Tre' Care Group Limited

Trefula House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Trefula House on 6 and 7 November 2017. The inspection was unannounced. At the last inspection, in July 2016, the service was rated Good. At this inspection we found the service required improvement and identified two breaches of the regulations.

Trefula is a 'care home'. 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. Trefula accommodates 44 people across two separate units, each of which have separate adapted facilities. One of the units specialises in providing care to people living with dementia.

The service had 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.

We had some concerns about personal care and skin care for some people. We concluded the registered persons should have liaised more promptly with tissue viability nurses when there were concerns about the effectiveness of pressure relief, and when people's skin conditions failed to improve as planned.

We also had some concerns about whether people's rights to consent to their care, and measures taken if people could not, were suitably managed within the boundaries of the Mental Capacity Act 2005. The majority of people did not have capacity. However not everybody had a fully completed mental capacity assessment. Due to some people's behaviour, approved techniques to assist people to minimise any difficult behaviours needed to be used. However guidance, about individuals needing this support, was limited. There was no evidence that the multi-disciplinary team had made decisions, through a best interest process, about the techniques used.

People were safe. For example, one person told us: "Staff make me feel safe. They are nearby if I need them." Suitable policies and procedures were in place to ensure people were protected if there was any allegations of abuse. Staff had received safeguarding training.

The service had suitable policies and procedures about risk assessment to monitor any risks to people (such as poor nutrition and hydration, and falls) or others (such as aggression).

Equipment (such as hoists and wheelchairs) were suitably maintained. Health and safety checks (for example checking fire precautions, and electrical checks) were routinely completed appropriately.

Staffing levels were satisfactory. Call bells were answered promptly on the day of our inspection and an external professionals commented: "The staffing levels seem appropriate and carers appear caring and supportive." Satisfactory staff induction processes were in place. Staff were generally appropriately trained to carry out their jobs, although we did think training about pressure ulcer prevention, and wound care could be improved. Staff recruitment checks were satisfactory. The staff supervision and appraisal system needed to be improved so staff received more frequent meetings with their supervisor. However, staff told us they felt supported by management.

The medicines system was generally satisfactory, although the management of creams, eye and ear ointments needed some improvement. We have made a recommendation in relation to this.

The service was clean and hygienic. Staff received training about infection control and understood the need to wear protective clothing as necessary. There were suitable pre admission assessment procedures, to check if people's needs could be met. Every one had a care plan and these were regularly reviewed.

People were happy with the food. People had a choice of meals. Someone told us: "The food is always hot and tasty. "Where people needed to have what they ate and drank monitored, records could be improved.

Generally there were good links with external professionals. People could access relevant external professionals such as GP's, community matrons, chiropodists, dentists and community psychiatric nurses. External professionals were positive about the care provided at the service. Comments included: "They deal with some very complex people, but they do a good job. They are always looking to make improvements."

The building was suitable for the people who lived there. Most people could walk around the home, and had access to a garden having to ask staff to accompany them or access different areas. The building was suitably maintained, warm and comfortable.

People, their relatives and external professionals thought the service was caring. Comments received included: "All staff are kindly, patient and caring," and "People flourish at Trefula." The majority of care practice we observed was to a good standard. Staff did not rush people and were patient. People could see visitors when they wanted, and visitors said they felt welcome.

There was a range of activities on offer. For example crafts, arts and various entertainers. A full time and a part time activities organiser were employed.

The service had a complaints procedure. Records were kept of any complaints made. People and their relatives who we spoke with said they could talk to staff if they had any concerns. The people we spoke with said they felt if they had any concerns and complaints these would be appropriately responded to.

The service had a suitable approach to supporting people with end of life care. The registered manager said there were good links with GP's to ensure people received suitable medical care during this period of their lives.

Management were viewed positively. Comments received included that management were: "Approachable," and "Very good." There was a clear management structure and always senior staff on duty to ensure shifts were well managed and staff could seek support.

The service had suitable approaches to ensure the service was maintained to a satisfactory standard. There were a range of audit systems in place for example to check care planning, training, and standards of care were appropriate. An annual survey was completed. The published results were positive. However the management of the service had not picked up the concerns we found in this report and this has resulted in a breach of regulations.

You can see what action we told the provider to take at the back 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?

Good

The service was safe.

People were protected and suitable action taken if there were allegations of abuse.

The service has satisfactory staffing levels and people received prompt support if they needed help.

The medicines systems was generally well managed although some improvement was needed about the management of creams, lotions, and ear and eye drops.

Is the service effective?

Requires Improvement

The service was not effective.

Wound and pressure relief care were not always effectively managed.

People's right to consent to care, and action taken if they lacked capacity, were not always protected in line with the Mental Capacity Act 2005

People liked the food, had a choice of meals, and received suitable support at mealtimes. However, records of what people ate and drank were not always comprehensively maintained.

Is the service caring?

Good

The service was caring.

Staff were seen by people, their relatives and external professionals as kind and caring.

People's right to privacy and dignity were respected.

Visitors could visit at any time and said they felt welcome.

