Cornwallis Care Services Ltd

# Trecarrel Care Home

## Inspection report

Castle Dore Road
Tywardreath
Cornwall
PL24 2TR

Tel: 01726813588

Date of inspection visit:
17 July 2018
18 July 2018

Date of publication:
19 October 2018

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Inadequate** |
| Is the service caring? | **Inadequate** |
| Is the service responsive? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

Trecarrel is a care home which offers care and support for up to 44 predominately older people. At the time of the inspection 39 people were living at the service. Some of these people were living with dementia.

The service was last inspected in November 2016 and was rated as Good. In July 2018 we received serious concerns from health and social care professionals about the care that people received. The concerns were in relation to, personal care needs not being met, care plans and risk assessments were not in place for some people, medication, nutrition, staffing levels, staff culture, staff training, moving and handling concerns, infection control practices, lack of confidence in record keeping, and concerns regarding leadership of the service. Due to these concerns we brought our inspection forward. The inspection found significant concerns at the service.

This comprehensive inspection took place on 17 and 18 July 2018 and was unannounced. Two inspectors and a Specialist Advisor visited the service on the 17 July 2018. An inspector visited the service on the 18 July and met with the senior management team to discuss our findings of the inspection.

The service is required to have a registered manager. Following the safeguarding concerns being raised the manager was no longer employed by the organisation. On being informed of the concerns, the provider promptly deployed their operational management team to address the concerns and support the service. On the 9 July 2018 an interim manager was appointed at the service. Following the inspection, the operational manager clinical lead was appointed to manage the service as they had more experience to address the level of concerns at the service.

Some care staff had not received any training in safeguarding and had limited or no knowledge about the safeguarding process and how to recognise potential signs of abuse or mistreatment.

Some people's care plans, were not effectively updated to ensure they were reflective of people's current care needs. Following commissioner's reviews of people's care needs, it was evident that some people's health needs had changed. This meant that people's health needs had not been reviewed appropriately by the service to ensure they could continue to meet the person's current health and care needs.

People's risks were not safely managed at the service. For example, a number of people were at risk of falls or risks in relation to their dietary needs. There was no relevant risk assessment in place or documentary evidence to support how the risks could be minimised to keep the person safe. Consultation with those involved with the person was not evident. Therefore, we were not assured that risks had been properly considered and addressed.

The interim manager had developed a new handover system as they were aware that, due to the lack of accurate care plans, staff had limited guidance, information or direction in how to meet people's needs. The interim manager was aware that this needed to be developed further.

The Local Authority systemic safeguarding meeting raised concerns about the safe administration of medicines at the service. Due to this a community pharmacist visited the service on the 16 July 2018. They undertook an inspection and identified where further action was needed to ensure the safe management of medicines. We reviewed their notes and inspected medicines and found the same issues as the community pharmacist.

The senior management team were unable to identify which person had been subject to a mental capacity assessment. They were also unable to evidence where any applications had been submitted to the Deprivation of Liberties Safeguard (DoLS) team. The clinical lead was able to inform us that they had identified two people who had conditions attached to their DoLS authorisation and these conditions were not being met. This meant it was not possible to understand what decisions the service had taken on behalf of others or to assess whether these decisions were in the person's best interest and the least restrictive available. In addition, where conditions had been approved these were not being met to ensure a person received care in the manner agreed.

People were not protected from the risks associated with cross infection. Due to concerns in respect of the environment the provider had arranged for an external contractor to come into the service to provide a deep clean which was in progress on the first day of our inspection.

Staff had not received infection control training and lacked knowledge, skill and expertise in this area. For example, the service had shared slings to use when transferring people. These examples demonstrated that there continued to be a risk of cross infection.

Cornwallis Care Services Ltd had an organisational induction process for new staff, but it had not been followed. Staff said the induction was not completed.

People were not always supported by staff who had received training to carry out their role effectively. Training records showed that there were significant gaps in training for care staff. For example, moving and handling training. Staff confirmed they had been in post for "some months and had been using equipment and supporting people to transfer since they started work. The lack of training and induction meant that staff did not have the correct skills and knowledge to safely care for people's needs.

