OakRay Care Ltd

Trent House

Inspection report

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Date of inspection visit:
27 July 2017
28 July 2017

Date of publication:
05 September 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
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

Trent House is a care home that provides accommodation and personal care for up to 19 people. There were 14 people living at the home when we visited including people with dementia care needs.

The home is based on three floors with an interconnecting passenger lift, plus a basement that houses the manager's office, store rooms and a laundry.

The inspection was conducted on 27 and 28 July 2017 and was not announced.

A registered manager was not in place at the time of the inspection, although the manager had applied to be registered with CQC and their application was being processed. 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.

A fire safety risk assessment conducted by the provider identified that remedial work was needed, particularly to fire resisting doors, to bring the home up to modern fire safety standards. Following the inspection, the fire and rescue service issued a 'deficiency notice' requiring the provider to make these improvements by 30 November 2017.

A quality assurance system was in place, but this had not always been effective in bringing about improvement in a timely way. For example, although some improvements had been made to the environment since our last inspection, further work was needed to refurbish the home. The issues had been identified in audits conducted by the manager, but the provider had not developed plans to complete the work until we raised concerns during the inspection.

Staff sought verbal consent from people before providing support and followed legislation to protect people's rights. However, applications to deprive people of their liberty had not been submitted to the local authority and staff were not clear of the action to take if people tried to leave the home unsupervised.

Staff were skilled and competent. They felt supported in their role by the manager; however, none had received an appraisal in the past year and some said they did not always feel supported by the provider.

People told us they felt safe and staff knew how to identify, prevent and report incidents of abuse. Individual risks to people were managed effectively in a way that promoted their independence. There were procedures in place to deal with foreseeable emergencies.

Medicines were managed safely and people received their medicines as prescribed. There were enough staff to meet people's needs and recruitment procedures helped ensure only suitable staff were employed.

People praised the quality of the meals and were supported appropriately to eat and drink enough. They were also supported to access healthcare services when needed.

Staff were kind and caring. They supported people in a quiet, patient and unhurried way. They supported people to build and maintain important relationships. They protected people's privacy, encouraged them to remain as independent as possible and involved them in planning the care they received.

Care and support were delivered in a personalised way according to people's individual needs. People were empowered to make choices about all aspects of their lives. They had access to a range of activities based on their interests.

The provider acted on feedback from people. People new how to make a complaint and felt listened to. They also felt the service was run well by the manager.

There was a clear management structure in place. Staff had confidence in the manager, understood their roles and worked well as a team.

There was an open culture; visitors were welcomed at any time and the manager notified CQC of all significant events.

We identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken 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?

Requires Improvement

The service was not always safe.

Improvements were needed to bring the home up to modern fire safety standards. However, people said they felt safe and staff had received training in safeguarding adults.

Risks to people were managed appropriately and in a way that helped them retain their independence. There were plans in place to deal with foreseeable emergences.

Medicines were managed safely and people received their medicines as prescribed.

There were enough staff to meet people's needs and recruitment practices helped ensure only suitable staff were employed.

Is the service effective?

Requires Improvement

The service was not always effective.

The garden was not accessible to most people and areas of the home needed to be refurbished. Following the inspection, the provider sent us a plan to complete this work.

Staff sought verbal consent from people before providing care. However, applications to deprive people of their liberty had not been submitted to the local authority, as required and staff were not clear of the action to take if people tried to leave the home unsupervised.

Staff were skilled in meeting people's needs and felt supported by the manager.

People praised the quality of the meals and were supported to meet their nutritional needs. They were also supported to access healthcare services whenever needed.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They created a calm atmosphere, interacted positively with people and spoke about them fondly.

Staff supported people to build and maintain relationships. They protected people's privacy and promoted their independence.

People (and their families where appropriate) were involved in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their individual needs. Care plans contained comprehensive information and were reviewed regularly.

People were empowered to make choices and all aspects of their lives.

People had access to a range of activities based on their individual needs. The provider sought and acted on feedback from people.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A quality assurance system was in place, but this had not always been effective in bringing about improvement.

There was a clear management structure in place. Staff understood their roles and had confidence in the manager; however, some felt they were not always supported by the provider.

People were happy living at Trent House and felt it was well run. There was an open and transparent culture.

Trent 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27 and 28 July 2017. It was unannounced and was conducted by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We also received feedback from a social care practitioner from the local authority commissioning team.

