Care Quality Commission

TLC Care Management Ltd

Calderdale Retreat

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 18 and 20 September 2017. After this date we continued to receive concerns regarding people's care and the management of the home. We undertook an unannounced focused inspection of Calderdale Retreat on 18 December 2017. This inspection was done to check that improvements planned by the provider to meet legal requirements after our comprehensive inspection on 18 and 21 September 2017 inspection had been made or were in progress. The team inspected the service against three of the five key questions we ask about services: is the service well led, safe and effective. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

Calderdale Retreat is a care home which provides residential, nursing and dementia care to people. The service is registered for up to 81 people. There were 31 people living at the home when we carried out this inspection. 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 people across three separate units, each of which have separate facilities. One of the units specialises in providing care to people living with dementia.

The home had an acting manager in post who was in charge of the home until a new registered manager was appointed. 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.

We found continuing concerns in relation to the three key questions and therefore the service still was not providing safe, effective or well-led care and identified continued breaches in regulations. Although some minor improvements were evident, the key priorities for people's basic care needs to be met, had not been addressed sufficiently.

The management of risks to individuals was poor.

Care documentation was poorly or inaccurately completed and staff did not have sufficient access to key information about people's needs.

There was a lack of management oversight of risks, such as the analysis of accidents and incidents.

Staff lacked direction and clear leadership.

The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service remains in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in 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?

Inadequate

We found that insufficient action had been taken to improve safety.

There was poor management and lack of oversight of risks to individuals.

Staff deployment was not always managed to meet people's needs.

There was a lack of oversight of accidents and incidents.

Is the service effective?

Inadequate

We found that insufficient action had been taken to improve the effectiveness of people's care.

Staff induction and training was not robust.

There were concerns around people's access to food and drinks.

There was poor monitoring of people's dietary intake and nutritional needs.

Is the service well-led?

Inadequate

We found that insufficient action had been taken to improve the leadership and management of the service.

There were concerns at the lack of management oversight of risks and practice in the home.

Staff lacked direction and clear leadership.

Key priorities for improvement at the last inspection remained unaddressed, with little impact upon people's care.

CareQuality Commission

Calderdale Retreat

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Calderdale Retreat on 18 December 2017. There were three adult social care inspectors. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 18 and 20 September 2017 were being made. The team inspected the service against three of the five questions we ask about services: is the service well led, safe and effective This is because the service was not meeting some legal requirements.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection
We gathered and reviewed information before the inspection. This included information from other stakeholders and notifications submitted by the service. We had continued to receive concerns about the service since our inspection in September 2017.

We spoke with six people using the service and three relatives. We spoke with three staff as well as the cook, the acting manager and the nominated individual. We observed people's care and reviewed four people's care records. We looked at accident and incident records and the available management audits.

Inadequate

Is the service safe?

Our findings

At the comprehensive inspection in September 2017 we found concerns in relation to people's safety, the management of risk and staffing levels, There was a continuing breach of legal requirements at this inspection.

We arrived at 10am and found 14 out of 19 people were still in bed on the nursing unit. Some people had clearly not been supported with personal care as we found strong odours of faeces and urine in people's rooms. We saw one person had been incontinent of faeces and they had to wait an hour and a half for staff to support them, despite us pointing out this to the registered general nurse.

We heard two people called out repeatedly for help. We looked for staff to inform but no staff were visible. We saw the registered general nurse seated at the nurses' station and we asked them to attend to one of the people who was shouting for help. The unit manager, before seeing the person, told us there was nothing wrong with the person and they 'just wanted attention'.

Staff were not always visible in the nursing unit. We spoke with one care assistant at midday and they told us they still had people to attend to, having systematically supported people to be washed and dressed, room by room. Staff told us there were two 'teams' who took half the unit each. Throughout the day there were times when no staff were visible because they were providing care to people in their rooms.

Staff we spoke with said there were not enough staff to meet people's needs in a timely way and they did not always get their breaks on time; the first break for one member of staff who started at 8am was 2.30pm. On the dementia unit, staff breaks were not organised around people's needs; we saw between 11am and 12 noon two staff took breaks which left the unit manager alone in the lounge trying to serve refreshments and support people with complex needs who needed close supervision. At times we saw people had to wait for support if they required two staff, as only one staff was available.

Staff we spoke with did not know how to access the computer or people's care information.

The acting manager told us agency staff were all regular and familiar with the home and people's needs. However, we saw one agency nurse on the nursing unit who had not worked in the home before. We asked to see what information had been obtained prior to this agency staff working in the home. The acting manager told us the information had not yet been obtained. We saw there was no induction or introduction for the agency staff. We spoke with the member of agency staff and they confirmed there had been no information given to them; they had not been shown round or had anything explained. They told us they had just been given handover notes, they did not know where care records were kept or how to access the computer. They said, "I've not been told anything, don't even know where the toilets are. Just handed the meds keys and left to get on with it". We asked the registered general nurse about the agency nurse induction. They told us the night nurse should have done this, although they then offered no support to the agency nurse.

