

Cornwall Care Limited

Trevern

Inspection report

72 Melvill Road
Falmouth
Cornwall
TR11 4DD

Tel: 01326312833

Website: www.cornwallcare.org

Date of inspection visit:
25 January 2018

Date of publication:
09 April 2018

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

We carried out an unannounced focused inspection of Trevern on 25 January 2018. At our previous comprehensive inspections in May and November 2017 we identified breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in respect of the management of identified risks to people's well-being, gaps in monitoring records and the oversight of the service. As these were repeated breaches we issued warning notices following our inspection in November 2017. At our inspection in November 2017 we also had concerns about the safety of the environment and identified a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our last inspection the provider wrote to us detailing the actions they planned to take to ensure they were meeting the requirements of the Regulations. We carried out this focused inspection to check they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Trevern on our website at www.cqc.org.uk.

Trevern is a 'care home' that provides nursing care for up to a maximum of 40 predominately older people. 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. At the time of the inspection there were 34 people living at the service. Some of these people were living with dementia. The building is split into three units known as, The Wing, The Flats and The House. The Wing is used for people who have complex health needs. Trevern is part of the Cornwall Care group which has several nursing and residential homes in Cornwall.

The service is required to have a registered manager. 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. There was a manager at the service who had been in post since early September 2017. They had recently completed the appropriate checks and were applying to CQC to be registered.

We found the service was highly dependent on agency and bank staff. Although as far as possible, staff who were familiar with the service were used, this was not always the case. Staff told us, even when the service was fully staffed there were not enough care assistants on shift to meet people's needs in a timely manner. This was more difficult if some of the staff team were unfamiliar with the service and people's needs. We identified a breach of the regulations.

We still had concerns in respect of the effectiveness of auditing systems. We found gaps in monitoring records used to record when people had received care. Although these records had been audited the gaps had not been noted or any action taken to look at why the records had not been completed. Audits to give

an oversight of people's weights had failed to identify when people were not being weighed as often as outlined in their care plan.

Behaviour records had not been completed correctly. This meant potentially relevant information to guide staff to support people in a way which meant they were less likely to become anxious and distressed was not being captured. We concluded the provider had failed to take adequate action to ensure the conditions of the warning notice were met.

Risks to people's well-being and health were well documented. There was clear guidance for staff to follow to protect people from foreseeable harm. Staff communicated at handover and throughout the day to help ensure they were aware of any change in people's needs.

Improvements to the environment had been made since our last inspection. Confidential information was kept securely. Keypads had been fitted to various doors throughout the building so potentially harmful products and equipment could be safely stored.

There were robust arrangements in place for the ordering, storing and administration of medicines.

Cornwall Care had a clear management structure in place. The manager told us they were well supported and had regular contact with the senior management team.

Within the service there was a well-defined hierarchy. The manager was supported by a deputy manager. There was also a senior nurse employed who had responsibility for overseeing the management of medicines.

There were plans in place to improve and develop the service. For example, the call bell system was due to be improved to make it easier for staff to quickly identify which bells had been activated and increase the volume of the bells.

The service was rated as Requires Improvement. This is the fourth consecutive time the service has been rated Requires Improvement. We identified breaches of the Regulations. 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?

The service was not entirely safe. Staffing levels were not sufficient to meet people's needs.

Risk assessments clearly guided staff on the actions they should take to protect people from foreseeable harm.

Improvements had been made to the safety of the environment.

Requires Improvement ●

Is the service well-led?

The service was not entirely well-led. Records to show the care people had received were not consistently completed. Audits had not identified the shortfalls.

Staff had clear roles and responsibilities.

There were regular meetings for staff, residents and relatives.

Requires Improvement ●

Trevern

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.

We undertook an unannounced focused inspection of Trevern on 25 January 2018. This inspection was done to check that improvements to meet legal requirements planned by the provider after our November 2017 inspection had been made. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led? This is because the service was not meeting some legal requirements in these areas.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our on-going 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.

