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 caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Calderdale Retreat provides accommodation, personal care and nursing for up to 81 people. There were 35 people living in the home at the time of the inspection. This was the first inspection of the service since it registered in April 2017. We found multiple breaches of the regulations in relation to: person-centred care, dignity and respect, need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs, receiving and acting on complaints, good governance, staffing, fit and proper persons employed.

There was a registered manager named, but who was no longer in post. 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 provider had enlisted the support of a care management company to oversee the running of the home and they were in the process of appointing a new manager.

There were no safe systems in place to ensure individual risks to people's health and well-being were known and managed. People did not receive safe care and treatment and they were not protected from abuse and avoidable harm.

Staffing levels and deployment of staff did not ensure people's care needs were met. Recruitment procedures were not robust to ensure those working with vulnerable adults were suitable to do so.

Staff did not know the fire procedures in the home or how to evacuate people in the event of an emergency.

Many staff had not received an induction or any training and supervision and they lacked the knowledge and skills of how to meet people's needs.

Staff did not understand the impact of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; there were no available policies and systems in the service to support staff practice.

People's nutritional and hydration needs were not managed well.

Some staff interactions were kind and caring; other staff interactions were not so caring and people did not receive compassionate care. People's dignity and privacy was not respected.

Care was not person-centred. Documentation relating to people's care and support was not completed accurately or used to plan their care effectively and safely. People's individual wishes were not respected and their basic personal care needs were not met. Many people remained in bed without good reason.

Complaints had not been managed well, although the new management team was taking steps to address this.

There was a serious lack of leadership and direction for staff, with no oversight of clinical risks or key issues for people's care. Systems and processes for monitoring the quality of the provision were weak and there was no robust management of the service. At the time of the inspection there was a new management team installed and they had begun to produce action plans for improving all aspects of the service. However, it was too soon for us to assess the impact of this upon people's care.

The overall rating for this service is 'Inadequate' and the service has therefore been placed 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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

The service was not safe.

Staff were not suitably vetted to ensure they were suitable to work with people and there were not enough skilled and trained staff to meet people's needs.

Medicines were not managed safely or effectively.

Risks were not assessed or monitored to ensure people had safe care and treatment.

Is the service effective?

Inadequate

The service was not effective.

Staff lacked training and support to enable them to care for people effectively.

People's nutritional and hydration needs were not met.

Staff did not understand people's needs in relation to mental capacity and they did not seek people's consent to care.

Is the service caring?

Inadequate

The service was not caring.

Staff approach was variable; some staff were kind and caring whilst others disregarded the needs of individuals.

Staff did not know people or their individual needs and care was mostly focused on completing physical tasks.

People's dignity, privacy and rights were not respected.

Is the service responsive?

Inadequate

The service was not responsive.

Care was not person-centred and people's preferences for care were not regarded. Many people remained in bed, with no good

reason.

Care documentation was not adequately in place or maintained to meet people's needs.

Complaints were not managed well or responded to.

Is the service well-led?

Inadequate

The service was not well led.
There was a serious lack of leadership and direction for staff.

There was no oversight of the risks to people's health, care or well-being.

There were no systems in place to assess or monitor the quality of the service.

Care Quality Commission

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 was planned to check 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 18 and 21 September 2017 and was unannounced. The inspection was carried out by three inspectors, a specialist professional advisor in nursing care, an assistant inspector and an expert by experience with experience of services for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioners and the safeguarding adults team. We had been informed of a high number of complaints and concerns, including whistleblowing concerns about poor practice and management in the home.

We spent time observing people's care and support. We spoke with 14 people who were using the service, 11 relatives, 11 care staff, the cook, the nominated individual and the designated management team acting on behalf of the provider. We looked at 14 people's care plans and associated care records and documentation to show how the service was run.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at Calderdale Retreat, but we found significant concerns at the inspection about people's care and treatment.

Recruitment procedures were not robust. Records of staff recruitment were not complete and we found insufficient evidence staff had been properly vetted to make sure they were suitable to work with vulnerable adults. Where agency staff were used their identity was not always checked. One member of agency staff said they had not been asked to show any identification and their identity was assumed because they wore a uniform.

We concluded the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 19, Fit and proper persons employed.

Staff were not deployed effectively and there were not enough skilled or competent staff to meet people's needs. Staff were extremely rushed and had little time to spend with people due to them completing physical care tasks. There had been a high turnover of staff and the service was in the process of recruiting new staff. In the interim there was a heavy reliance on agency staff, and although we were told regular staff were requested, we met some agency staff who had not worked in the home before and did not have a clear understanding of people's needs.