Health and social care professionals had raised concerns prior to the inspection that the service was not following advice that they provided. We found that monitoring records were not consistently completed so that it was not possible to understand the care that was being provided and whether people's health concerns were being addressed appropriately.

Some people had significant weight loss at the service. This had not been identified previously as people's weights had not been monitored and food and fluid charts not completed consistently. Due to this the interim manager implemented a paper record of food and fluid chart. This demonstrated that the previous system for monitoring people's wellbeing was not safe and placed people at risk.

People spoke to us about staff fondly. However, people's privacy and dignity was not always respected. During the inspection we spoke with staff, people and relatives. A recurring theme in our conversations was one of a 'chaotic' situation. This was born out by our observations, particularly in shared areas of the service. We found the service was crowded with little room for people to have privacy or quiet time without going to their rooms. Due to the crowded situation staff found it difficult to observe what was happening and there were occasions when staff failed to notice when people needed support.

There were concerns about the environment. We checked the temperature of water coming from taps and found that the water temperature in some areas were too hot and people were at risk of scalding.

There were some activities arranged by Trecarrel for people. There were no evidence people's preferences were taken into account when organising their routines.

There had been a number of staff changes at the service since February 2018. There had been management changes and some new staff had been recruited. With a lack of leadership, new staff had not receiving a completed induction and staff in general had lacked access to training and supervision. Therefore, they were unable to provide effective care that met the needs of the people they supported. There was ineffective communication between the senior managers and to staff and the people they supported. Health and social care professionals also gave a mixed response to the manager's approach and how the service responded to advice given to ensure people's needs were met.

Due to the safeguarding concerns the provider increased staffing levels at the service. Staff said they felt there were sufficient staff levels on duty to meet people's current care needs. The rotas demonstrated that there was a high reliance on agency staff to cover staffing levels at the service. It is of concern that as there was a lack of up to date care records staff were unaware of people's current care needs. An agency worker told us "You just have to ask carers and hope they know what you need to do." This meant that people were being cared for by staff who were unaware of their care needs and how they needed support.

Recruitment systems were not always robust. We found that not some new staff did not have all the relevant pre-employment checks completed before starting work.
Records required by the service had not been kept up to date. For example, care records, finance records and records relating to the overall running of the service. The last completed accident/incident occurred in December 2017. The senior managers were aware that incidents have occurred in the service since that time but there were no records to evidence this at the inspection.

Peoples records were not stored securely and therefore people's privacy was not respected.

The organisation had a quality assurance system in place to make sure that any areas for improvement were identified and addressed. The operations manager, who was responsible for the overall monitoring of the safety and quality of the service met with the manager eleven times from March to June 2018. In addition, the nurse consultation met with the manager on ten occasions. The operations manager said that the visits were part of the managers induction. What is of concern is that whilst the manager met with both the operations manager and nurse consultant regularly that issues of concerns were not identified or monitored. Therefore, checks carried out by the operations manager and nurse consultant, had also failed to identify where improvements were required.

The provider has implemented an action plan to address the systemic safeguarding concerns. This document is being monitored to ensure that the actions they have stated they will take are complied with.

Following this inspection, the overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not, enough improvement is made within this timeframe, and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this

service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found breaches of regulation and made a recommendation in respect of recruitment. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

People were not always protected against the risk of abuse or mistreatment because not all staff had received recent training in this area.

Risks to people were not being adequately assessed or addressed to keep people safe.

Medicines were not always administered correctly, managed or stored securely. This meant there was a potential risk of errors and people might not receive their medicines safely

People who used the service were put at risk because cleanliness and hygiene standards were not maintained. We observed poor infection control practices which put people at risk.

### Is the service effective?

**Inadequate**

Staff did not have an understanding of the legal requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards. For some people restrictive practices were in place without evidence of consent or adequate assessment and authorisation.

Staff did not receive appropriate induction and training so they had the up to date skills and knowledge to provide effective care.

People's healthcare needs were not always met. We received mixed feedback from health professionals, with both of those we spoke with raising concerns over some aspects of care.

### Is the service caring?

**Inadequate**

The service was not caring.

People's privacy and dignity was not always protected.

Staff did not always know the needs of the people they supported.