The agency nurse highlighted several errors with medicines management. These included missing medicines, which the registered general nurse had said were as a fault of the pharmacy. Medicines administration records (MARs) were in a folder labelled 'building certificates'.

We saw on the dementia care unit one person dropped a tablet and the nurse promptly picked it up and recorded it as destroyed. However, we saw this tablet was left on top of the medicines trolley in a pot, accessible to people as the trolley was left unattended in a corridor.

Staff were unable to access records to show when they had applied topical creams for people. Only verbal instructions were available to staff at handover about how and where to apply creams, there was no written guidance.

On the dementia care unit we found the unit manager was alert to falls prevention and ensured people had the right equipment, such as their walking frame, glasses and suitable footwear.

We saw staff accessed a trolley with clean laundry, gloves, aprons and continence pads. There was one pack of continence pads which all four care staff confirmed were used for everyone who needed them, regardless of size.

Moving and handling directions for people were not always clear to staff. For example, one person's record referred to a large sling, but there was no other guidance. We saw one sling was used for two people consecutively; this may not have been suitable for both people's needs and would not prevent the risk of infection if being used for more than one person.

We concluded all the evidence above demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

Inadequate

Is the service effective?

Our findings

At the comprehensive inspection in September 2017 we found concerns in relation to staff training and competency, and people's diet and nutrition. There was a continuing breach of legal requirements at this inspection.
We saw out of the 14 people who were in bed on the nursing unit, only half of them had access to a drink; some people had no drink in their room and some people had drinks out of reach.

Documentation in people's rooms was not completed effectively to show how their needs had been met with regard to eating, drinking and repositioning. Two peoples' rounding chart, intended as a system for carrying out regular checks, showed no repositioning entries since 6am the previous day. One person's chart showed they had not been supported with continence or repositioning care since the previous night.

We saw mealtimes were not organised well, with some people having breakfast very late for example and close to their lunchtime meal scheduled for 12.30. At lunchtime on the nursing unit, people were served at different times; some people had lunch whilst others sat without. We saw one person fell asleep when their meal was in front of them and there were no staff available to support them. One person in their own room sat with their lunch cold and uneaten in front of them; we pointed this out to the registered general nurse who asked a member of care staff to change the person's meal and support them.

We saw entries in records within people's rooms to show people had eaten and drank, when their food and drink was left untouched in their room. One entry showed a person had eaten all of their meal, yet we had observed them throughout and their meal had been taken away uneaten. The entry in their record stated they had eaten a meal which was not even on the menu. We brought this to the attention of the acting manager.

There was a list in the dining room which showed people's dietary needs. Staff told us they referred to this list. We spoke with the cook about how they knew people's dietary needs and they showed us a list on each meal trolley which had people's names and their requirements. However, we found the list on the trolley did not correspond with the list staff referred to in the dining room and there was mismatching information. For example, one person was shown to need a soft diet according to the list in the dining room, yet this was not on the list on the trolley. Another person was listed on the trolley as needing a diabetic diet, yet the information was not on the dining room list. One person on the dining room list as needing a soft diet, was missing altogether from the list on the trolley.

We saw one person was listed as needing a soft diet, yet we saw they were offered biscuits and food with crusts on as well as chips and carrots. We spoke with staff about this and they told us the person sometimes could eat normal textured food, although they were not clear how this was assessed. Staff we spoke with did not know what foods could be offered to a person on a soft diet. The person's care record showed both normal and soft textured dietary needs but there was no indication as to how this was decided.

We saw drinks and snacks of fruit were offered to people on the dementia care unit and we saw a typed

snacks menu on dining tables, but with no pictures to support people's communication or understanding. People were asked their choices for the next day's meal, but people living with dementia may not have retained this information and this was done without any visual aids.

We found recording of people's dietary intake on the dementia unit was completed from staff memory, a long time after the meal. The unit manager stated everyone had had 200mls of drink during the morning break, but we saw this was not the accurate amount as we had seen one person's drink was removed and another person's was untouched. Weekly weights had only been completed for three people and so monitoring of people's needs was not robust.

No drinks or snacks were offered to people on the nursing unit morning or afternoon. Two relatives we spoke with expressed concern around meals, drinks and snacks. One relative told us their family member was diabetic and they were concerned at the lateness of the lunch on their family member's blood sugar levels. Another relative told us they asked for their family member to have a hot drink at night, which did not often happen. They said their family member did not have enough to eat at teatime, which may have impacted upon their mood.