Relatives we spoke with were unhappy with the staffing levels. One told us, "There are never enough, sometimes there are just three over the weekend which meant everybody stayed in their beds" and another relative said, "They need to get a grip on their staffing". Another relative told us, "Nine times out of 10 there are not enough staff". Three relatives reported low staffing had directly impacted on their family members' care.

We asked staff if they were always deployed in sufficient numbers. One staff member told us, "There's no structure and not enough staff. Last night there were three agency staff on and no one else; they don't know people. During the day we often have agency nurses and they don't know who people are. We have to show them what to do, we lose other staff time doing that."

We asked the unit manager about dependency levels on the dementia care unit. We found they did not have access to this or any information relating to the way staffing levels were decided. Staff told us there were eight people on the dementia care unit who needed two staff to assist them. One person who needed one member of staff to support them at all times only had support from 8am to 8pm. Another person's care plan showed they needed three staff to assist them with personal care but this level of support was not available. There were five staff on this unit in addition to the nurse, but they were supporting others.

On the nursing unit we saw people waited long periods of time for staff to come and support them. When people called for staff, they were told, 'we will be with you soon,' but staff were unable to offer prompt assistance due to them caring for others. We observed relatives supported their family members, and one

relative told us, "If I'm not here I'm worried there are not enough staff to support my [family member]." Another relative said they organised with their family for someone to be present as much as possible because they could not rely on staffing levels. Some people told us staff supported them when they rang their buzzer and came quickly, but others said 'nothing happened' if they rang their buzzer.

We saw one relative made a complaint because their [family member] had requested to get out of bed; it was early afternoon and they had not been supported. The relative told us, "If my [family member] lived in their own home, they would have been up and dressed and enjoying the day hours ago". We observed similar instances where people remained in bed in their nightclothes well into the day. We asked staff why this was and no staff could give a good reason. One member of staff shrugged their shoulders when we asked why people had not been supported to get up. Another member of staff said, "I'm not too sure, I don't know". One staff member said, "I will be honest, we haven't got time and there are not enough of us. Lots of people need two [staff] so we can't do it when we are busy doing other things, like taking people their food."

The provider could not demonstrate how staffing levels had been planned in order to meet people's needs.

We concluded the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18, Staffing.

Staff did not know the risks to individual people and this meant they could not make sure their care was safe. For example, staff did not know who was at high risk of falls or malnutrition. Where people required particular textures of food so they could eat safely, staff did not always support them with this. For example, one person needed a soft diet, yet we observed they were given fish and chips and records showed they had been given a variety of food, such as a roast dinner. Another person should have been offered pureed food, yet they were given toast on more than one occasion.

Staff we spoke with told us they did not understand how to provide safe care for one person who presented with behaviours which challenged the service. Staff told us this meant the person did not receive basic personal care, particularly at night. One member of staff said, "Night staff are scared of [person] so neglect [their] needs. [Person's] bed is soaked when we come in. They [night staff] are scared so they just leave [person]" We asked the interim manager to immediately review this person's needs and the care they were receiving.

Fire safety procedures were not known by any of the staff we spoke with. Some staff told us they had to familiarise themselves with the building in case there was a fire, but they had not been shown what to do should they need to evacuate and no fire drills had been recorded. The security within the building was by authorised access and not all staff had the necessary fob to open doors. This meant people's emergency evacuation might be put at risk. We asked the management team to review fire safety procedures in the home with immediate effect.

Personal Emergency Evacuation Plans (PEEPs) were completed in people's care plans, and those we saw contained detail relating to people's co-operation, response to loud noises, physical ability and knowledge of the site. These were not stored accessibly, such as in people's rooms or elsewhere on the unit. Staff would have to log on to the electronic system to access these in event of an emergency. However, staff we spoke with lacked understanding of how to obtain key information from the computer.

On the first day of the inspection we saw the doors to one area on the dementia care unit were locked. We asked staff why this was, but no staff knew the reason. This meant they had not been made aware of the risk to people if they were able to get through the doors. On the second day of the inspection we found one

person from the dementia care unit had been taken to hospital. Staff told us the person had been able to access an unsecured lift which was behind the doors we had found locked on the first day of the inspection. They told us the doors were not locked on this occasion and the person had been able to get to the ground floor before falling and sustaining a fracture.