Is the service responsive?

Good

The service was responsive.

Everyone had a care plan, and these were regularly reviewed.

The service provided a range of activities.

People and their representatives said they could approach staff or management if they had a complaint. People felt complaints would be responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not entirely well led.

People, their representatives, staff and external professionals thought management were supportive and managed the service well.

The service had a suitable approach to quality assurance, however this had failed to pick up the concerns raised in this report.

Trefula House

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 checked 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 6 and 7 November 2017 and was unannounced. The inspection team consisted of a lead inspector, and a different second inspector on each day. On the first day of the inspection, there was an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience used had experience of caring for a relative with dementia. A specialist advisor, who was a registered nurse, also attended the inspection on the first day of the inspection. The specialist nurse had experience of working with people with dementia.

Before the inspection we reviewed information we kept about the service and previous inspection reports. This included notifications of incidents. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern. We also emailed professionals and relatives of people who used the service to find out what they thought about the service.

During the inspection we used a range of methods to help us make our judgements. This included talking to people using the service, their relatives and friends or other visitors, interviewing staff, pathway tracking (reading people's care plans, and other records kept about them), formal observations of care, and reviewed other records about how the service was managed.

We looked at a range of records including eight care plans, records about the operation of the medicines system, four personnel files, and other records about the management of the service.

Before, during and after the inspection we spoke with three people who used the service and communicated by email or telephone with thirteen relatives of people who used the service. We spoke with eight staff. We also communicated with seven external professionals including specialist nurses, GP's and social workers.

Many of the people at the service could only answer simple questions or were unable to speak with us due to their disabilities. As a consequence, we used the Short Observational Framework for Inspection (SOFI) on the first day of the inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Our findings

People told us they felt safe. One person said, "Staff make me feel safe. They are nearby if I need them." The majority of relatives were positive about the service, although some people did worry for people's safety due to the behaviour of others. People and their relatives told us that staff were good at "diffusing things," when some people became agitated. A health care professional described the service as a "Safe, effective, nursing home who take great pride in caring for their residents." Another professional said, "I think it is very safe for staff and residents."

The service had a satisfactory safeguarding adult's policy. All staff had received training in safeguarding adults. However some staff, as outlined by the registered provider's policy, needed to receive refresher training in this area. The registered manager said safeguarding processes were discussed with staff at team meetings and in supervision sessions. Staff were individually provided with information about who they should contact, and what action they should take if they had concerns about somebody being subject to abuse. Staff demonstrated they understood how to safeguard people against abuse. Staff told us they thought any allegations they reported would be fully investigated and satisfactory action taken to ensure people were safe. Where necessary the registered provider had submitted safeguarding referrals to the local authority.

Risk assessments were in place for each person. For example, to prevent poor nutrition and hydration, skin integrity, falls and pressure sores. Risk assessments were reviewed monthly and updated as necessary. Health and safety risk assessments were completed for all areas of the building, as well as tasks which may present a risk.

The registered manager said the majority of people who lived at the service did not have capacity, but the service minimised restrictions where possible. For example if people were physically and mentally able, they could walk around the building, spend time in their bedrooms and were encouraged to make a range of choices such as what to wear, what to eat and how to spend their time. The registered manager said where people had limited, or lacked capacity, staff supported them to maximise choice and independence. For example some people were funded to have one to one support so they were monitored closely and could participate in individual activities. The registered provider had developed a secure garden area which people could safely use without staff support. The door to access this area was always open so people to go outside without asking staff.

Records were stored securely in the main office or nursing offices. Records we inspected were generally up

to date, and were accurate and complete. All care staff had access to care records so they could be aware of people's needs.

The registered manager said there were formal handovers between each shift. These enabled staff to share information and concerns about the care of people. There were also staff meetings to ensure important information was discussed.

The service had a whistleblowing policy so if staff had concerns they could report these without feeling they would be subject to subsequent unreasonable action for making valid criticisms of the service. Where concerns had been expressed about the service; for example if complaints had been made, or there have been safeguarding investigations; the registered persons had carried out, or co-operated fully with investigations. Suitable action had been taken where there had been investigations for example by improving documentation, renewing equipment and improving facilities available to people.

Equipment owned or used by the registered provider, such as specialist chairs, adapted wheelchairs, hoists and stand aids, were suitably maintained. Systems were in place to ensure equipment was regularly serviced, and repaired as necessary. In regard to moving and handling equipment, one of the senior staff was given the responsibility of ensuring visual checks were completed, and ensuring any maintenance was arranged as necessary.

Health and safety checks on the premises and other equipment were carried out appropriately. The boiler, gas appliances and water supply had been tested to ensure they were safe to use. Portable electrical appliances had been tested and were safe. A current gas safety certificate was in place. The electrical circuit had been tested and was deemed as 'satisfactory'. There was a risk assessment to minimise the risk of Legionnaires' disease, and systems were in place to take action to minimise the risks identified. There was a system of health and safety risk assessment in place. There were smoke detectors and fire extinguishers on each floor. Fire alarms, emergency lighting and fire extinguishers were checked by staff, the fire authority and external contractors, to ensure they worked. The service had a fire risk assessment.