The inspection was carried out by two adult social care inspectors. During the inspection we spoke with Cornwall Cares' operations director and assistant director of operations. We also spoke with the manager and ten members of staff and three visiting relatives. Due to people's health needs they were unable to verbally give us their views of the service. We observed staff as they supported people with day to day tasks.

Before the inspection we reviewed the information we held about the service and notifications of incidents we had received. A notification is information about important events which the service is required to send us by law. We had not requested a recent Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make

We looked at six people's care plans, medicine records, staff rotas, monitoring records and other records relating to the management of the service.

Is the service safe?

Our findings

At our previous inspection in November 2017 we had found the service was understaffed and there was a high dependency on agency staff. Before this inspection visit we had received concerns about staffing levels. We discussed staffing arrangements with the manager. They told us the service had been understaffed and staff from agencies and Cornwall Cares' bank staff were used regularly. This was for both nursing staff and health care assistants. The manager told us that, as far as possible, agency staff who were familiar with the service were used. We looked at rotas for the period between January 10 and January 18 2018. These showed agency and bank staff had been used on a daily basis during this period. On three days, eight or nine care shifts had been covered by agency or bank staff.

The rotas showed there had been occasions when staff levels had fallen below those identified as necessary for the service. The manager told us this was due to unexpected sickness or staff failing to turn up and happened infrequently. We identified five shifts over the period of nine days when the service had been short staffed. Staff told us that, even when the service was staffed according to the numbers identified as necessary for the service, this was not enough to provide people with the care they needed due to the level of their needs. One commented; "Even when it's fully staffed it isn't!" On the day of the inspection some people were still being supported to get up at 11.30. Staff told us this was not people's personal choice but because they had not had the time to support people sooner.

The service was spread across three units, The Wing, The Flats and The House. The Flats had bedrooms on two separate floors. There were thirteen people on this unit at the time of the inspection, nine needed support from two members of staff for personal care and to help them with transfers. Some people needed support at meal times and several required repositioning every two hours. The unit was staffed by a nurse or senior support worker and three care assistants. This meant at key points of the day such as when people were being supported to get up or go to bed and at meal times, staff were particularly pushed. On the day of the inspection this unit was staffed by a nurse, a permanent member of staff who did not usually work on that unit, a member of staff who was new to the service and an agency worker. This meant people were not being supported by staff with a good knowledge of their needs.

Although some agency and bank staff were very familiar with the service and people's needs, others were less confident. On the morning of the inspection The Wing was staffed by a member of the permanent staff team, a member of Cornwall Cares' bank staff team and two agency workers. The agency and bank staff were heard to ask the permanent care worker about people's needs in respect of their day to day care on several occasions. A member of staff told us; "It's not too bad if you have a strong staff team, it's not fair if it's all agency."

During our conversations with staff it was clear they found the situation difficult and upsetting. They told us they were frustrated at not being able to provide people with care in line with their preferences. For example, one member of staff told us about an individual who spent most of their time in their room due to their health needs. They said; "Ideally we would like to get [person's name] up once or twice a week but it's just not possible." Another told us; "It feels like it's always rushed and you can't give the care people need."

We found the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A recruitment drive was on-going. The manager told us two members of staff were due to complete their induction the week following the inspection. Six new members of staff had recently appointed and were waiting for recruitment checks to be completed before they started the induction process. However, we had been given similar assurances at our previous inspection. We need to see a period of sustained staff stability before we can be confident the provider is meeting the requirements of the Regulations.

The service had a suitable recruitment procedure. Before new staff started work pre-employment checks were completed to help ensure they were suitable for the role. This included the taking up of references from previous employers and a Disclosure and Barring Service (DBS) check.

At our previous comprehensive inspection in November 2017 we had concerns relating to the documentation and management of risk and we identified a breach of the regulations. There was a lack of guidance in place for staff on how to care for people who had been identified as being at risk. Where risks to people's health and well-being had been identified action to protect them from foreseeable harm was not consistently taken or was not effectively monitored.