When we looked at the incident record in the person's care plan it did not match the staff's recollection of events. We raised this with the interim manager who told us they were aware the incident record did not match the sequence of events and had commenced an investigation. We asked the interim manager if there were any risk assessments in place relating to the lift. They told us there were none, and that the five rooms beyond the door were unoccupied. We had seen that one person was living in one of these rooms, and asked if there had been any consideration of the risk. Following the accident we saw signs had been put on the doors reminding staff to ensure they were closed, however the lift was still in operation. This meant the provider had not taken sufficient action to ensure the circumstances of the accident could not be repeated.

We observed one person who had fallen and there was a lack of organisation following this. We heard a member of staff say three times "Shall I go and do an incident form?" and then "I don't know what I'm doing on here, I'm not used to this unit". Another staff member offered the person some coffee which they agreed to, but then asked another member of staff "Can [they] have this?" which showed they did not know the person's needs. We spoke with a staff member about the person's high risk of falls and were told "There are not enough of us to deal with [them] properly; it varies from day to day. A lot of what [the person] does is for attention but we don't have the time to sit with [them] and give that attention. Like today, we have a [member of staff] on here who isn't here normally, [they] normally work downstairs. We really need more permanent staff as it completely varies day to day".

We looked at the records of accidents and incidents and found these were not clearly documented, were lacking in detail and there was little evidence of any follow up or oversight by managers. One person had three falls in 30 minutes but there was no evidence of any follow up action; care plans and risk assessments were not updated.

Care plans contained some risk assessments, such as a malnutrition universal screening tool (MUST) and a skin integrity (Waterlow) assessment. However, there were no risk assessments in relation to falls. Guidance for staff to manage people's individual risk was generic, unclear and not person centred. For example, when one person was at risk of choking the guidance stated 'provide assistance with eating and drinking when necessary' but there was no explanation of when this was necessary, and 'ensure [person] is positioned appropriately', but no information about what that positioning should be. It was not clear what action was being taken where people's MUST assessments showed them to be at high risk of weight loss.

Where people had bed rails in place, there was no assessment of the risks to them using the equipment. There were no risk assessments for moving and handling equipment, such as hoists and slings. This meant there was no guidance for staff to know how to move people safely.

Although the qualified nurses were aware of how to prevent, identify and treat pressure ulcers, staff we spoke with had limited knowledge of how to care for people where they were at risk of pressure damage. For example, staff did not understand how to assess a person's skin for signs of soreness, or what equipment could be used to minimise the risk of pressure ulcers occurring. When we spoke with the agency night nurse on day one, they told us they had checked everyone's skin as they were concerned about what the care staff were observing when they provided personal care. They told us a number of people had red skin, which suggested people were not being repositioned frequently enough. A member of staff said, "I am questioning what is happening during the day. A lot of [incontinence] pads were wet when we started our shift."

During the handover in the morning the night nurse gave detailed information about people including the observations about people whose skin was red, however we did not see any additional action taken during the day. One member of staff challenged an observation that one resident was not getting pressure relief by saying, "But [they] are in a chair during the day so we can't turn [them]."

Reposition charts did not always show people received the care they needed and there was no clear guidance in place where people had pressure ulcers. We saw one person had a very crumpled sheet underneath them, increasing the risk of pressure ulcers and skin breakdown. We saw this person was using a standard bed and mattress when they were at very high risk of skin damage and needed more specialist equipment.

We asked the nurse in charge of the nursing unit what the current key risks were for the people. They told us there was no information or overview readily available for them to understand the needs of people when they came on duty and as such it would be more difficult for them to detect if a person's health was deteriorating.

There was no oversight of people's clinical risks and there was no leadership for people's nursing care, which meant care was not provided safely.

Staff we spoke with did not know how to spot the signs of abuse and did not know how to report any concerns about people. One member of staff said, "I really wouldn't know what to do, or even what the signs are."

We saw no medicines management policy or procedure and the nursing staff we spoke with had never seen one. We saw medicines supplies, including the supplies of controlled drugs, were stored securely in the home and clinical rooms were kept locked at all times. However, on the dementia care unit we found one tablet within a pile of documentation and it was not possible to identify what it was, who it was for or how long it had been there. We gave this to the unit manager. There were inconsistencies in the recording of room and refrigerator temperatures to ensure medicines were stored safely.

