted to hospital. The provider was working with all the agencies involved including the local authority and integrated care board (ICB) to address these issues.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people who use the service and others were not identified, assessed and mitigated. Medicines were not managed safely and properly.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to ensure compliance with the relevant regulations were not always operated effectively. Accurate, up to date and complete records were not always maintained in respect of each service user.