Cornwall Care Limited

Trevern

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This comprehensive inspection took place on 21 November 2016 and was unannounced. The last inspection took place on 30 June 2015 when we identified a breach of the legal requirements relating to staffing. Staffing levels defined as necessary for the service were not consistently met and there was an overreliance on agency staff. Following the inspection in June 2015 the provider sent the Care Quality Commission an action plan outlining how they would address the identified breach. After that inspection we received concerns in relation to staffing levels, management arrangements, monitoring records, and the security arrangements of the building.

We undertook this inspection to check the provider had followed their plan and to confirm that they now met legal requirements. We also looked at the areas that had been raised to us as concerns.

Trevern is a care home that provides nursing care for up to a maximum of 40 predominately older people. At the time of the inspection there were 36 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.

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. Although there was a registered manager in post at the time of the inspection the service was being overseen by an interim manager.

The service had identified the minimum numbers of staff required to meet people's needs, these were not being consistently met. The management team had identified there were high levels of staff absenteeism due to last minute sickness and this was contributing to low staffing numbers. Action was being taken to address this issue and a new sickness management policy had been introduced. However, it was too early for us to evaluate the effectiveness of this new policy.

Care plans contained risk assessments for a range of circumstances. The assessments were updated regularly to reflect people's changing needs. There was a lack of guidance in place for staff on how to care for someone who had been identified as at risk.We have made a recommendation in the report about the management of risk.

Systems for the management and administration of medicines were robust. Medicines were stored safely and securely and regular audits were carried out.

Improvements had been made to the environment and more were planned. Some areas were in the process of being redecorated. Arrangements to minimise the effect of the redecorating on people's daily lives were in now place although previous improvements had not been well planned.

People had access to activities. Two healthcare assistants had additional responsibilities as activity co-ordinators. They organised visits from outside entertainers as well as providing activities themselves. There were also regular trips out to local events and landmarks. People who stayed in their rooms had more limited access to activities.

People's health needs were monitored. However, records documenting this were inconsistently completed. There were gaps in records and some had not been dated. This meant it was difficult to establish whether people had received care according to their plan of care.

There was a lack of clear oversight of the service. Although some staff had been given responsibility for various areas, for example, rotas and auditing, this had not prevented the problems identified at this inspection from occurring. An interim manager was in place but they had not gained a good working knowledge of the service. Relatives were not clear as to the arrangements for managing the service and some told us communication had been poor.

The provider was implementing changes within the service and new systems had been introduced to achieve this. Changes had been made to the way in which staff were deployed throughout the service. Staff and relatives told us this was a positive move which helped ensure people received continuity of care. However, the new processes were not sufficiently embedded to allow us to make a judgement as to their effectiveness. We will check this at the next comprehensive inspection.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the end of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not entirely safe. There were not always enough staff available to meet people's needs in a timely manner.

Risk assessments were in place but these did not contain sufficient guidance for staff on how they could minimise the risk.

There were robust systems in place for the management and administration of medicines.

Is the service effective?

Good

The service was effective. The provider was following legal requirements as laid down in the Mental Capacity Act and associated Deprivation of Liberty Safeguards.

Newly employed staff were required to complete an induction before starting work. This covered organisational policies and procedures and training in areas identified as necessary for the service.

The premises were arranged to help meet the needs of people using the service.

Is the service caring?

Good

The service was caring. People and relatives told us staff were very caring.

Staff displayed a positive and compassionate approach when describing how to support people who were distressed.

Care plans contained information about people's individual needs and preferences.

Is the service responsive?

Requires Improvement

The service was not entirely responsive. Monitoring records to evidence the care people were receiving were not consistently completed.

Systems were in place to help ensure staff were updated about

any changes in people's needs.

Activities were organised for people in line with their interests.

Is the service well-led?

Requires Improvement

The service was not entirely well-led. There was no clear oversight of the service.

Relatives were not informed of changes to the day to day running of the service.

Audits had failed to identify gaps in records of the care and treatment provided.