At this inspection we found any risks to people's health and well-being were clearly documented. Risk assessments contained clear guidance for staff on the action they should take to keep people safe. For example, some people required regular repositioning to protect the condition of their skin. Care plans contained information on how often this should occur. These were updated regularly to help ensure the information was relevant. We attended a staff handover and heard staff discuss people's needs to check they were still providing appropriate care. One person had been admitted to the service with wounds associated with poor skin integrity. Records showed the wounds were being treated in line with the care plan, were healing and the person's health in this aspect was improving.

Some people had air mattresses to help protect them from damage to their skin. We checked the settings on six mattresses and found all but one had been set in line with the person's weight. One of the mattresses was incorrectly set. We brought this to the attention of a senior care worker who immediately reset it. They told us the person had lost weight very recently. Pressure relieving cushions were available for use in shared areas. These were in good condition and clean.

At our previous comprehensive inspection in November 2017 we had concerns relating to a particular individual who was at risk of falling. Following the inspection the provider contacted us to tell us of measures they had put in place to help ensure the person's safety. We checked on this individual again at this inspection and found the level of care provided was appropriate to their needs. Since this additional care had been put in place the person had not had any further falls.

We found the service was now meeting the requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous comprehensive inspection in November 2017 we had some concerns in respect of the safety of the environment and we identified a breach of the regulations. Rooms containing potential hazards or confidential information were not secured effectively. Cleaning schedules were not in place in all areas and we saw unnamed toiletries in shared bathrooms. Sharing of these products increases the risk of cross contamination.

At this inspection we found improvements had been made to the environment. Traditional key locks had been replaced by keypads to access rooms which contained potentially hazardous substances or equipment. Confidential information was kept securely. Carpets had been replaced in shared areas and the activity room. Some furniture had also been replaced. Bathrooms had been cleared of clutter and were clean. One bathroom had a glass panel on the door which did not protect people's dignity. This had been covered over with coloured paper to allow privacy. A member of staff had been given the role of infection control lead. They were supported by a team of six members of staff, two from each unit. They were responsible for highlighting any concerns relating to infection control to the lead member of staff. Cleaning schedules were in place and these had been completed appropriately. The service was clean, tidy and free from unpleasant odours on the day of the inspection.

We found the service was no longer in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a safeguarding policy in place which was updated regularly. The policy contained the latest contact details for the local safeguarding team. Staff were required to read this when they first started working at the service.

People had Personal Emergency Evacuation Plans in place (PEEPs) to provide first responders to emergencies with information on the support people would need to help them exit the premises. Equipment to support people unable to mobilise independently was available at key points in the building. External doors and doors connecting units were operated using keypads. These had been updated since our previous inspection to limit the number of codes used.

The service had suitable arrangements for the ordering, storage and disposal of medicines. Nurses and suitably qualified and trained senior care workers were responsible for the administration of medicines. Medicines which required stricter controls by law were stored in a separate cupboard and records kept in line with relevant legislation. Some medicines were being used that required cold storage, there was a medicine refrigerator at the service and the temperature was monitored. Medicine Administration Records (MAR) were completed appropriately. Any handwritten entries were double signed to help prevent any errors. The lead nurse audited MARs monthly.

Some people were receiving medicines hidden in food or drink (covertly). Care plans showed there were clear protocols in place for staff to follow in these circumstances. Decisions to administer medicines covertly had been taken in people's best interest and the correct legislative processes had been followed.

Is the service well-led?

Our findings

At our previous comprehensive inspections in May 2017 and November 2017 we found audits to monitor the quality of the service were not effective and we issued a breach of the regulations. We identified gaps in monitoring charts and there had been a failure to effectively monitor the cleanliness of the environment.