Staff routines and preferences took priority over consistent care and peoples preferences.

## Is the service responsive?

**Inadequate**

The service was not responsive.

The service failed to respond to people's changing needs by ensuring amended plans of care were put in place. This meant people did not always receive support in the way they needed it.

People had access to activities within the service.

There was a organisational system in place for receiving and investigating complaints.

## Is the service well-led?

**Inadequate**

The service was not well led.

There was a lack of communication and involvement from the manager to staff.

We found a number of concerns during our inspection which had not been identified by the provider or manager. This showed a lack of robust quality assurance systems.

Records relating to the management and running of the service and people's care were not consistently or adequately maintained.

# Trecarrel Care Home

**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.

The service was last inspected in November 2016 and was rated as Good. In July 2018 we received serious concerns from health and social care professionals about the care that people received. The concerns were in relation to, personal care needs not being met, care plans and risk assessments were not in place for some people, medication, nutrition, staffing levels, staff culture, staff training, moving and handling concerns, infection control practices, lack of confidence in record keeping, and concerns regarding leadership of the service. Due to these concerns we brought our inspection forward.

This comprehensive inspection took place on 17 and 18 July 2018 and was unannounced. Two inspectors and a Specialist Advisor visited the service on the 17 July 2018. At that time 39 people were living at the service. An inspector visited the service on the 18 July and met with the senior management team to discuss our findings of the inspection.
Before visiting the service, we reviewed information we kept about the service such as previous inspection reports and 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.

During the inspection, we looked around the premises. We observed the lunchtime experience and interactions between people and staff. We spoke with five people who lived at the service and observed others who could not communicate their wishes and feelings verbally. We also spoke with three relatives, 12 members of staff and a visiting health and social care professional.

We looked at six records relating to people's individual care, medicine administration records (MAR), training records for all staff, staff personnel files, policies and procedures and a range of further documents relating to the running of the service.

Inadequate

# Is the service safe?

## Our findings

It is important that staff are confident about safeguarding processes so they are able to protect people who may be at risk of abuse. Some care staff had not received any training in safeguarding and had limited or no knowledge about the safeguarding process and how to recognise potential signs of abuse or mistreatment. They were unable to tell us who they would report concerns to outside of the service. Some staff had attended safeguarding training which need to be updated.

The interim manager acknowledged that care plans were not up to date and did not reflect people's current care needs and that some people did not have a care plan in place. Some people could become anxious or distressed leading them to behave in a way which could be difficult for staff to manage. There were no care plans in place to guide to staff on how to support people during these times. Care staff acknowledged that they might provide support in a different way to their colleagues. This meant staff may have been inconsistent in their approach to people which could have resulted in them becoming increasingly confused and anxious.

Risk assessments are important when identifying the appropriate measures to be put in place to minimise risks to people. For example, how staff should support people when using equipment, reducing the risks of falls, the use of bed rails and reducing the risk of pressure ulcers. We had concerns in relation to the management of identified risk. Guidance contained in risk assessments did not always reflect the actions being taken by staff to protect people.

Systems for assessing risk were not robust. For example, where people were at risk of falling out of bed. Staff had placed mattresses on the floor next to the person's bed in order to keep them safe. However, there was no relevant risk assessment in place. A person was at risk of choking on food. Speech and Language Therapists had provided advice on how foods should be prepared. The person did not want to eat foods prepared this way and was eating foods which presented a choking risk. This was not referred to in the care plan and no risk assessment in this respect was completed. There was no documentary evidence to support why or how these decisions had been reached or if the person, their family or other health or care professionals from outside the service were involved in this decision. There was no evidence to show what action should be taken in this respect. Therefore, we were not assured that the risk had been properly considered and addressed.

We checked the temperature of water coming from sink taps and found that the water temperature in some areas were too hot and people were at risk of scalding. For example, the communal toilet next to the lounge which people used, sometimes unsupported by staff. Therefore, the risk of scalding was high. A water temperature monitoring record had been completed in July 2018 and it identified a number of bathroom/ toilets and bedrooms where the temperature was above 43 degrees centigrade. There was no evidence any action had been taken to address this. Thermostatic monitoring values had not been fitted on all water fittings.