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 comprehensive inspection of Trevern on 21 November 2016. The inspection was carried out by two inspectors. Before the inspection we reviewed the information we held about the home. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

Not everyone we met who was living at Trevern was able to give us their verbal views of the care and support they received due to their health needs. We looked around the premises and observed care practices and interactions between staff and people.

We spoke with the interim manager, Cornwall Care's operations project director and the senior nurse. We spoke with four people and seven members of staff. Following the inspection we spoke with five relatives.

We looked at care documentation for three people living at Trevern, medicines records, three staff files, training records and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in June 2015 we identified that the service was sometimes short staffed and agency staff were used frequently to cover gaps in the rota. Before this inspection we had again received concerns about staffing levels at the service. We had been told people were being left without staff support for long periods of time. The concerns were that staff only had time to meet people's personal care needs, the care was very task based and people's social needs were not being met.

The service had identified the minimum numbers of staff required to meet people's needs. We looked at rotas for the first two weeks of November and found there had been five occasions during the day when these staffing levels had not been met and two occasions during the night. All of these gaps had been due to last minute staff sickness. We discussed this with the interim manager and operation's project director who told us they had identified there were high levels of staff sickness within the service. In order to address this, a new sickness management procedure was being introduced which would highlight if staff were developing poor sickness records.

Staff told us, when the minimum levels were met, there were enough staff to meet people's needs. However, they said staffing levels were; "tight" and if one care worker was sick this impacted on their ability to deliver care which met people's health and social needs. An activity coordinator told us they were sometimes required to carry out care duties instead of organising activities. We discussed this with the interim manager and senior nurse. They told us they were available to cover care duties if required and staff only needed to ask for this additional support. The interim manager said; "This door is always open." They agreed they would remind staff they had this option open to them if needed.

Although action was being taken to address low staff numbers the systems were not yet in place to allow us to judge whether or not they were effective. We will check this at our next inspection.

The staff team had an appropriate mix of skills and experience. There was always one nurse on shift who was supported by two Level 3 health care assistants. On the day of the inspection people's needs were usually met quickly. We did see one person, who required the support of two members of staff to help them move, needed to wait for twenty minutes after asking for help, before two members of staff were available. A relative told us; "Because of the shortage of staff he can be left [waiting for support] for up to half an hour if two carers are taken up with one person." At the time of the inspection there were 58 hours of care worker vacancies. The operations project director told us recruitment was on-going.

We concluded there was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living in 'The Wing' had complex health needs and required high levels of support. When staff levels were low these people's needs were prioritised and staff were moved to ensure there were always sufficient numbers in that particular area. Agency staff were sometimes used to cover staff absenteeism. These were either from Cornwall Care's own internal agency group, 'Flexicare', or from an outside agency. In both cases

staff familiar with the service were used. A member of staff told us; "We use some [agency staff] in particular very regularly."

Relatives views on staffing levels were mixed. Those relatives who had family members in 'The Wing' told us staffing was good and people's needs were met quickly. Other relatives were less positive about staffing levels. All said they believed their family members were safe. Some thought people's social needs were not always met. Everyone we spoke with told us the staff were caring and responded to any requests for support as soon as they were able to.

Care plans contained risk assessments for a range of circumstances including moving and handling, skin integrity and the likelihood of falls. The risk assessments were updated regularly to reflect people's changing needs. There was a lack of guidance in place for staff on how to care for someone who had been identified as at risk. For example, one person had developed a minor pressure sore and required dressings to be changed regularly. The care plan did not stipulate how often the dressings should be changed or what type of dressing should be used. In another person's records it had been recorded they were at risk due to poor nutrition and were losing weight. A GP had been consulted and had advised the person be encouraged to have fortified foods. There was no guidance for staff on how they could support this action. Staff told us they were aware of people's changing needs and records confirmed people were receiving appropriate care. However, staff less familiar with people's needs may not have had access to relevant information to enable them to help ensure people's needs were met and they were protected from identifiable risk.