At this inspection we found although some improvements had been made, the systems in place were still not robust enough to assess and monitor the quality of all aspects of the service. Monitoring charts to record when people had been repositioned were in place. We looked at one person's records who required repositioning every two hours. The records for the 24 January 2018 had been completed at 4.55, 7.00, 8.40, 10.40, 16.00, 18.30 and 23.30. This meant there had been a gap of four hours and twenty minutes and one of five hours when there was no record the person had been repositioned. We spoke with the nurse on duty who told us they believed this was a recording issue rather than an indication the care had not been delivered as required. A new auditing system had been introduced two days before the inspection which required the nurse on duty to sign the front sheet of room records to indicate the records had been checked. This sheet had been signed despite the fact the records had not been completed. There was no record to show any action had been taken to follow up on the failure to complete the records appropriately.

Behaviour records used to identify possible triggers which might lead to people becoming agitated or distressed had not been completed correctly. Rows below the initial description of the behaviour meant to be used to record triggers, actions and any outcomes had not been filled in with this information. The rows had been incorrectly used to record the next entry. This meant potentially relevant information to help staff support people was not being captured.

Another person's care plan directed to staff to weigh them every week. Records showed they had been weighed on 26 November 2017 and then not until 30 December 2017. They had then been weighed on the 23 and 24 January 2018. The weights audit which was completed monthly recorded the person's weight at the end of December and stated; "Remain on weekly weights." There was no evidence to show the audit had identified that the person had not been weighed according to the guidance in the care plan.

We saw one person's weights had not been recorded in their care plan although they were documented elsewhere. A member of staff told us they were sceptical the recordings were accurate as they showed the person had lost approximately two kilograms in two days. They said the person was eating well and also having fortified drinks and the weight loss seemed unlikely. They told us the scales were old and unreliable.

One person had moved to Trevern recently from another Cornwall Care service. The person's care plan stated; "Staff to be aware of [person's name] communication methods." There was a further reference to communication cards which could be used to support meaningful communication. Staff told us they had not seen these cards and they had not been with the person's belongings when they arrived at the service. The deputy operations director then discovered the cards referred to were not specific to the person but were kept at every Cornwall Care service. Staff and the manager were unaware of this and were unable to locate the cards.

We concluded there was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Trevern requires a registered manager. 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. There was a manager at the service who had been in post since early September 2017. They were in the process of completing their application to register with CQC as the registered manager.

Cornwall Care had a clear management structure in place. The manager was supported by Cornwall Cares' clinical matron, a director of operations and an assistant operations director. The manager told us they were well supported and had regular contact with the senior management team. A weekly conference call had recently been introduced for all managers to share information and examples of good working practice. Regular meetings and quality groups had been put in place to support the development of Cornwall Care and individual services. A quality assurance group met regularly to look at themes and trends across services.

Within the service there was a well-defined hierarchy. The manager was supported by a deputy manager. There was also a senior nurse with responsibility for overseeing the management of medicines. They were also the infection control lead. Nurses, or senior care workers oversaw the shifts on each unit.

Staff meetings were held regularly for the whole staff team and 'hub' meetings were held for unit staff teams. This meant staff were able to focus on issues which directly affected them. Handovers were held between each shift. These were used to share details about people's care. This meant staff had the information they needed to provide consistent care in line with people's changing needs.

Residents and relatives meetings were held to gather the views of people living at the service and those who mattered to them. A sign in the foyer advertised a relatives meeting which had been organised for early March 2018. Relatives told us they were kept informed of any developments and considered the service to be well-managed.

There were plans in place to improve and develop the service. For example, the call bell system was due to be improved to make it easier for staff to quickly identify which bells had been activated and increase the volume of the bells.

The registered persons had ensured all relevant legal requirements, including registration, safety and public health related obligations, and the submission of notifications had been complied with. The previous rating issued by CQC was displayed in the service and on Cornwall Care's website.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems or processes were not established or operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

The enforcement action we took:

We imposed a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed.

The enforcement action we took:

We imposed a condition