Any behaviours which the service found challenging were recorded in individuals' care plans. Staff recorded all incidents that occurred and these are reviewed by senior staff. Where people regularly demonstrated behaviours which the service found challenging, the service used recording tools such as 'ABC charts.' These outlined what the person was doing before the behaviour occurred, a description of the behaviour, and what happened afterwards. This helped staff to understand the behaviour, and where possible minimise the risk of it happening. All staff were trained in recognised behaviour management techniques to help them deal with any behaviour which may put the person, or others at risk. When these techniques were used suitable records were kept.

There were enough staff on duty to meet people's needs. On the first day of the inspection, in both the nursing and the dementia services there were six care staff on duty in the morning. In the afternoon, evening and overnight, there were four staff on duty in each service. In addition to these staff, there was a registered nurse on duty, in both services, throughout the 24 hour period. At the time of the inspection the service received additional funding to support some people with one to one, or two to one staffing. This was due to these people demonstrating behaviours which the service found challenging. The service also employed cleaning, kitchen, laundry, maintenance and administrative staff to help ensure the service ran effectively. External professionals said, "There always seems to be a lot of staff on duty in both areas of the home" and "The staffing levels seem appropriate and carers appear caring and supportive." Some staff commented that staff sickness could be a problem, "Particularly on Sundays." This matter was discussed with the registered manager, and we were told the matter was being monitored.

The registered manager ensured staff on duty had a suitable mix of skills, experience and knowledge. For example, where possible there was always a registered mental health nurse on duty in the dementia service, and a registered general nurse on duty in the nursing service. Any new and inexperienced care staff were always shadowed by experienced staff. All staff were provided with suitable training for example, in moving and handling, and first aid, so they could meet people's needs and deal with emergencies. If staff were off sick the registered manager said she always ensured, where possible, agency staff were employed, to avoid staff shortages.

The service had a suitable recruitment procedure. Recruitment checks were in place and demonstrated that people employed had satisfactory skills and knowledge needed to care for people. However, the current recruitment application form did not state when people started or finished working at previous jobs. This meant it was difficult to check if there were any gaps in people's employment history. All staff files contained appropriate checks, such as two references and a Disclosure and Barring Service (DBS) check. The registered manager said she felt that the key attribute she looked for when recruiting staff was that they cared, "From the heart," so people subsequently received good, compassionate care.

Staff received effective training in safety systems, processes and practices such as in moving and handling, fire safety and infection control. We observed staff safely using hoisting equipment; for example when moving people from wheelchairs to more comfortable furnishings. This was carried out according to best practice. Staff talked through with the person what they were doing, and carried out the manoeuvre slowly and carefully. Individuals were provided with their own slings for safety and hygiene purposes. All nurses and senior care staff were qualified fire wardens, so they received external training about best practice in fire prevention and dealing with emergencies.

The registered provider has a suitable policy regarding the operation of the medicines system based on current guidance such as issued by the Royal Pharmaceutical Society and NICE. Nurses and the registered manager were responsible for the administration of medicines. These staff had received suitable training about the operation of the medicines' system. Medicines were given to people at the correct times. Suitable administration records were kept. There were no gaps on medicine administration records. At the time of the inspection nobody self-administered their own medicines. Suitable systems were in place for medicines which required additional security. The service had systems in place to order medicines, ensure they were stored securely in locked, purpose built cabinets, and where necessary disposed of safely. There were occasions where some people needed to have their medicines administered covertly. The service had appropriate procedures about this. These medicines were only ever given this way with the authorisation of external medical professionals.

People's behaviour was not controlled by excessive or inappropriate medicines. Some people did have some prescribed medicines to help them manage distress or confusion, (for example as a consequence of dementia or mental health issues) but these medicines were prescribed and reviewed by external medical professionals. When these medicines were prescribed to be given 'as required', rather than at specific times, guidance was in place when this should be given. People had suitable links with their GP's, consultant psychiatric nurses and medical consultants who prescribe and review people's medicines. Where necessary staff appropriately consulted with medical professionals to ensure types of medicines prescribed, and dosages were helping people with their health needs.

When we inspected the medicines system we did note that creams, eye and ear ointments were not labelled when staff commenced using them. This was important as if items were used for too long once opened they could become ineffective. The registered manager and nurses told us items had usually been labelled but this had obviously lapsed recently. In the case of the examples we saw it was clear all items had been

dispensed from the pharmacist in the last month so they remained effective.

We were also concerned that cream charts, kept in people's bedrooms, were not always completed. The nurse we spoke with said that application of creams was recorded on medicine administration records. The nurse said nursing staff did not check the cream charts. We saw two containers of prescribed creams, in people's bedrooms, which were not labelled correctly.

We recommend more robust recording and monitoring systems are introduced regarding the administration of creams and lotions by care staff.