We looked around the building and found several doors marked, "to be kept locked" were unlocked. These were doors to cupboards used for storing items such as laundry, bedding and food supplements. The door to an office containing care plans was also unlocked. This meant people's personal information was not protected. Some bathrooms contained equipment such as wheelchairs, and other mobility aids. This meant the room would need to be cleared before using the bath and people would not be able to access the rooms independently. The senior nurse commented; "We are very low on storage." Some bathrooms contained unnamed toiletries, and in one we saw several pairs of socks and a blanket, again unnamed. This meant people were not effectively protected from the risks associated with accessing unsecured and cluttered areas of the service. There was also a risk of cross contamination from sharing toiletries and clothing.

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

We had received concerns regarding the security of the premises. Arrangements to access the building had recently been changed and relatives were now required to ask staff to let them enter or exit the building. We were told staff did not question people who they were not familiar with, about their reason for visiting the service or who they wanted to see. We discussed the concerns with the interim manager who told us they had changed the keypad code as a matter of good practice as it had been in place for some time. They told us they had witnessed visitors allowing others onto the premises and felt they needed a higher level of control so they could be aware of who was in the building. They assured us they would remind staff of the importance of checking why people were visiting the service and who they were there to see.

There were robust systems in place for the management of medicines. Staff completed daily medicine audits and the senior nurse more detailed weekly audits. Medicines were stored safely and securely. There were suitable arrangements for keeping any medicines subject to stricter controls by law. We checked a sample of Medicine Administration Records (MAR) for these medicines and found there were no errors. Checks on patch medicines used to control pain were carried out daily to protect people from the risks associated with the administration of medicine in this way. Systems for administering medicines had

changed following a medicines error. This demonstrated action was taken to learn from mistakes and develop more robust systems.

All staff had received training in safeguarding. They told us they would report any concerns they had to a member of the management team and believed they would be addressed. Staff were less confident about where they could report concerns outside of the organisation. There was information available on noticeboards regarding the Local Authorities safeguarding processes.

Recruitment systems were robust and new employees underwent the relevant pre-employment checks before starting work. This included Disclosure and Barring System (DBS) checks and the provision of references including a reference from the previous employer.

The environment was clean and hand washing facilities were available throughout the building. Personal protective equipment (PPE) such as aprons and gloves were available for staff and used appropriately. We had received concerns that improvements to the premises were not well managed and had impacted negatively on people's daily lives. We discussed this with the senior nurse who told us the staff team had not been aware of arrangements to refurbish the kitchen until two days before the work started. They had immediately transferred equipment out of the area and arranged for meals to be served directly from the main kitchen. On the day of the inspection the lounge area in one part of the building was being refurbished. People who regularly used the area were asked if they wanted to use a lounge in another part of the building and we saw one person had accepted this opportunity. We spoke with the building contractor who told us they started work early to enable them to complete as much as possible in a day and minimise the impact on people. Any work likely to create noise did not start until after 9:00am. We concluded there were adequate arrangements in place to minimise the impact of work to the building on the people living there.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Applications for DoLS authorisations had been made where relevant and the service was awaiting the outcome of these from the local DoLS team. There were no authorisations in place at the time of the inspection. Records showed best interest meetings were held appropriately.

People were cared for by staff who had a good understanding of their needs and were skilled in delivering care. People and relatives told us they considered staff to be competent. Relatives comments included; "Everyone knows what's what. They're really spot on" and "They're all clued up." We looked at training records for moving and handling, infection control, safeguarding and MCA and DoLS. These showed staff had all received training in these areas within the last three years. One member of staff told us; "The training was good, very helpful."

Newly employed staff were required to complete an induction before starting work. This included familiarising themselves with organisational policies and procedures. Staff new to care were required to complete the Care Certificate. This is designed to help ensure care staff have a wide theoretical knowledge of good working practice within the care sector. All new staff completed in-house training in fire safety, health and safety, food hygiene and infection control. There was also a period of working alongside more experienced staff until such a time as the worker felt confident to work alone.

Not all staff had received supervisions recently. However, supervision sessions had been booked for most staff members to take place in the next few weeks.