We spoke with six people living at the home and one family member. We also spoke with the provider's compliance manager, the manager, the deputy manager, five care staff, an activity coordinator and a cook. We looked at care plans and associated records for five people, staff duty records, recruitment files, records accidents and incidents, policies and procedures and quality assurance records.

We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The service was last inspected in May 2016 when we identified no breaches of regulation. Following the inspection, we shared our concerns about the large number of fire safety improvements that were required with the Isle of Wight Fire and Rescue Service.

Requires Improvement

Is the service safe?

Our findings

A fire safety risk assessment, conducted by the provider in April 2017 identified 70 hazards that needed to be addressed to bring the home up to modern fire safety standards. The majority of these related to ill-fitting doors or the absence of smoke seals around fire resisting doors. Following the inspection, the provider sent us an action plan stating that all defects would be rectified by 30 November 2017. We alerted the fire and rescue service to our concerns about the high number of defects at the home. Following a visit, they issued the provider with a deficiency notice requiring them to complete this work by 30 November 2017.

Other fire safety precautions were already in place. The fire alarm system had been divided into zones to help staff identify the source of a fire more quickly; fire safety equipment was maintained and checked regularly and people had personal evacuation plans in place. These included details of the support people would need if they had to be evacuated. Copies were kept in an accessible 'grab bag', together with other equipment that might be useful in an emergency, such as torches and foil blankets. Staff were aware of the action to take in the event of a fire and had received fire safety training, although two staff members told us they had not been trained in the use of evacuation sleds; these were in place to evacuate people from the upper floors of the home. However, we found further training had been arranged to address this shortly after the inspection.

People told us they felt safe at Trent House. One person said, "I feel quite safe here, knowing I can rely on [the staff]." Another person told us, "There's nothing to worry about; I'm quite happy." Staff had received training in safeguarding adults; they knew how to identify, prevent and report incidents of abuse, and how to contact external organisations for support if needed. They had confidence that any allegations would be dealt with effectively by the manager. One staff member told us, "If I thought someone was being [abused], I wouldn't hold back. I'd report it to the manager and to safeguarding and to CQC." The manager shared with us details of a safeguarding concern about a person's discharge from hospital that they had referred to the local safeguarding authority, having investigated the concern as far as they could in respect of action taken by staff at Trent House.

Individual risks to people were managed effectively. Risk assessments had been completed for all identified risks and measures put into place to mitigate them. For example, some people were at risk of developing pressure injuries and the level of risk had been assessed using a modified version of a nationally recognised tool. This had led to the introduction of measures to reduce people's level of risk, including the use of special pressure-relieving cushions and mattresses. We saw the cushions were used when needed and the mattresses were set correctly, according to the person's weight. Staff were also aware of the importance of promoting good nutritional intake and good continence care to help reduce the risk further.

Other people had diabetes and clear plans were in place to monitor the person's health. Their blood-sugar levels were checked regularly, depending on the level of concern and staff had access to information to help them identify if the person's blood-sugar levels were dangerously high or low. Records showed staff had taken prompt action when people's blood-sugar levels were found to be outside their usual range, for example by seeking medical advice and giving the person sugar-based gel.

People were supported to manage risks in a way that respected their independence. For example, one person with diabetes but had chosen not to have a low-sugar diet. They had capacity to weigh up the risks and had decided to eat a normal diet. Staff respected the person's decision whilst remaining vigilant to signs of the person becoming unwell. Other people were at risk of falling, but chose to mobilise independently. A staff member told us, "We don't stop people walking; we just take care to watch them and be ready to intervene."

Where people had fallen, the person's risk assessment was reviewed and staff considered additional measures that could be taken to protect the person. For example, bed rails had been put in place for a person who had fallen out of bed following a discussion with the person, their family and their GP. The risks associated with the use of bed rails had also been assessed. The manager monitored the incidence of falls on a monthly basis to help identify patterns or trends.

Environmental risks were also managed appropriately. For example, a wardrobe in one person's room was not secure, so, with the person's permission, staff had screwed it to the wall. The temperature of the hot water at all outlets was monitored weekly, to prevent people being scalded, and staff checked the temperature of the bath water before supporting people to have a bath.

There were appropriate arrangements in place for the safe handling, storage, administration and disposal of medicines. Medicines were administered by staff who had been trained and had their competence to administer medicines assessed. Medicines administration records (MAR) had been fully completed for all medicines; this indicated that people had received all their medicines as prescribed. Staff usually recorded the date when topical cream containers were opened to help ensure they were not used beyond the manufacturers' expiry date, although two of the eight creams we checked did not have the date recorded. We discussed this with the manager, who took immediate action to remind staff to do this.