The service had suitable arrangements in place to ensure the home was kept clean and hygienic. There was however, a very strong smell of disinfectant, in the nursing wing, particularly on the first day of the inspection. We were concerned the door to the sluice room was unlocked all day, on the first day of the inspection. The service had suitable policies about infection control which reference national guidance. The service has two lead staff about infection control: a registered nurse and a senior care assistant. The registered persons understood who they needed to contact if they need advice or assistance with infection control issues. Cleaning staff were employed to work in the morning and afternoon, over seven days, and had clear routines to follow. All staff received suitable training about infection control practices. and staff understood when it was necessary to wear protective clothing such as aprons and gloves.

Relevant staff had completed food hygiene training. Catering staff were on duty from breakfast time until the evening. Suitable procedures were in place to ensure food preparation and storage meets national guidance. The local authority environmental health department has judged standards has to a high standard.

The registered persons understand their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these internally and externally as necessary. Staff told us if they had concerns management would listen and take suitable action. The registered manager said if she had concerns about people's welfare she liaised with external professionals as necessary, and had submitted safeguarding referrals when she felt it was appropriate.

Since the last inspection, there had been a series of safeguarding meetings about the care of one person who had used the service. The registered manager said the service had learned from the concerns raised for example, in terms of improving recording about some matters, so they could demonstrate suitable practice took place at the service. Key learning points had been shared with key staff within the service. The registered persons had participated in and co-operatied fully with these external investigations.

The service did not keep monies or valuables on behalf of people. When people needed to purchase items such as for toiletries and hairdressing items the person's representatives were invoiced for any expenditure. Records of invoices were kept at the registered provider's office. Where necessary the registered manager said she would provide families with receipts and invoices for any expenditure. The registered persons did not act as appointee for any people who used the service, and staff did not have any access to people's financial accounts.

Requires Improvement

Our findings

We were concerned about the quality of personal care and skin care provided for some people. We received allegations, during the inspection that one person was not being washed regularly and appropriately. We looked specifically at this person's wound and associated care records. We were concerned the wound care provided was not appropriate as the person's skin did not look clean, the wound appeared to smell and there was evidence of discharge. The person spent their time in bed, and we were concerned, based on comments from a relative, the person was not turned regularly. The registered manager provided us with records which demonstrated the person was washed regularly, and turn charts provided assurance that the person was regularly moved according to their needs. Records also showed prescribed medicinal lotions were regularly applied, and there had been regular liaison with external professionals such as tissue viability nurses. We were provided with a timeline of the care of the wounds. This showed there was regular liaison with external professionals for several months but then contact became more sporadic. At our request, the tissue viability team visited the person. It was judged wound care, in the case of this individual, was not satisfactory. Staff were advised to dress the wounds, and keep in regular contact with the tissue viability nurses to ensure there was improvement.

We also had a concern about pressure care for another individual who had a pressure sore on their foot. Records showed there had been liaison with external professionals. One of the person's relatives said they felt the person was, "Well looked after," and they did not have any concerns about their care. At our request the tissue viability nurse checked the persons care. They were concerned staff had not recognised pressure relief was not effective. There was also a risk of the person falling as the pressure relieving footwear provided was not designed for people to walk in.

Another person was observed with a number of abrasions on both arms which were bleeding and uncovered. The person picked the wounds making them bleed further and there was dried blood under their finger nails. We were concerned that the only staff reaction to this was, "(They) always do that." The person's relative said they did this because they were bored. Records showed staff regularly applied creams to reduce skin irritation.

Overall we were concerned about the lack of knowledge staff, particularly nurses, had about pressure relief and wound care. We were told two of the service's nurses attended a wound awareness group and a pressure ulcer reduction group. However, it was not clear how information was shared with other staff, or how the rest of the staff group got their pressure ulcer prevention training. There was a lack of suitable review and reassessment of pressure area care particularly in the first two cases. Treatment had not been

reviewed and changed as necessary and further advice had not been sought when pressure relieving devices had proved ineffective.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

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 to 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).

The registered manager said the majority of the people accommodated did not have capacity. Consequently applications to deprive people of their liberty had been submitted for everyone who lived at the service. The registered manager said some DoLS applications had been approved, and she was waiting for the remaining applications to be authorised.

Most people had a mental capacity assessment on their files. However, these were not in place on some files. Some mental capacity assessments were not dated and some assessments only contained very basic information. This was a concern as there was no formal system to assess if people had capacity or not. Copies of DoLS applications were in people's files, along with any approvals received. The registered manager said she had a system for monitoring DoLS orders to ensure they were implemented, and reviewed before any authorisations expired.