We reviewed the accident record file. The last completed accident/incident form was completed in

December 2017. The senior managers were aware that incidents had occurred in the service since that time but there were no records to evidence this at the inspection. The clinical nurse lead was completing a notification "in retrospect" of where a person had suffered a head injury. We discussed with the management team the need to evidence when accidents/incidents have occurred and what action had been taken. The audit process for monitoring falls in order to identify any trends or patterns was not being completed. This meant the management team did not have the information necessary to assist them to take action to protect people from risk.

These examples show that there was an inconsistent approach to risk assessments completed for the safety of the people supported at the service. We could not rely on the accuracy or relevance of the assessments in place. Risks were not consistently identified or assessed adequately and there was not always action agreed on how any risks could be minimised.

The Local Authority systemic safeguarding meeting raised concerns about the safe administration of medicines at the service. Due to this, a community pharmacist visited the service on the 16 July 2018. They undertook an inspection and identified where further action was needed to ensure the safe management of medicines. We reviewed their notes and inspected medicines and found the same issues as the community pharmacist. For example, there were some gaps in Medicine Administration Records (MAR) charts. There was no guidance for staff in when to administer medicines for pain relief. Medicines were not given at the prescribed times and one person had been administered more medicines than prescribed. Therefore, we could not be confident that medicines were administered as prescribed.

Due to the concerns identified the provider had changed the arrangements for the management of medicines. The deputy manager had been given the responsibility for overseeing and administering medicines. When they were not present a senior member of staff administered medicines.

Staff had a general understanding of infection control practice, such as when to wear aprons and the appropriate use of hand gel. Training in this area was lacking. The systemic safeguarding forum had raised concerns about infection control practices at the service. The service had shared slings to use when transferring people. The environment needed to be cleaned to ensure that any infection control risks were minimised. The provider arranged for an external contractor to come into the service to provide a deep clean which was in progress on the first day of our inspection. These examples demonstrated that there continued to be a risk of cross infection.

Therefore, we concluded risks to people's health and welfare had not been consistently identified, assessed and monitored and there was a lack of sufficient guidance to help staff safely manage risks.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment systems were not always robust. We found that in two out of three new staff did had not had all the relevant pre-employment checks completed before starting work. For example, there were insufficient appropriate references taken. Staff did have Disclosure and Barring System (DBS) checks gained before commencing work.

We recommend that appropriate recruitment checks are undertaken to evidence a person's suitability to carry out their role before they commence employment.

Due to the concerns regarding how people's care needs were being met the provider had recently increased

staffing levels. They increased the staffing level from five to nine care staff, a deputy manager and interim manager. In addition, the service had an administrator, domestic, catering and maintenance staff on duty. At night the level of staffing had also increased from three to four care staff. Staff said, prior to the increase in staff levels there were insufficient staff to meet the needs of the people they supported. With the recent increase in staffing levels staff now felt there were appropriate staff levels on duty to meet people's current care needs.

The service had a number of staff vacancies. Nine experienced care staff had left the service in the six weeks before the inspection. Their posts had been advertised but not yet filled. Therefore, there was a reliance on agency staff to cover vacant shifts. The interim manager had also deployed staff from another Cornwallis Care service to work some shifts at Trecarrel so that sufficient staffing levels were in place at the service. The rotas demonstrated that there was a high reliance on agency staff to cover staffing levels at the service. This meant people were at risk of being supported by staff who were unfamiliar with their needs and preferences. This was of particular concern in light of the lack of up to date care records. An agency worker told us "You just have to ask carers and hope they know what you need to do." We concluded there were insufficient staff with a knowledge of people's needs in place to support people in line with their needs.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people 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. 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. Staff had completed training in this area.

The senior management team were unable to identify which people had been subject to a mental capacity assessment. They were also unable to evidence if any applications had been submitted to the Deprivation of Liberties Safeguard (DoLS) team. The managers were unsure who, if anyone, was subject to a DoLS authorisation. This meant it was not possible to understand what decisions the service had taken on behalf of others or to assess whether these decisions were in the person's best interest and the least restrictive available.

The clinical lead informed us that they had identified two people who had conditions attached to their DoLS authorisation and these conditions were not being met. Where conditions had been approved these were not being met to ensure a person received care in the manner agreed.