When people were prescribed 'as required' (PRN) medicines, there was clear information available to guide staff about when this should be given. For example, one person was prescribed a PRN medicine for when they became anxious. Guidance in their care plan specified other strategies and de-escalation techniques that staff should try before reverting to the use of medicine. When we spoke with staff, they demonstrated a good understanding of these techniques and records showed the person had rarely needed to take the medicine.

There were enough staff to meet people's needs. The manager told us the staffing levels were based on people's needs and people confirmed there were enough staff deployed to support them effectively. We observed that people's call bells were answered promptly and staff were available to support people in communal areas of the home at all times.

Appropriate recruitment procedures were followed. The manager completed reference checks and checks with the disclosure and barring service (DBS) to ascertain candidates' suitability before they were employed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these procedures were followed before they started working at the home.

Requires Improvement

Is the service effective?

Our findings

Some improvements to the environment had been made since our last inspection. One of the lounge/dining rooms had been redecorated, as had one of the bedrooms; and the lift that had been unreliable had been replaced. The garden had been cut back and one person used it to fill bird feeders. However, the garden was still not accessible to most of the other people living at Trent House. The paths and lawns were very uneven and could only be accessed down a steep flight of steps. A chair lift designed to take people from a small balcony area down to the garden below was not working. One person told us, "I haven't used the garden as the footing is a bit dodgy; it isn't safe."

People told us they were happy with the environment inside the home, which they described as "homely". One person said, "It feels like home. I've got all my things around me [in my bedroom]. They've just fixed the aerial for us and the telly works much better now." However, we found the inside of the home was in need of refurbishment. Carpets and floor coverings in corridors, bathrooms and people's rooms were worn and heavily soiled. The manager acknowledged that significant improvement was needed to the internal environment. Following the inspection, the provider sent us an action plan detailing timescales for these improvements, which they said would be completed by 30 November 2017.

People told us that staff asked for their consent before supporting them and we heard staff doing this throughout the inspection. Where people had capacity to make decisions, this was recorded in their care files, which people had signed to show their agreement with the care and support being delivered.

Staff followed the principles of the Mental Capacity Act 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

Where needed, in all but one case, staff had assessed people's capacity to make decisions and made best interest decisions on their behalf, after consultation with family members. These included decisions relating to the provision of personal care and the administration of people's medicines. However, the ability of one person to make the specific decisions had not been assessed, even though information in their care plan indicated that they lacked the capacity to make certain decisions. We discussed this with the manager who undertook to complete the necessary assessment immediately after the inspection.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was not meeting the necessary requirements. DoLS applications had been prepared for six people by the previous registered manager, but none had been submitted to the local authority for assessment, as required. One dated back to 1 January 2016 and another was for a person who

repeated asked to leave the home. When this happened, we saw staff distracted the person and reassured them that their family would be visiting later. When we spoke with staff, none of them knew whether any DoLS authorisations were in place and they were not clear about the action they would take if people tried to leave the home without staff support. One staff member told us, "I really don't know. I think I'd have to speak to the manager if someone wanted to leave." This posed a risk that people might be detained unlawfully. Following the inspection, the provider wrote to us to confirm that they would ensure the DoLS applications were submitted as a priority.

People's care needs were met by staff who were skilled and competent. One person told us, "The staff are very good; they look after you well." Another person said, "They [staff] seem to know what they are doing." A third person said of the care they received, "I can't fault it." Feedback provided to the provider by relatives included the comments: "It's a comfort to me that [my loved one] is cared for so well" and "I have always been satisfied with the care that is given to [my relative]".

The provider required staff to complete 'mandatory' training at regular intervals to help maintain their knowledge. Records showed most staff were up to date with this training or had been allocated dates by which to complete it. Most staff were positive about the training they received and said they could ask for any additional training they felt would benefit people. For example, one staff member told us, "All my [essential] training is up to date. I asked for some training in Parkinson's [disease] and this is being arranged."

New staff completed an induction programme before they were permitted to work unsupervised. Arrangements were also in place for staff who had not worked in care before to complete training that followed the standards of the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. In addition, a high proportion of staff had completed, or were undertaking, vocational qualifications in health and social care.

Staff demonstrated an understanding of the training they had received. For example, when interacting with a person with dementia, the staff member made eye contact with the person at their level, used simple, short questions and remained patient when the person continually repeated themselves. When supporting people to take their medicines staff followed best practice guidance and demonstrated an understanding of the purpose and possible side effects of each medicine.