Each unit had a lounge area and basic kitchen facilities where drinks and light snacks could be prepared. One large bedroom had been refurbished and set aside for people to use who were receiving end of life care. There was room for a sofa bed for relatives to use if they wanted to stay with their family member overnight. Facilities for making tea and coffee would also be provided in the room.

We observed some people over the lunch time period. People who needed assistance or encouragement to eat were supported with kindness and humour. The food appeared appetising and people were offered a choice. We saw one person was given a second helping. Staff displayed a good knowledge of people's likes and dislikes regarding food and drink. For example, one member of staff remarked, "I know you like your

sausages!" Care plans recorded when people needed additional support maintaining an adequate diet and offered guidance for staff on what people might like to eat. For example, in one care plan we saw written; "Offer mashed banana and cream." We observed the person was provided with this.

People had access to external healthcare professionals including GP's, opticians and chiropodists. Care records contained records of any multi-disciplinary notes.

Good

Is the service caring?

Our findings

Not everyone living at Trevern was able to verbally tell us about their experience of living there due to their health needs. Relatives and people told us staff were very caring. Comments included; "They're all very, very dedicated" " If mum's tired and wants to go to bed someone will help her" and "He is well cared for and as comfortable as he can be."

During the day of the inspection we spent time observing people in the lounge and dining areas. Although staff were clearly busy, they were patient in their approach with people and spent time reassuring people. We discussed with staff how they could support people when they became anxious or distressed. Staff demonstrated a positive and compassionate approach to this. One commented; "You need to keep talking to people, always explaining what you're doing. Things are usually easily resolved."

People were treated with dignity and respect. Everyone had access to health products which were suitable for their individual needs. Slings were kept in people's rooms to help ensure they were supported to mobilise with the correct equipment. This is important to enable staff to support people with dignity.

Care plans contained information about people's hobbies and interests. For example, the kind of music people preferred. One person's care plan stated; "Ensure [person's name] wears his glasses." We saw staff helped the person put their glasses on when they went into the person's room to check on their welfare.

Bedrooms were decorated and furnished to reflect people's personal tastes. People had personal photographs and possessions in their rooms. There were photographs and pictures hanging throughout the building. This helped create a homely atmosphere. Christmas decorations were being put up and these were cheerful and eye catching.

We saw thank you cards and messages which had been sent to Trevern by relatives. Messages included; "Your care was dignified", "I was deeply impressed and so glad I chose Trevern" and "No-one could have done more."

Requires Improvement

Is the service responsive?

Our findings

We had received concerns people were not being monitored effectively when it had been identified they were at risk. We checked monitoring records and found there were some gaps in the records. For example, one person needed to be repositioned regularly in order to protect their skin from pressure damage. Records to evidence this was taking place as needed were not consistently completed. Although we were satisfied the person was receiving the appropriate care it is important this is documented accurately. Another person had been identified as being at risk because they were not drinking enough. Fluid monitoring records had been put in place but these were not always completed. The records that were in place were not always dated and it was difficult to ascertain if the person was getting the fluids they needed to stay well. We concluded the concerns we had received were substantiated.

This contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans contained information on a range of aspects of people's support needs including mobility, communication, nutrition and hydration and health. There was also information in respect of people's preferences and interests. This is important as it helps staff establish meaningful conversation with people. Staff were able to describe to us the care people needed and we saw staff supporting people in line with their care plans.

Daily notes were consistently completed and enabled staff coming on duty to get a quick overview of any changes in people's needs and their general well-being. Handovers took place between shifts and these helped staff to keep up to date with any changes in people's health needs. Staff told us this was an effective system. One member of staff commented; "The communication between staff on shift is very good."

There were opportunities for people to take part in activities. At the time of the inspection two health care assistants had some hours set aside to work as activity coordinators. This meant an activity coordinator was on duty five days a week. One of the activity coordinators was leaving the service and the operation's project director told us their position would be replaced. Activity coordinators were sometimes required to cover care shifts as outlined in the safe section of this report. The activity coordinator told us they spoke to people to identify what activities they enjoyed. They also tried to engage with people who chose to stay in their rooms or had to because of their health needs. However, they did not always have the time to do this. This meant people who were in their rooms all day were at risk of social isolation.