We were told there were some difficulties with the supply of medicines and we noted one person had been discharged from hospital with a limited supply, which had run out and resulted in them being without medication for two days. The interim manager told us they were taking steps to address this. We were told only registered nurses administered medicines to people and we observed nurses completing medicine rounds. We saw nurses checked how people liked to take their medicines before supporting them, and waited until people had taken their medicine before supporting others. However, medicine rounds took far too long to complete which meant some people had their medicines much later than prescribed. We observed one person crying in pain and they had pain relief later than when needed. The nurse was interrupted several times to respond to queries from care staff.

We reviewed the records for one person who was prescribed controlled drugs in the form of a weekly skin patch, which should be replaced at the same time each week to ensure optimum effect. However, records for the past three weeks showed the times had been variable.

We saw medicines administration records (MARs) were fully completed, although the space for the nurse to sign was very small, particularly if two signatures were needed. We saw the MAR for one person showed their room number as 12, although the person had changed rooms since the record was made, which could have resulted in medicine being given to the wrong person. Another person's MAR showed they had been given medication to help manage their agitation on 11 occasions in the month. There was no PRN protocol in

place to describe the circumstances in which this medicine should be given, and no records to show which less restrictive options had been explored first.

Staff lacked knowledge of appropriate infection prevention and control procedures. We saw staff administering medicines without sanitising their hands. Personal protective equipment (PPE) was in place, although staff did not always routinely use it. For example, we saw a member of staff carried dirty bed linen without wearing gloves or an apron.

All of the above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12, Safe care and treatment.

In the outdoor bin store area we saw excessive quantities of clinical waste bags which had over spilled from the large container bins onto the floor. Some of the bags were split, exposing the contents of the bags. Although the premises were visibly clean overall, there were strong odours, particularly on the dementia care unit. One relative said, "It's clean enough, it doesn't smell" and another said, "You expect there will be some smells, but it's usually not too bad".

We saw the maintenance staff was actively engaged in checks of the premises and there were daily, weekly and monthly checks documented. The maintenance staff told us they had experience of their work in a previous care setting and they understood what checks they had to carry out and when.

Inadequate

Is the service effective?

Our findings

Staff lacked the basic skills required to care for people, and they had limited knowledge of how to meet people's needs. Many staff we spoke with said they had received no induction, training or support since starting work in the home. Many staff we spoke with said they felt they were expected to care for people with needs more complex than the level of training they had received.

One staff member said, "I had no induction. No training at all since I started, and I wasn't told anything about the people on the [dementia care unit]. I don't have a log-in for the care plans, so I can't even read those. I tried to tell the manager about this but [they] just said 'I haven't got time, I'm too busy.' That's how they were with everyone."

Another member of staff said they had not done any induction, shadowing other staff or any training. They told us, "I was just thrown in at the deep end and I had to find out for myself as I went along". This member of staff told us they had limited experience of care before they started. We spoke with qualified nurses who said they relied upon their own professional skills as nurses because they had received no induction or training since working in the home.

Qualified nurses told us they relied on their prior knowledge and experience to support people, but there had been no training provided. We saw some nurses lacked the skills they needed to carry out basic observations. For example, one nurse was unable to record a person's blood pressure despite three attempts using a manual and an electronic device and we noticed the cuff was not placed correctly.

Staff competencies were not checked or monitored. Agency staff worked in the home with no oversight of their practice. One agency staff said they had been allowed in the building, but not asked any questions about their identity or competence. When we asked the nominated individual what checks had been made about the agency staff's abilities they could not confirm any checks had been done. Regular staff expressed concern about agency staff competence and said, "They don't know what they are doing."

No staff we spoke with were able to confirm when they last had a supervision meeting with their line manager. One member of staff did not know what a supervision meeting was and none of the nursing staff had received any clinical supervision to support them in their role.

There were no systems in place to identify a lack of competency, poor skills or training needs amongst the staff team.

This meant the provider was in breach of in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18, Staffing.

We observed a handover meeting from night staff to day staff on both units. The information given was detailed, although there was very poor deployment of staff after the handover and we saw staff did not know where they were meant to be working. On the dementia care unit we spoke with an agency nurse who

did not know any of the staff or the people in the home. They had taken their own notes from the handover meeting but had otherwise received no information to enable them to do their 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 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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff lacked understanding of people's needs regarding mental capacity and there was no evidence they understood best interest discussions should be held where people needed support to make decisions.

Care plans we looked at contained no assessments of people's capacity or records of best interest decisions. The service was not compliant with best practice guidelines on the covert administration of medicines (giving people their medicine without their knowledge, sometimes disguised in food and drink). For one person, staff used a letter from a previous GP and a previous care home, without reviewing this. The person's family representative had no knowledge this agreement was in place and there was no evidence of a best interest discussion.