Staff felt they were supported appropriately in their role by the manager. They attended staff meetings and received individual sessions of supervision where they were able to discuss their training and development needs, raise concerns or seek additional support. Staff told us they interacted with the manager on a daily basis and that the manager had "an open door policy" if they needed to discuss personal or professional issues. One staff member told us, "We get supervisions and [the manager] has been really good to me with child care arrangements."
However, we found appraisals had not been completed for any staff member in the past year. The manager told us they felt they had not worked with staff long enough to complete these and could not provide an explanation for why the previous manager had not completed any.

People praised the quality of the meals. One person told us, "We get a modest choice. Someone comes and asks what you want and they'll do something completely different if you want it." People were supported to meet their dietary needs. Each person had a nutritional care plan detailing their needs and preferences. For example, one person's care plan identified drinks they should avoid as they were taking a blood thinning medicine. Another person's plan advised that staff should encourage the person to receive a low-sugar diet, but acknowledged that the person sometimes chose a normal diet. Records confirmed that people's

nutritional plans were followed; people were offered alternatives if they did not like the main meal and were offered snacks throughout the day and at night if they were awake.

Staff supported people to eat where needed. For example, one person had swallowing difficulties and was given meals in a softer format and monitored discreetly while they were eating, in line with recommendations made by a speech and language therapist. Staff monitored people's weight and were clear about the action they would take if people experienced unplanned weight loss. This included monitoring the amount they ate; providing additional support; offering regular snacks; fortifying their meals with additional calories; weighing them more often; and referring them to their GP if these measures did not work. One person living with dementia was at risk of losing weight and we saw they declined their lunchtime meal. The staff member tried to encourage the person again, by showing them the prepared meal, but they again declined. Ten minutes later, the cook approached the person and offered them a meal which they accepted. A staff member commented, "You have to keep encouraging and a fresh face often works." This demonstrated an understanding of how to meet the needs of people living with dementia.

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. They also had access to dental care and eyesight tests when needed. One person told us, "If I'm not well, they ask if I want the doctor. They nag me, in a nice way, and in the end I see the doctor." Another person said, "The staff are very good; they even arranged a scan [at the hospital] for me."

Good

Is the service caring?

Our findings

People were cared for with kindness and compassion. They described staff as "lovely" and "caring". One person said of the staff, "They're very friendly and you can rely on them."

All interactions we observed between people and staff were positive, encouraging and supportive. For example, when a person's clothing was falling off them, a staff member approached and offered support saying, "Let's do you cardigan up [person's name]; that's better, you look lovely now." The person smiled at the staff member and squeezed their hand.

Staff created a calm atmosphere by supporting people in a quiet, patient and unhurried way. When people were helped to mobilise, staff allowed them to move at their own pace whilst giving encouragement and reassurance. While supporting a person who was frail, the staff member used gentle, appropriate touch, spoke in a calm, reassuring way and showed interest when the person started talking about their family. At mealtimes, staff offered people the option of using a napkin or a clothes protector. One person chose to use neither and staff told us they supported the person to "change their clothes twice a day" instead.

Staff spoke fondly about the people they supported and clearly knew them well. For example, they talked warmly about a person who had recently died, who had lived at Trent House for many years. They described how they "really missed" the person and their humour.

Staff supported people to build and maintain friendships and important relationships. Two people had recently formed a friendship; staff supported them to spend time together and to go upstairs to bed at the same time, which one person told us they liked. A new person to the home described how staff had encouraged them to socialise in the lounge and take part in group activities. When people had birthdays, other people made them a card which everyone was invited to sign. The cook also made cakes for people so they could celebrate by sharing it with others.

To help a person living dementia to remember a relative, staff had given the person a blackboard with information about where their relative was and when they were planning to visit next. We saw the person using the blackboard and this visibly reduced their level of anxiety. People's bedrooms were personalised with photographs of friends and families and mementos to help them remember their loved ones.

People's privacy was protected and their dignity respected. One person told us, "I like to eat in privacy and staff respect that." Another person said, "They [staff] always knock and ask if they can come in." Our observations confirmed that staff knocked and sought permission before entering people's rooms. Staff took care to make sure toilet and bathroom doors were closed when they were in use and described the practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible, explaining what they were about to do and checking people were ready and willing to receive support. Confidential information was held securely and only viewed by those authorised to see it. In addition, staff held handover meetings in a secure, private place, so they could share information about people's current needs in confidence.