Where physical restraint was necessary to keep people and others safe approved techniques (known as MAPA) were used. This was to assist people to minimise any behaviours which challenged the service. Senior staff assessed what particular techniques needed to be used. Techniques used were based on the principles of minimal, proportionate contact to minimise the risk of injury. The registered manager said the techniques were currently only routinely used with two people. However written guidance in care plans, for regular behaviours, was very limited. There was also no record that any 'best interest' process had been used to determine the techniques used were appropriate, and if and when they should be used. This could put both people and staff at risk if techniques used were not appropriate, not consistently applied and/or not regularly reviewed

The registered manager said senior care assistants, managers and nursing staff had received training about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The registered manager said staff have some awareness training within their induction, although we did not see any evidence that care staff received specific training in this area. Care assistants we spoke with had limited knowledge about the principles of the act, and what actions they should take, to ensure people are not being unnecessarily deprived of their liberty.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

The service had suitable processes to holistically assess people's needs and choices. Before moving into the

home the registered manager told us she went out to assess people to check the service could meet the person's needs. People, and/or their relatives, were also able to visit the service before admission. Copies of pre admission assessments on people's files were comprehensive and one persons relative commented, "(The manager) came out to meet (my relative) and we spoke for three hours." Information gathered during these assessments was used by staff to develop people's individual care plans .

Nobody we spoke with (for example people who used the service and staff) said they felt they had been subject to any discriminatory practice for example on the grounds of their gender, race, sexuality, disability or age. The registered persons' had an anti discrimination policy, but this currently only covered staff. The registered manager said this would be reviewed so it covered people who used the service.

The use of technology and equipment to assist with the delivery of effective care, and promote people's independence was limited. There was however a call bell system which people could use to alert staff in emergency. We observed staff responding to call bells promptly. The people said they did not have any concerns about staff responsiveness to call bells.

Staff had appropriate skills, knowledge and experience to deliver effective care and support. The registered manager said when staff started working at the service they received a full induction. This involved spending a day one to one with a senior member of staff, and then a two week induction where they worked shadowing more experienced staff to learn their roles. We were told that after six months staff were then enrolled to complete a level two qualification in care. Staff were required to complete this qualification. The registered manager said she was aware of the Care Certificate, which is an identified set of national standards that health and social care workers should follow when starting work in care. The registered provider's preference was to not use the Care Certificate framework. We inspected records of the induction process completed for some of the staff who had commenced employment in the last year. Records of induction were thorough, and staff we spoke with said they thought they had received a thorough induction.

Records showed staff received comprehensive training which enabled them to carry out their roles. For example, all care staff had a record of receiving training about techniques to manage behaviour which challenged the service, first aid, fire safety, infection control, moving and handling, safeguarding and dementia awareness. In addition nursing staff had received training about anaphylaxis, buccal midazolam (administration of medicine for people with epilepsy), catheterisation, flu vaccination, and first aid. We were however concerned about training regarding pressure relief and wound care as we have highlighted elsewhere.

Staff told us they felt supported in their roles by colleagues and senior staff. There were some records of individual formal supervision with a manager. Supervision is a process where members of staff sit down with a supervisor to discuss their performance, any goals for the future, and training and development needs. However, records showed that staff members were not having regular one to one supervision meetings. For example, according to records we were provided with, the last recorded supervision meetings which some staff had were in June 2017. There were no records made available to us that staff had received an annual appraisal. However the staff we spoke with said they could approach nursing and senior staff for help and support if they had a problem. There was always a senior member of staff or a registered nurse on duty who staff could approach if they needed help. Senior carers and registered nurses were also responsible for leading all shifts and ensuring the effective day to day management of the service, particularly if the registered manager and deputy manager were absent from the service.

We recommend a supervision and appraisal system is developed for all staff who work in the service.

The service had a four week rolling menu. At breakfast time people could have cereal and /or toast, eggs or a full cooked breakfast. People had two choices of lunch time meal. People were not involved in developing the menu. The registered manager said if people did not like what was on the menu people were always offered an additional choice of meal. In the evening people were offered sandwiches or a hot snack such as soup, eggs or quiche. Currently there were no people who used the service who had specific cultural or religious preferences about the food they ate. The service had some people who were vegetarian. The registered manager said the current chef was skilled in vegetarian cookery and prepared vegetarian meals from primary ingredients. The registered manager recognised that meals were an important part of people's day. The registered manager judged the current menu ensured people had a balanced diet which promoted healthy eating and correct nutrition. Meals were appropriately spaced and flexible to meet people's needs. For example people could have their breakfasts in their bedrooms. All meals we saw looked appetising and were nicely presented.

Everyone had eating and drinking assessments in their files. Where a person was at risk of for example malnutrition, dehydration or choking guidance was provided on how to minimize risks.

We did have some concerns about records kept for people who needed careful monitoring about what they ate and drank. When we checked fluid charts we saw the total intake of liquids were not always being added up. This was the case with two of the five care records we inspected. When we asked why this was the nurse on duty said: "We should add them up but we do not always get time to do that."

One relative raised a concern that one person would not eat properly if they did not assist. The registered manager said staff were always allocated to assist individuals who required support, and records were kept so the service could demonstrate people ate well, and regularly.

We observed the support people received during one lunchtime. Staff mixed with people while they were helping them to have their meals. Staff appeared very caring and supportive. People appeared to enjoy their meal. The occasion was unrushed and appeared pleasant. However, we were concerned that none of the people in one of the communal lounges was asked if they would like to eat at a table and their food was served to them at individual tables over their armchairs. All of the people we spoke with, and family members were complimentary about the quality, choice and amount of food available. People said: "Food is good quality," "The food is always hot and tasty," "They have a good cook, "and "You always get a choice." Family members said: "I have not tasted it but it always looks and smells good," and "The food is very nice and they will give me a meal too if I want one."