We looked at one person's weight chart which showed they had lost over two kilogrammes in an 11 day period, yet this was not reflected in their malnutrition universal screening risk assessment or care plan.

We concluded all the evidence above demonstrated a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

We saw a notice which stated all training was cancelled until January 2018. We asked the acting manager about this and they told us a programme of training was scheduled. We spoke with a member of care staff who said they had recently started work, had only one day induction which covered moving and handling, but no other training.

Inadequate

Is the service well-led?

Our findings

At the comprehensive inspection in September 2017 we found concerns in relation to the way the home was being managed. There was a continuing breach of legal requirements at this inspection.
At our last inspection the home was being managed by an acting manager on behalf of a management company. The nominated individual told us a new manager had been appointed and was due to start in January 2018. They said there would be a thorough handover from the acting manager to the new manager.

On the day of the inspection there was the nominated individual, the acting manager and two further managers from the management company who were supporting with addressing improvements.

Some relatives we spoke with told us things had improved since the last inspection. One relative said, "it's not like it was before, it's getting better but it's slow" and another relative said they felt communication was better, relatives views were considered and apologies given where care fell short. Two relatives said they remained concerned about the food and drinks. One relative said "Care feels disjointed but individual staff are great".

One member of care staff on the dementia care unit told us they felt the home was improving, they had specific tasks to complete on each shift and their shift pattern was manageable. They said they had flash meetings and morale had improved, although they had not had any supervision or appraisal.

We found continued concerns about how the service was being managed. On the nursing unit in particular there was no leadership or direction and no prioritising of people's care. There was no clear oversight of clinical risks.

There was a lack of oversight of the needs of people living with dementia. On the dementia care unit, the unit manager engaged people in conversations, although care staff did not engage well with people and lacked skills in communicating with people living with dementia. We heard the unit manager direct staff with "Let's get people into the lounge and then we can start with activities" and there was no element of individual choice. Christmas music was played loudly throughout the home without evidence of people's choice.

There were some signs the acting manager had considered some of the concerns raised at the last inspection. For example, staff now wore uniform to identify their roles and some new furniture had been obtained and more staff had security fobs to enable them to move through the building. There was a member of staff responsible for activities and we saw a cinema and craft session taking place. The laundry was in the process of being reorganised. However, there were significant areas of high priority, relating to people's basic care needs still not addressed. For example, people remained in bed unsupported during the morning and with little access to drinks. Staff were still unable to access people's care records and these continued to be held on the computer system which staff did not know how to access.

There was no analysis of accidents and incidents and the acting manager was unable to tell us how these

were being monitored. We were already aware there had been little in the way of notifications to CQC and we looked at a sample of accident and incident records since our last inspection. None of the records we looked at showed what management action or review had been taken. The acting manager told us they had not yet reviewed these and was not aware of the content. Records showed the nature of each accident or incident but the follow up and management report sections were blank.

One incident report on 24 September 2017 showed a discrepancy in the stock of controlled drugs, but there was no evidence of any action taken. We asked the acting manager about this and they were unable to show us what, if any action had been taken to investigate this or report it appropriately. We also saw records of unseen falls, some of which had resulted in hospital trips; and altercations between people. The acting manager was unable to confirm whether all incidents notifiable to CQC had been reported. The registered general nurse was unable to locate information on the computer system to evidence what action had been taken.

One person's care record detailed they had had 17 falls since our last inspection in September 2017. Their falls risk assessment had not been updated since 17 October 2017, there was no falls care plan and no evidence of action taken in response to the falls or that risks had been reviewed.

Other care records we looked at gave conflicting information and there was no evidence of any management oversight. For example, one person's weight record showed they were 55.1kgs on 22 November 2017; 60.6kgs on 23 November 2017 and then two further entries the same day, one showing 60kgs and the other 64.4kgs.

Another person's night care plan stated the person made no attempts to get out of bed, yet there were three entries which showed they had been found on the floor during night time checks.

We spoke with the acting manager and the nominated individual who both acknowledged there was a problem with the computerised 'care docs' system, the computer system used by the service, for maintaining care records and there was further work required.

Handover documents we saw showed each person's name, photograph and room number as well as information to be shared between each shift. However, we found the names, photographs and room numbers on the documents, did not correspond with the people in their rooms. Rounding charts with all daily notes were incomplete or not completed at all.

The acting manager told us they had implemented twice daily walk around to check the quality of the provision. We accompanied the acting manager on part of their walk around and we saw they made a visual check of the premises, a sample check of daily records and observations of people. However, these checks were not recorded so it was not possible to see how regularly they were completed, whether any issues had been identified or acted upon, or for the acting manager to reflect on any reoccurring themes.

We concluded all the evidence above demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.