There was no summary available to staff to show who may have a DoLS in place, and care plans contained references to DoLS being needed but did not evidence any applications had been submitted. There was no overview of DoLS in the home, and the nurses on duty on day one of the inspection said they would not know who on the dementia care unit had a DoLS in place. We saw 16 applications had been made but there were no authorised safeguards in place.

Where care practice was restrictive, such as through the use of bedrails for people's safety, this was stated in care records as being the least restrictive option. However, there was no evidence of consent or reason why these were needed.

Staff did not understand restraint. One person's 'behaviour reports' linked to the management of behaviours that challenged during personal care evidenced use of restraint on seven of 39 occasions. When we looked at the person's care plan there was contradictory information about their behaviours and no reference to the use of restraint. We spoke with a member of staff about the care provided to this person. They told us, "[Name] is very violent. I don't think there is a care plan for that. Staff have told me what works but I think it is restraint. They say restraint is the only way to deal with [this person].

We found staff lacked skills and understanding of the needs of people living with dementia, particularly where their behaviour challenged the service. We observed one incident where a person was angry and distressed. They gripped onto a staff member's arm very tightly and would not let go when requested. Another staff member came and both staff prised the person's hands off the staff members arm quite forcefully causing the person to cry out. During this time the person's slipper had fallen off, the staff member gripped the person's ankle and forced their slipper back onto their foot despite them resisting this. We alerted the unit manager and the management team who agreed they would investigate this and refer the incident to the local safeguarding authority.

We identified some concerns around the inappropriate restraint of one person. Staff did not understand how to meet the person's needs and we saw many records which showed personal care had been given

against the person's will. We referred this to the local safeguarding team and asked the management team to review this with immediate effect.

The provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 11, Need for consent.
The provider was also in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 13, Safeguarding adults from abuse and improper treatment.

People's nutritional and hydration needs were not managed effectively. We spoke with the cook who said they 'had no idea' about people's dietary needs and there was a lack of communication from the staff team and the management in the home. We saw a file of information, but this lacked detail and was not correct for the people who used the service. The cook told us, "That's all out of date".

We saw lunch time was very rushed and staff were removing main courses from in front of people to make time to serve dessert. The whole experience took 25 minutes in total and was very chaotic and stressful for people. There was no encouragement from staff for people to eat. One person had not finished their meal but was served pudding. Staff offered no alternative and removed their food without asking if they had finished.

People we spoke with said they enjoyed the meals and told us there were snacks available. One person said, "The food is exceptionally good. There is plenty to eat and there are good choices". Another person said, "You can have snacks and drinks and fruit whenever you want". Relatives we spoke with said the meals were satisfactory. One relative, whose family member had pureed food said they did not always know what had been pureed and staff were not always able to tell them.

Staff told us about one person who needed fluids adapting in order to ensure their safety when swallowing, and we saw information in their nutrition care plan stating the amount of thickener to be added to defined volumes of fluid. However, we saw another person who required thickener in their drink was given drinks without this.

We looked at records relating to food and fluid intake. We found these were kept both electronically and on paper, and did not evidence robust monitoring. Gaps were found in records. There was no system in place to monitor intake over time, and no indication of what a safe or effective intake for each person would be.

The provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 14, Meeting nutritional and hydration needs.

There was limited documented evidence of active liaison and support for people to access a range of health services, such as speech and language therapy (SALT) podiatrist, optician, specialist nurses and dentist. Some relatives we spoke with said their family member had the right support from their doctor or chiropodist if needed.

Inadequate

Is the service caring?

Our findings

People we spoke with said they felt the staff were caring. One person said, "They try their best to look after you" Relatives said staff were caring, but most said there was a lack of consistent staff. One relative told us, "The regulars go beyond what they need to but there are too many agency ones, you can't build relationships". Another relative said their family member's dignity was supported, "I go out of the room and they close the door and curtains". One relative said their family member's independence was supported. They told us, "They encourage [my relative] to do things. They give [them] the cloth to wash [their] face instead of doing it for [them]".

Some staff were very caring and we saw occasions where interaction was positive between staff and people who used the service. For example, we saw staff asking a person what they would like for breakfast. The staff member made eye contact, knelt down and gave the person different choices. However, on the whole we found staff were too busy completing tasks associated with people's physical care and therefore did not have time to spend listening or engaging with people in meaningful ways.