The registered manager said the service had good links with external professionals. The registered manager said the service had strong links with the elderly ward at the psychiatric hospital where many of the people who lived at the service came to live there from the psychiatric hospital. The home was also part of a wider group of services, and people came also to live at the service from the provider's other locations for example if a person's needs could no longer be met at these services. The service worked closely with a wide range of professionals such as community psychiatric nurses, social workers, community matrons and general practitioners to ensure people lived comfortably at the service. Where staff had concerns about somebody's welfare the service had good links with professionals to ensure any changing needs were reassessed, and, for example, if necessary, hospital admissions were arranged for people where their needs could be better met.

The registered manager said people had access to a wide range of health care professionals to ensure their health care needs were met. For example the registered manager said relationships with local GP surgeries was good. Chiropody and dental services were also available and these professionals regularly visited the

service. The registered manager said where appropriate referrals were made for additional support from these professionals and others such as occupational therapists, and speech and language therapists. The registered manager said she felt referrals to external professionals were actioned in a timely manner, and there were no significant delays in people subsequently receiving support.

External professionals made many positive comments about care and support at the service. Comments included, "I am quite impressed with them…they wanted to get things right…the operating standards are good," "They deal with some very complex people, but they do a good job. They are always looking to make improvements."

The nurses employed by the service ensured people's day to day health care needs were met, but other professionals such as community matrons, and tissue viability nurses provided support when this was required. We raised a concern, earlier in the report that the service should have liaised more promptly with tissue viability services.

The building was described, by the registered manager, as a 'secure unit' and all the external doors were locked, and could only be opened by inputting a code into key pads situated on all external exits, and some internal doors.

Since the last inspection the dementia unit had been extended to provide more bedrooms, a second larger lounge, and an enclosed garden which people could use without staff supervision. The enclosed garden had soft flooring so if people fell there would be less risk of injury. The dementia unit also had a second, larger garden which people could use when it was dry. The external door to this however was locked as it was only used with some staff supervision. There was also a third garden, off the nursing unit, which people could use with supervision. A wooded area next to the care home had been partly cleared, and a pathway had been created so people could go for walks through this area. There was also a children's play area there which people's grand children could use.

The nursing unit had two lounges and a small dining room. People could receive visitors either in their bedrooms or one of the lounges. Activities took place either in the dining room or one of the lounges. The dementia unit had limited dining space which meant people either had to have their meals in one of the lounges or their bedrooms. The building was clean and reasonably well decorated. The dementia unit was purposefully organised so corridors formed a circular path so ultimately people following the corridor would end up where they started.

Access for people with physical disabilities was generally good. Marked disabled parking bays were located immediately outside the building with level access to the main building. The dementia unit was on one floor. Although access was possible, wheel chair access was more challenging in the nursing unit, in the older part of the building. There was a small lift to the first floor of the nursing unit, which the registered manager said would be replaced soon with a larger lift. The layout of the building could be quite confusing and there was limited signage. Bathroom doors were generally painted yellow, the muted colours of doors throughout the building made it challenging for someone with visual or cognitive impairments to find their way around.

We received a concern, at the inspection, that heating in one room was not working and a window was broken. However, the registered manager assured us the radiator was functioning correctly, and was 'cool to the touch' to prevent scalding. We were also told maintenance staff completed weekly room checks to ensure heating was functioning correctly. A relative also said a window was broken, and although this had been temporarily repaired, there could be a draft. The registered manager said the window was not broken, and all windows in this part of the building were due to be replaced shortly.

Good

Our findings

We received many positive comments about the attitudes of staff. People and their relatives said people were treated with kindness, respect and compassion. Relatives said, "All staff are kindly, patient and caring," "Staff are fantastic. It is 110%. I could not give them any less," and "Care is exemplary. Staff are marvellous with (my relative.)" Health care professionals told us , "The staff are professional, courteous and respectful. They deal with residents and their families with a great deal of humanity…this is an excellent care home." "(My client) gets safe and professional care," and "People flourish at Trefula."

We observed staff sitting and talking with people in lounges, on the whole, in a respectful and friendly manner. We observed staff in the communal areas, throughout the day, being caring and maintaining people's dignity. For example, one person said they felt hot. A member of staff offered to help remove their cardigan. The member of staff explained what they were doing and held the person's blouse so it did not lift up. The staff member then tucked the person's blouse back in and made sure the person was comfortable. However, we did see a less positive example of staff practice. One person was calling out repetitively. The member of staff asked what was wrong, the person did not respond and continued to call. The member of staff, rather than going to see the person, or trying again to seek a response, just told the person to stop shouting.

Staff did not rush people and took time to listen to them. A relative said, "(My relative) always gets what they want. Staff will fall over backwards," and "Personal care is very good. (My relative) always looks lovely." External professionals said, "I witness good support being given in general and on a one to one basis. I come across residents walking along the corridors and have never seen any distress displayed." and "They are an outstanding team."