Staff encouraged people to remain as independent as possible within their abilities and to do as much as possible for themselves. For example, they described how they let people attend to their own personal care when they could, but supported them by washing areas they were unable to reach. One person told us, "I don't need help in the bath, but I just have someone to watch over me in case I get into any problems." Guidance in care plans also helped staff promote people's independence. For example, one care plan said, "I am able to shave, but require my carer to prepare the things I need for the task."

When people moved to the home, they (and their families where appropriate) were involved in assessing and planning the care and support they received. Comments in care plans showed that this process was on-going. For example they recorded discussions with family members when their relatives were involved in incidents or their health needs changed; and they recorded people's views about the way they wished to be supported.

Good

Is the service responsive?

Our findings

People told us they received highly personalised care and support that met their individual needs. One person said, "The staff are very good at knowing what I want." Another person told us, "Staff let you do what you want; they just check you're okay and if you need anything."

Each person had a comprehensive care plan detailing their specific needs and the way in which they wished them to be met. One person could become agitated during personal care and behave in a way that might challenge staff. Their 'behaviour support plan' provided clear direction to staff about how to support the person effectively at these times. For example, it stated: "During these behaviours, [the person] is clearly communicating their decision surrounding personal care and carers are to respect this." When we spoke with staff, they were clear about the particular way they supported the person and care records confirmed that they had followed the guidance in the person's care plan. Another person had been prescribed medicine to help calm them when they became anxious. Their care plan included clear information about de-escalation techniques and checks that staff should complete before resorting to the use of medicine. Staff described how they followed this plan and, as a result, the person rarely needed to be given the medicine.

Care plans also included a section called: "A day in my life". This provided a summary of the person's preferred day time and night time routines. When we spoke with staff, they demonstrated a good awareness of people's individual routines, their support needs and their likes and dislikes. They knew how each person preferred to receive care and support, including which people needed to be encouraged to eat and drink; for example, they knew that one person ate very little at breakfast but liked a large lunch and that another person ate a good breakfast and preferred a small lunch. They recognised that some people's mobility varied considerably from day to day and, in particular, how a degenerative disease affected one person's movements from hour to hour. They described how they assessed and accommodated the level of support the person needed at any particular time.

A 'hospital admission pack' had been created for each person. This included key information about the person to help medical staff understand their care and communication needs, in the event of an unplanned admission to hospital. A staff member told us, "Everyone's got one, they're a brilliant idea."

Each person had an allocated key worker to act as a point of contact with the person's family and to review the person's care plan on a monthly basis to help ensure it reflected their current needs. One of the key workers told us, "My role is also to manage [the person's] personal accessories, support them to buy things they need, keep their room tidy, check they have clean clothes. We were also asked to write a pen-picture to help other staff get to know [the person]." Other staff said the pen pictures were useful and helped them understand more about the people they were supporting.

People were empowered to make choices and staff were led by people's wishes. We heard staff asking people where they wished to take their meals and where they wanted to spend their day. People told us they could choose when they got up and went to bed; and how often they were supported to have baths or

showers. One person said, "I have a bath on a Wednesday and a wash down each day. It's enough for me, but I could have more if I wanted to." Another person told us, "I like a cool bath and that's what I get; they [staff] do it for me." A further person said, "I can get up at any time, but I like to get up at 9:00. I stayed up late the other day to see [a particular TV programme]; they [staff] were fine about it." A staff member told us, "When I came [to work] here, it struck me that people have more freedom than any other home I've worked in. Everyone has choice. Even if we know they always have the same thing for breakfast, they're still asked what they'd like."

People had access to a range of activities based on their individual interests. One person told us, "We attend the musician; it's very entertaining, and [the activity coordinator] comes and chats to us and tries to get us going."

An activity coordinator provided 20 hours of dedicated activity time each week and the activities were varied according to people's interests. For example, one person liked to go for a walk to the shops and was supported to do this regularly. They also attended a local Alzheimer's café. Other people enjoyed doing arts and crafts and we saw their work displayed around the home. The activity coordinator told us they often adopted a theme for activities, such as Easter or Wimbledon or Cowes Week, but was flexible. For example, they had been given a large supply of flowers the previous week, so had supported people to arrange them. This had prompted discussion with people about gardening and their favourite flowers. Some people preferred to remain in their rooms, so the activity coordinator spent time with them on a one-to-one basis, for example reminiscing, going through the local paper or talking about TV programmes, depending on the person's wishes. The activity coordinator told us, "It's all based on what people want to do; for example, if I see they're interested in something on TV, I'll develop that. It's all personalised."