Activities included visits from outside entertainers, exercise sessions, walks in the local community and reminiscing sessions. Rummage bags were available in one of the dining rooms. These are bags which contain objects chosen to stimulate memories and conversation.

People and families were provided with information on how to raise any concerns they may have. Complaints were recorded appropriately and dealt with according to Cornwall Care's policies and procedures.

Requires Improvement

Is the service well-led?

Our findings

We had received concerns about the management of the service and the communication with relatives. At the time of the inspection the service was being overseen by an interim manager who had only been in post for five weeks and was not familiar with the service. For example, they were unable to tell us whether anyone was subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. This is important as it is a legal document which may contain conditions regarding the restrictions in place to keep people safe. The interim manager was supported by a senior nurse who had been at Trevern since early 2016, and a senior healthcare assistant who had worked at the service for many years. The healthcare assistant had been given responsibility for overseeing staff rotas and training needs. The senior nurse had some protected administration time to carry out audits for areas including medicines, pressure care and any active food and fluid charts.

Relatives were unclear as to arrangements for the management of the service. We discussed this with Cornwall Care's operation's project director who told us they would arrange for information to be shared with people and relatives as soon as they were able to do so. Due to the particular circumstances at the time of the inspection this was not possible at that time. We were told the senior management team were aware of families concerns and would address them as soon as possible. While it is acknowledged it was difficult for the senior management team to share specific information with relatives there was a lack of communication of any kind occurring. Some relatives told us they were unsure as to who was running the service and two told us they believed it was being overseen by the senior nurse. We found there was a lack of clear leadership at the time of the inspection.

People were asked for their views of the service annually by means of a questionnaire issued to all Cornwall Care homes. The last survey had taken place in 2015 and another was due to be circulated in the near future. Findings of the last survey showed 92% of the 14 people who completed the survey agreed with the statement; "I can speak to senior members of staff if I need to." No similar survey was made available to friends and families of residents.

Regular audits were carried out on various aspects of the service including care plans and records of support people received. These audits had failed to identify the gaps we found in the monitoring systems. Weekly checks of pressure mattresses were carried out to ensure they were in working order. There were no checks taking place to check they were set correctly in accordance with people's weight. Some of the mattresses were not correctly set and staff were unclear as to what the correct setting should be. This is important to ensure they are effective.

This contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us morale had been low but was improving. One commented; "Staff were really feeling they were on their own. It's like someone's put a big arm round us." A staff meeting had been held several days before the inspection and this had been particularly well attended. Staff told us they felt more positive about their

roles and had seen the meeting as an opportunity to raise any concerns they had. One member of staff said; "The communication has improved greatly."

Services are required to notify CQC of various events and incidents to allow us to monitor the service. The service was notifying CQC of any incidents as required, for example expected and unexpected deaths.

New systems had recently been introduced to improve how the service operated. For example, the new sickness management policy described in the safe section of this report had been introduced. In addition new systems for reporting incidents within the organisation had been introduced to help ensure any patterns or trends were quickly identified and could be acted upon. The system would help ensure that any incidents were categorised correctly and immediately forwarded to the relevant people for attention.

Changes had been made to the way in which staff were deployed across the service. The service was split into three units and staff had previously worked across all units. This had been changed so staff were based in one unit. Staff and relatives told us this helped ensure people received continuity of care from staff who knew them well. Staff told us it also led to more cohesive staff groups working together as a team. A new rota system had been introduced to reflect the change. This would also allow management to identify if staff were working particularly long hours. A member of staff told us; "They [senior management] are putting things in place." This demonstrated the provider was taking steps to improve the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established or operated effectively to assess, monitor and improve the quality and safety of the services provided or mitigate the risks relating to people's health, safety and welfare. Accurate and complete records regarding people's care and treatment were not maintained. Regulation 17(1)(a)(b)(c)

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