The service had recorded in people's records that family members had consented to elements of their care. However, there was no confirmation in what areas of care the representative held a lasting power of attorney (LPA) for and if therefore they had the appropriate authority to make such decisions.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff joining the organisation did not always receive a comprehensive induction, to ensure they were aware of the provider's policies and procedures. From reviewing staff files, it was evident that more recently recruited staff had not completed the organisation's full induction. For example, some new staff had not signed to indicate they had read policies on moving and handling. As part of the induction process staff were required to complete short knowledge tests to show they had read and understood the relevant policies and procedures. This was not consistently completed. It was also evident that supervision of staff had not occurred within recent months. Staff told us they had not received supervision since the previous manager left in February 2018. Records that we reviewed confirmed this.

People were not always supported by staff who had received training in order to carry out their role effectively. There were significant gaps in training for staff. For example, in the areas of first aid, fire safety and continence care. Training records showed that care staff had not received training in areas such as moving and handling. Staff confirmed they had been in post for "some months" and had not received moving and handling training. However, they had been using equipment and supporting people to transfer since they started work. Staff said they learnt how to do moving and handling by "copying" other staff and

were not sure if that was the right technique to use. The lack of training and induction meant that staff did not have the correct skills and knowledge to safely care for people's needs.

It is of serious concern that staff were not equipped with the correct skills and knowledge to undertake their role to ensure that people received effective and safe care.
This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received concerns about people's dietary and hydration needs and that people's fluid and food intake had not been recorded accurately. The manager had implemented a new food and fluid chart for care staff to record people's dietary and fluid intake. We saw staff completing these records and some were positive about this recording system. Some staff still felt they needed more clarity as to what they were expected to do; one commented "You have to figure it out for yourself, you have to write it down that's what it's like now."

The cook was aware of people's dietary needs and was positive about the introduction of the food and fluid chart. The chart specified how meals should be presented to people, for example soft mashed diet. However, this would benefit from further expansion, such as if meals should be presented in soft or thick pureed manner. The service was being prescribed two types of food thickener, which needed to be added to foods in different ways. People's care plans did not provide guidance on what food thickener was to be used and neither did the handover record. There were no Speech and Language Therapist assessments on how food and fluids should be presented to specific people. This meant that staff had limited guidance in this area and meant there was a risk people may not have their food and drinks prepared in a way which protected them from an identified risk.

The manager had altered the times of food being provided so that there was sufficient time intervals between breakfast, lunch and tea. We observed the lunch time experience. People were supported by suitable staffing levels to assist them promptly when necessary. Feedback on the food was positive. Comments included; "Yes, food's good" People were not aware of what the menu was for that day. People's dietary needs were known by the cook and recorded in the kitchen. Any changes to people's dietary needs were communicated with the kitchen staff.

Concerns about people's weights were identified prior to this inspection. The service acknowledged that people's weights had not been monitored in recent months. For example, one person's care plan stated that they should be weighed monthly. They had last been weighed on 21 April 2018. In response the management team had organised for everyone to be weighed and had identified eight people who had significant weight loss. This demonstrated that the previous system for monitoring people's weight and wellbeing was not safe and placed people at risk.

During our observation of lunch, we noted that people who were on pureed diets had their food presented in small pudding size bowls which limited the portion size. The cook stated that more food was available but from our observations we were not confident people would ask, or that staff would suggest a second helping. We discussed this with the provider who assured us this would be addressed and that plate guards could be used so that people had access to more appropriate food portions to support them to maintain a healthy weight.

We saw from people's care records that they had access to a range of health care professionals including GPs, speech and language therapists, district nurses, and chiropodists. Health and social care professionals had raised concerns prior to the inspection that the service was not following advice that they provided. We

found that monitoring records were not consistently completed so that it was not possible to understand the care that was being provided and whether people's health concerns were being addressed appropriately.

This contributed to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the inspection, we observed health and social care professionals attending to review people. From these assessments and due to the concerns in how the service was meeting people's care needs, commissioners decided to move some people to alternative care provision.