During the inspection, we saw people taking part in a 'cocktail afternoon'. Some people helped prepare cocktail umbrellas and low-alcohol drinks, while others just enjoyed drinking them. Everyone involved appeared to enjoy the event, which had the added benefit of encouraging people to drink.

The provider sought and acted on feedback from people, including through the use of feedback forms and 'residents meetings'. One person told us, "We have general meetings; they ask if you've got any complaints or if anything needs changing. We have the opportunity to make comments, for sure and they [staff] will listen to what you say." We saw menus had been changed, following feedback, and people had been involved in planning the refurbishments to the home by choosing colours for their bedroom doors. People knew how to make a complaint and there was a complaints procedure in place. One person told us, "If I needed to complain, I'd just see the manager. She's always about."

Requires Improvement

Is the service well-led?

Our findings

People were happy living at Trent House and felt it was well run. One person told us, "We see [the manager]; she's always bright and breezy and says 'morning'." Another person said, "Everything runs very smoothly."

An appropriate quality assurance system was in place, but this had not always been effective in bringing about improvement. The system included audits of key aspects of the service, such as care planning, the environment, medicines and infection control. Where changes were needed, specific actions were sometimes developed and implemented. For example, a medicines audit had identified that some photographs were missing from people's medication administration records and this had been addressed. A mattress audit had identified the need for a person's mattress to be replaced and this had been ordered.

However, deficiencies identified by other audits were not always addressed in a timely way. For example, the monthly infection control audits had identified a wide range of issues. Some of these had been addressed; for example, staff had been wearing jewellery and nail varnish and they told us the manager had now "clamped down" on this. Other issues, relating to infection risks posed by worn furnishings, had been added to the provider's refurbishment action plan for completion by the end of November 2017. However, this plan, and a further plan for remedial work identified by the provider's fire safety risk assessment in April 2017, were only developed and sent to us after we raised concerns during the inspection. Further issues identified in repeated audits since January 2017 had not been included in these plans or been addressed in other ways. These included the need to de-clutter the laundry and repaint its floor; and to ensure staff received yearly appraisals.

Although application forms had been completed by the previous registered manager for deprivation of liberty safeguards (DoLS) for some people, these had not been submitted for assessment. This had not been picked up by the provider's quality assurance processes until the new manager contacted the local authority to chase up an application that should have been submitted 18 months previously.

The failure to operate effective systems to assess, monitor and improve the service in a timely way was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a clear management structure in place consisting of the provider, the manager, the deputy manager and senior staff. Staff were organised in their work and understood their individual responsibilities. They told us they enjoyed supporting people, were a close team and worked well together. One staff member told us, "We all muck in together. We are a tight bunch here and look after each other."

Every staff member we spoke with expressed confidence in the manager, who they described as "firm but fair", "supportive" and "approachable". One staff member said, "Things are starting to happen now [the manager] is here. She's achieved a huge amount and she keeps us on our toes." Another told us, "The manager is great; she really looks after the staff. She has brought structure to what we do." A further staff member added, "[The manager] is always around and has no qualms picking us up if things aren't done right." A range of staff meetings was held to provide an opportunity for staff to express their views. One staff

member told us, "I went to a staff meeting and got things off my chest; I felt listened to."

However, staff said they did not always feel supported by the provider. For example, one told us, "Some of us still don't have contracts; [staff] have been asking for them and we're told they're ready, but we haven't seen them." Another told us they felt like "the poor relation" as they were working in a home that needed so much refurbishment. Two staff complained that they had been given new uniforms that they were required to wear, but had only been given one each. One of the staff members said, "How does that work when you have to work six shifts in a row? It doesn't encourage hygiene." A further staff member felt it was "not good" that they were asked to wear name badges but had to purchase these themselves; they said, "They don't cost much, but it's the principle really." The manager told us they would raise these concerns with the provider directly.

There was an open and transparent culture within the home. The provider's performance rating from their last inspection was displayed in the entrance lobby; visitors were welcomed at any time and were able to come and go as they pleased; and the manager notified CQC of all significant events. A duty of candour policy had been developed to help ensure staff acted in an open and honest way when accidents occurred. We were shown an example of where the policy had been followed; the manager notified a family member of an injury their relative had sustained and had followed it up in writing with a comprehensive letter.

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	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems to assess, monitor and improve the service in a timely way. Regulation 17(1)(a).