At times we saw staff approach was inappropriate and uncaring, with no regard for people's rights. For example we saw one person was being supported with porridge by a member of staff. The person was not spoken to once and we saw no interaction at all from staff. The member of staff was lifting a further spoonful of food up to the person's mouth before they had finished chewing. The member of staff also kept getting up to assist other staff and people and did not explain to the person where they were going, leaving their meal half finished. Following this the person's nose was running and they had food around their mouth. A staff member came from behind and wiped the person's face with a blue paper towel. The person was very startled by this and cried out as the staff member did not tell the person what they were doing and approached from behind. The person then fell asleep at the table at around 11am with nasal mucus on their face and remained there until lunch time at 12.20pm. The person was assisted by a different staff member at lunch time and again received no interaction.

Staff we spoke with expressed concern they did not have time to care for people properly. None of the staff we spoke with said the care would be good enough for a relative of theirs.
People's privacy and dignity was not supported and we found there were concerns in relation to people's continence needs being met in a timely way. Some people had bare feet and mismatched clothing and others had visible stains down their clothing. Some of the gentlemen were unshaven and some people had strong odours of urine. One person walked around the corridors in their nightclothes which were stained with food and urine. Two people regularly wandered into different people's rooms throughout the day with no intervention from staff. We saw two staff delivering personal care to one person, but their door was left open.

The provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 10, Dignity and respect.

Care plans we looked at lacked evidence of personalisation. The electronic system used had a section for a

'This is me' document, however this was not completed. This meant staff did not have access to information which may have been useful in helping build a rapport with people. Most rooms had the person's name and a small photograph on the door, however there was no information displayed or available in rooms to assist staff to understand each person.

Care records did not always detail people's religious or cultural preferences. Where there was some information, it was a brief statement of the person's religion, such as Christian, but with no details of how they wished to observe their beliefs.

We saw people's rooms had some photographs and some personal possessions, however we also saw continence products left in rooms and bathrooms which meant staff had not always been mindful of people's dignity. The dementia care unit manager told us they had seen this on their first day and intended to move continence products into cabinets and drawers in people's rooms.

We saw one person on the dementia care unit who spent their time walking in the corridor accompanied by one member of staff. Staff walked with them but rarely engaged with them, and some staff appeared to be leading the person by the hand rather than allowing them to go where they wished.

Staff were focused on tasks and had little time to spend with people. We observed people repeatedly call for help, with some delays in responding to them. When staff did respond they attended to people's immediate need, such as a request to go to the toilet but did not spend any time with them. At times we saw staff walked past people's rooms even though people gestured or called for help.

The environment was not well adapted for people living with dementia. Although hand rails and room doors were high contrast colours and the carpet was a single colour with no pattern, there was little for people to find to enable them to engage in independent activity and a lack of signage to help people orient themselves. There were some pictorial signs on doors to denote bathrooms and toilets, for example, but no signage to help people locate these independently.

There was limited evidence of end of life plans being completed in people's care plans. The 'end of life checklist' section of the care plans was not completed, however there was some limited information in the 'last wishes' section.

The provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 9, Person centred care

Inadequate

Is the service responsive?

Our findings

Some people we spoke with said staff responded to their needs, but others did not. One person said, "The regular staff know me well, even down to what vegetables I like". One person said they could have a shower when they wanted one 'if the girls are free'. Another person said, "It's a lovely place, they bring me food and everything". However, one person shook their head and said, "This is no life". Another person who had difficulty communicating with us verbally showed facial expressions to suggest they were not happy. We saw they had been trying unsuccessfully to alert staff to their needs. The person gestured to us they would like to get out of bed and tugged on their nightclothes whilst gesturing to their chair. It was early afternoon and the person indicated they wanted to get up.

We spoke with the person's visiting relative, who said they had asked staff several times to assist their family member. We heard and saw the relative also discuss with staff how to ensure people were comfortable when positioned in bed, as staff had placed a pillow under the person which created an awkward posture.

Other relatives we spoke with said they were aware staff were trying hard, but there was a lack of confidence their family member's care needs would be met. They told us, "We don't want to complain and we will always give praise where it is due, but we feel we are continually making excuses for poor care". One relative told us, "I just can't fault them; they're just so busy though. Rushed off their feet, it hasn't helped having no manager here for three weeks". Another relative said, "They seem to be well trained, they look efficient." Another relative said, "The staff don't even have the most basic of knowledge". One relative said agency staff were not skilled, "They are not trained enough, some can't shave people, some can't do the basic stuff, staff are reluctant to brush [my family member's] teeth. Another relative told us, "I often hear people saying they want to go home".