We did however observe staff using their mobile phones on three occasions. When observed the staff members immediately stopped when they realised they were being observed. This matter was communicated to the registered manager, who said agency staff were allowed to check their mobile's for messages for other work. We were however concerned there was no restriction when they could do this; for example only using their phones during their break times.

People and their relatives said staff responded to people quickly if they needed help for example, if people called or pressed the call bell.

The registered manager said when she recruited staff she was more interested in people having a good

caring attitude than them possessing relevant training and qualifications. Management subsequently tried to ensure a caring ethos was seen by all staff members as the paramount quality for the manner how the team operated.

When people came to live at the service, the registered manager gave a life history questionnaire to relatives, and requested it was completed. Staff could then have information about people's lives before they lived at the service. Unfortunately these were not always completed, so information about people's lives was variable. Staff however, did sit down and complete the profile with the individual concerned if these people were able to participate in this exercise.

People were encouraged to make decisions about their care, for example what they wished to wear, what they wanted to eat and how they wanted to spend their time. Where possible staff involved people in care planning and review. However, due to people's capacity involvement was often limited, and consultation could only occur with people's representatives such as their relatives. People and their relatives were provided with information about external bodies (such as the local authority community organisations and advocacy services) in the service user guide, which was issued when people moved to the service.

Staff we spoke with said they felt they had enough time to sit and spend time with people. We did not see staff rushing or ignoring people. Most of the time staff took time to listen to people, and give people time to respond to questions. Staff appeared friendly.

We observed staff making sure people's privacy and dignity needs were understood and always respected. Where people needed physical and intimate care, for example if somebody needed to change their clothes, help was provided in a discreet and dignified manner. When people were provided with help in their bedrooms or the bathroom this assistance was always provided behind closed doors. When people were experiencing physical pain, discomfort or emotional distress we observed staff providing suitable support to comfort people. Staff worked with people to encourage and / or respect people's right to be as independent as possible. We did not witness staff talking about people in front of others. Written information was stored confidentially.

The relatives we spoke with said they could visit the service at any time. Visitors said they always felt welcome and were offered a drink. We saw staff being attentive to relatives. For example, one relative arrived at the service, a chair was immediately made available next to the relatives loved one, and the relative was offered a cup of tea. The relative was later observed having a lunchtime meal with their loved one. One professional said, " I always get a lovely welcome. It is a home I enjoy working in. There is always a nice atmosphere." Relatives said staff always answered any questions they had. Visitors said they felt managers were helpful if they had any queries or concerns.

Good

Our findings

Everyone who used the service had a care plan. Where possible people, and their representatives, were consulted about people's care plans and their review. Care plans were detailed and included information about people's physical and mental health care needs and at least some basic information about their lives before living at the service. Care plans also included risk assessments for example in relation to people's mobility, and any risks in relation to eating and drinking. Care plans were written in the first person and where possible outlined people's preferences, interests and aspirations. All staff were able to access people's care plans which were stored in either of the two nursing offices. A relative said, "They know (my relatives) likes and dislikes, (their) care plan is so incredibly detailed and accurate and written to ensure his integrity remains intact."

The management of care planning was organised by each registered nurse acting as a key worker for six people. Keyworkers were overseen by the deputy manager which helped to ensure that care plans were kept up to date and reviewed regularly.

Some care planning documents were not fully completed. For example in respect of some people: mental capacity assessments, personal inventories, body maps, photographs of any body wounds / pressure areas, and wound care assessments. Where people had lost weight there was no assessment whether the weight loss was of concern, and if so, what action would be taken.

The service had two activity organisers to support people to follow their interests and take part in activities. One of the activities organisers worked full time, and the second person worked 16 hours a week. Activities available included coffee mornings, craft sessions, massage sessions, games such as dominos and ball games. The registered manager said external entertainers visited the service twice a week. These included drama therapy, pet therapy, singers and musicians. Groups of school children and choirs also visited the service. We saw people participating in a baking activity. Staff were observed getting people involved in the activity, and people subsequently had a hot drink and were able to eat the cakes they made. No external activities were currently regularly organised, and the service did not have any transportation, such as a minibus, which limited opportunities for people to go out. Most people now had limited ability to participate in life in the community due to their physical and /or mental health. An external professional said, "I am very impressed by the lady who provides entertainment and activities for the clients."

The service had a complaints procedure. This was part of the service's user guide, which was issued to people when they moved in. People and their relatives, who we spoke with, said if they had any concerns or

complaints, they felt they could discuss these with staff and managers without fear of discrimination. They felt any concerns and complaints would be responded to appropriately. Relatives told us, "We have never had a problem with the home, but we feel we can always approach them if we have any concerns," and "If I was not happy I know they would sort it out." The service had a record of any complaints made, and a record of how these had been responded to. The people we spoke with did not think they would be subject to discrimination, harassment or disadvantage if they made a complaint. The registered manager said when a complaint was made, the management team assessed the complaint and its findings and used the experience as an opportunity to learn from what had occurred for example through improving communication, better recording, managers checking that care procedures were carried out and regularly reviewed.