There was very little evidence of person centred care. People's individual wishes were not respected. Basic personal care was not being delivered. Too many people remained in bed without good reason.

We saw one person in bed during the daytime in stained nightwear. We noticed the person had a very dry, dirty mouth and poor dental condition with broken, loose and decayed teeth. We asked staff how they managed the person's oral care. One member of staff said, "We just wipe their mouth with a tissue". We looked at the care plan for this person and it stated staff were to support the person to clean their teeth daily. When we looked in the person's room there was no toothbrush and care staff confirmed they had never seen or helped the person use one. The staff member also could not explain why the person was still in bed and not dressed. The person's care plan said they liked to be in the company of others.

We saw one person on the dementia care unit was visibly distressed during breakfast time and was constantly banging on the table which was disturbing other people. Staff ignored this person until they began shouting. No attempt was made to comfort the person and they remained in their wheelchair until lunch time. Staff did not ask the person where they would like to sit and positioned them facing away from the other people.

At 2.35pm a staff member made a call to the nurse in charge on the unit below to report that a person was unresponsive to staff. This person was in their chair by the window wide open with blankets wrapped around them; their lunch remained on the table in cellophane. At the time we left at 3.35pm the nurse had not yet been to see the person. We requested an update on this and we were told 'they're coming up now'.

On another occasion a person was being assisted with personal care in their room. We heard the person was very distressed and was screaming very loudly which could be heard throughout the corridor. Following this the person came out of their room and was escorted by a staff member to the lounge area for breakfast. The person was getting increasingly agitated and began to swear and shout. No reassurance was offered to the person and they were told by staff to 'just sit down'.
Electronic records did not contain evidence of pre-assessment, although paper records were kept in a filing cabinet. Care plans lacked evidence of any reviews in which people and their relatives had been involved. Updates to care plans had been made in the month we inspected, however due to the format of these it was not possible to determine what, if anything, had been updated. Statements in care records were generic and did not differ from person to person.

Care plans were not accurately completed or effective; staff did not know what was in them or how to navigate the computer system which held the records. On the nursing unit, one nurse said, "I should know how to use the system, I'm responsible for the people, but I've never been shown so I've had to find my own way through the records and I can't always find what I need to know."

It was not clear from looking at people's care records what their needs were because information was incomplete and conflicting. For example, one person's records stated they had diabetes, yet another part of it stated they did not. People's preferences, such as for a bath or shower were not completed.

One person's care plan stated '[Person] requires constant supervision and support as [they] become anxious.' The care plan also showed isolation was a trigger for the person's anxiety, however when we arrived on the first day of our inspection the person's door was closed and they were calling out and banging on the table. Staff did not respond to this. On the second day of inspection the unit manager told us that he had asked staff to ensure they assisted the person to get out of bed and socialise. We saw this had happened by lunchtime.

Another person's care plan was contradictory. It stated, '[name] occasionally presents behaviour that can be predicted and managed by trained staff who are able to maintain a level of conduct that does not pose a risk to [the person] or others. [The person] is nearly always compliant with care.' The care plan also stated, '[name] becomes anxious during personal care.' Where daily notes were kept of people's care, such as food and fluid intake, catheter care, wound care and positioning, we found these were often partly completed or not at all.

There were no meaningful activities taking place on either day of our inspection. On the first day most people spent time in their rooms, even though this was not always their choice. A member of staff told us, "Most people are in their rooms in the morning, then we take them into the lounge for a sing-song." We did not see this happen. On the second day of our inspection more people were using the lounge, however there was no organised or independent activity evident. We were told a church service was planned, however we did not observe staff asking people if they wanted to attend and did not see people being taken to another area of the home to participate in this.

We heard one person ask a member of staff whether they could go to their room and sit in their chair, but the person was told "You need to stay in your wheelchair" very abruptly by the staff member. In the

afternoon in the larger lounge all the people were seated in a circle. There was no television or music on, very little interaction from staff and the room was very silent. The temperature was also uncomfortably hot.

Another person stood in the doorway of their room shouting for help, covered in faeces and asking staff for a shower. Staff ignored the person for around 10 minutes, during which time they smeared faeces on the wall outside of their room. Throughout the day this person was visibly distressed, repeatedly shouting 'help me' but staff rarely responded.

The provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 9, Person centred care

Complaints had not been managed well and these were still coming into the service during the inspection. We spoke with relatives who were very unhappy with the basic care of their family members. One relative told us they had complained personal care was not being delivered often enough or effectively, leading to their family member being dirty and unkempt. Relatives told us they sometimes heard staff complaining to one another about the standards in the home. There were some signs the new management team were listening and reacting to complaints from relatives. Relatives and people we spoke with said they would feel comfortable to complain to any of the staff. One relative said, "The carers are easy to talk to". The complaints record showed not all complaints had been recorded or responded to appropriately.

The provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 16, Complaints

Inadequate

Is the service well-led?

Our findings

The service did not have a manager who was registered with the Care Quality Commission. There was a registered manager listed, but we were informed they had not been in post for some time and the provider had enlisted the services of a management company, Careport to take over the running of the home.

There had been several changes to the management structure since the home was registered in April 2017. All the staff we spoke with were unsure about the current line management structure and unclear who they should speak with to raise any concerns.

People did not all know who was running the home. One person said, "I don't actually know who the manager is", although another said, "There has been a few settling in hiccups but generally it is [managed] ok". Visitors told us they were not all sure who was managing the home and even who the staff were. Staff were not required to wear uniform and it was not easy to identify staff from visitors. One qualified nurse however told us they preferred to wear their own uniform as it was more professional and they wanted to be identified as the nurse.

Relatives we spoke with were not happy with the way the home was run. One relative said, "It is mediocre, maybe 60% happy. They need a manager". Another relative said, "There needs to be better communication. They need a plan of action about what's getting done". Another relative said, "I haven't gone to any meetings and I haven't done any questionnaires", but another said, "I go to them all but I never see anything happen because of them". Some relatives said they would not recommend the home to others. They told us, "They are isolated in their rooms, it's not homely".

Staff lacked direction and leadership in their work and did not understand their roles and responsibilities. There was an atmosphere of chaos during the days of the inspection with little evidence of any organisation or structure. For example, staff did not know which unit they were meant to be working on and we saw some confusion with staff asking on arrival 'where am I meant to be today?' and 'I don't know what's going on'. We saw one hoist was out of action and staff told us this had not been charged so would not work. This resulted in people having to wait to be assisted with moving and handling. We saw staff were visibly stressed and unhappy, and they confirmed this was typical in the service.

There was a significant lack of leadership and oversight. Systems and processes to manage the service were weak with no monitoring of quality. There were no audits in place and no checks of practice. This meant the provider was not aware of the failures in the service or how to address them.
Information in care plans was not analysed to determine whether there were any trends or themes which could be acted on to improve care. For example, where incidents involving behaviour that challenges were recorded there was no evidence of review to establish if there were any repeated circumstances which caused the incidents that could be changed.

There was a very negative culture with poor communication throughout the service. We saw a lack of coordinated team work and we saw some staff reluctantly agreed to work with others. There was very little

evidence of team meetings or engagement between the management team and the staff providing care. Staff morale was very low and although some staff were well meaning, others lacked motivation. Some staff told us they were 'fed up' and 'exhausted', and one member of staff said they had worked seven shifts in a row. Staff we spoke with all said they did not feel valued or supported to care for people living at Calderdale Retreat. One member of staff told us they had tried to raise concerns with managers in the home but no action had been taken. This included in relation to their lack of training and lack of access to people's care plans.

On the second day of our inspection a unit manager had been appointed for the dementia care unit. They told us they were new to the service. One member of staff said, "We weren't told [name of unit manager] was coming. No one tells you who is coming or going." We spoke with the unit manager about their initial impression of the unit. They told us they felt there had been a lack of clarity and direction for staff, and said they wanted a consistent staff team in order to improve the effectiveness of the care provided. They said, "We need to improve communication by eliminating rush."

The unit manager on the dementia care unit told us they had found the acting manager responsive to their suggestions so far. They said a request to change the nurse shift times to improve communication had been actioned and we saw rooms had been re-arranged to put the dining area in the larger of the communal lounges.

Documentation relating to care was difficult to navigate and there was evidence of repetition in the records kept. For example, people's food and fluid intake was recorded on a paper form and in the electronic system. The care system had 33 different sections for 'forms', multiple sections for care plans and a third section for the recording of care information such as weights and food/fluid intake. On the second day of our inspection one unit manager told us they had reviewed the documentation in use and reduced it. The new management team told us they were planning to stop using the electronic system and use paper based care plans to improve staff access to them.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17, Good governance.

The new management team showed us an action plan they had devised to tackle the main issues and instil some structure and clear management systems and processes into the home. However, at the time of the inspection it was too soon to assess the effectiveness of this and there was limited evidence of impact upon people's care.