People were supported at the end of their lives to have a comfortable, dignified and pain free death. The staff worked within the principles of the 'Gold Standard Framework.' This is a national initiative to improve and ensure good standards regarding palliative care. Where appropriate people had an end of life care plan which outlined their preferences and choices for their end of life care. The service consulted with the person and their representatives about the development and review of this care plan. The registered manager said the deputy manager was responsible for providing internal training for all staff. The deputy manager and nursing staff were also currently undertaking external training about end of life care. The registered manager said nursing staff met on a weekly basis to discuss the needs of people who were receiving end of life care and they had developed good links with GP's to ensure people received suitable medical care during this period of their lives.

Requires Improvement

Our findings

This inspection resulted in two statutory requirements. The registered persons, for example through their quality assurance systems, had failed to pick up the issues we have raised as concern in this report. The overall rating for the service, and the area of 'Well Led' cannot be better than 'requires improvement' if there is a breach of regulations. This is because providers rated as good are meeting the standards set out in the regulations and display the characteristics of good care (i.e. to be rated good means more than just meeting the standards set out in the regulations)

The registered manager said she spent time within the service so she was aware of day to day issues. The registered manager said it was important she spent time listening to staff and enabling them to share ideas about people's care. The registered manager said she believed it was important to make herself available so staff could talk with her, and to be accessible to them. She said it was important to treat staff equally and well, and this resulted in there being "One Team," rather than cliques or division. She said the most important attribute of how the team operated was to provide "A high standard of care." She believed that it was important for "Staff to spend time with people," and "not to be only task orientated." The registered manager said she met regularly with staff, seniors and nurses both informally and formally to discuss any problems and issues. There were handovers between shifts so information about people's care could be shared, and consistency of care practice could be maintained. External professionals were positive about the management of the service. Comments received included, "Responsive…communication is very good. They are upmost for the residents," "They were (about a funding issue) abit defensive and aloof, but nursing staff are wonderful," "They will fall over backwards and will sit down with me and if they do not know they will find out for me," "Approachable," and "Very good." Care staff told us, "It is the best home I have worked at by a mile," and "Management are really, really approachable."

The service had a clear management structure. The registered manager reported to a general manager who oversaw the group of three services on behalf of the registered provider. The registered provider was a locally based organisation so the general manager of the organisation visited the service regularly. The registered manager had a deputy manager. There were always two nurses on duty, usually one general nurse and one mental health nurse. The registered manager said she tried to ensure there were always four senior care assistants on duty during the day, and one at night.

The registered provider had a quality assurance policy. The service's approach to quality assurance included completion of an annual survey. The results of the most recent survey had been positive. We also saw the service received lots of thank you letters from relatives. There was also a system of audits to ensure quality

in all areas of the service was checked, maintained, and where necessary improved. Audits regularly completed included checking care practice; checking the quality of the food provided; monitoring care plans were to a good standard and regularly reviewed; monitoring accidents and incidents; auditing the medicines system, and checking property standards were to a good standard. Although the service had a supervision and appraisal policy this was not currently fully operational. We have made a recommendation about this matter.The inspection also resulted in two statutory requirements about matters which the registered persons had failed to take actions about before CQC raised concerns. Audits and checks on care practice and documentation were therefore not entirely effective at picking up shortfalls such as the matters we have reported on.

The registered persons had ensured registration, safety and public health related obligations, and the submission of notifications had been complied with. The previous rating issued by CQC was displayed.

The registered manager said issues relating to previous inspections had been communicated to staff. The registered manager said she thought staff had a clear understanding of their roles and responsibilities. This was evident to us throughout the inspection.

The registered manager said both paper and electronic data was stored securely, and there were systems in place to ensure data security breaches were minimised.

Relatives of people who used the service said the registered manager was friendly and approachable. We were told they could discuss any problems with her, and relatives we spoke with said these matters would be addressed. The registered manager had recently started having a relatives' meeting which it was hoped would continue to develop communication.

The registered manager said she though relationships with other agencies were positive. Where appropriate the registered manager said she ensured suitable information, for example about safeguarding matters, was shared with relevant agencies. We received numerous positive comments from external professionals including, "There is very good team working. I receive very good co-operation."

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 11 HSCA RA Regulations 2014 Need for consent Records were not comprehensive where people lacked capacity. Not all people had a mental capacity assessment.There was not clear, agreed guidance, which was regularly reviewed, when physical interventions needed to be used with individual service users. There was insufficient evidence that care staff had awareness training about the principles of the Mental Capacity Act 2005, and Deprivation of Liberty Safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Pressure relief and wound care was not satisfactory. There was insufficient evidence of suitable care plan review in some cases. There was insufficient evidence of liaison with external professionals about pressure relief and wound care particularly when care approaches were not working. There was insufficient evidence of staff training about pressure relief and wound care particularly for nursing staff.