People's bedrooms were personalised with personal belongings, soft furnishings and photographs. People were encouraged to have things they felt were particularly important to them and reminiscent of their past around them in their rooms.

The premises were not meeting people's needs. One of the lounges had been closed as it required deep cleaning and redecorating. Therefore, people only had access to one lounge. This was crowded and people's individual needs could not be met. As some people had used the closed lounge to eat meals in the dining room was also overcrowded as a result. A relative told us this had been closed for some time. Please see caring section of this report which demonstrates this.

We had concerns that some areas of the service were tired and needed attention. For example, on entering the dining room the floor sunk underfoot as you stepped on it. Part of the dining room had a glass roof and there was a large scorch mark on the flooring from the sun. The furnishings and décor were tired and did not contribute to people's emotional well-being. We also saw bedrooms that needed redecoration, and furnishings, such as divan beds that were old and needed replacing. There were outdoor areas which looked as if they had been used by people in the past. For example, we saw raised garden beds which could be used by people in wheelchairs. However, although it was a warm pleasant day we did not see anyone using the garden area. Furniture from the unused lounge had been moved into this area and it was not inviting or conducive to relaxing in.

This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service caring?

## Our findings

Whilst people were positive about the care they received this was not what we found. Comments from people included "Staff are lovely" and "It's beautiful here." Relatives told us "The care is brilliant. We are involved in all decisions. The staff are wonderful." However, we found staff were not always kind, caring or thoughtful. They did not always respect people and they were not always aware of people's needs.

We spent time in the shared lounge to observe how care was delivered and received. During the inspection people only had access to one of the two lounges as the other had been closed for some time so it could be redecorated. There were twenty-two people in the lounge with six care staff and the room was crowded with most of the seating occupied. One person was saying repeatedly they were uncomfortable in the chair they were sitting in. They repeatedly called out for assistance and on two occasions staff responded by saying that they couldn't do anything as; "That's your chair." This demonstrated people were unable to make basic, simple day to day choices about where they sat.

A relative entered the lounge with their family member. They were looking for somewhere to sit. The only chair left did not have a cushion on it. Staff bought a new chair into the room and the person who was still saying they were uncomfortable in the chair they were seated in, asked if they could sit in it. Staff told them they could not. The relative intervened and asked the person if they would like to sit in the new chair, which they tried. Staff were not supporting this person or paying any attention and left the relative to assist the person and their own family member to sit in their respective chairs.

Staff were unaware of the relative's family member's mobility needs and asked the relative if their family member needed help with transferring from their wheelchair to the chair. They then supported the person to stand by holding on to the person's hands and placing a hand on the person's back. The person needed to turn to sit in the chair. Staff then had to let go off the person's hand and leave the relative to support their family member. This manoeuvre demonstrated staff were not competent when assisting the person with the transfer and needed the support of the relative to keep the person safe. Staff were not aware of how to support the person to transfer from the wheelchair to the chair This demonstrated that staff were unaware of the person's mobility needs.

We observed people during the lunch time period. Most people ate in the dining room and this was crowded and very busy. Two people were sitting next to each other at the dinner table. One person did not want their potatoes or leeks and picked them off their plate and placed them into the cup of tea of the person next to them. This person started to drink their tea and noticed that food was in their drink. They then attempted to take the food out of their drink. They repeatedly sipped the drink and then stopped to remove large particles of food. Although there were several members of staff in the dining room they did not notice this. Eventually we intervened and asked staff to change the drink. Staff left without taking the cup away and came back with a jug of juice. The person did not want to drink juice and continued to drink the cup of tea with food in it. This demonstrated staff were not alert to or considerate of people's needs.

We saw that when staff assisted people with their meals they did not speak to the person they were

supporting. We instead saw staff talking about their breaks and where to access files that they could not locate. In some cases, the staff member was standing up when assisting the person with food and so was not engaging effectively with them. This did not show respect to the person or provide any encouragement for the person to eat their meal.

People's privacy was not always respected. For example, we saw one person with their bedroom door open sitting with only a t shirt on and continence pad. The continence pad had slipped down slightly. We asked staff to intervene to ensure the person's privacy and dignity were respected. This did not protect the person's dignity.

These examples demonstrated that staff were not providing sufficient attention, or monitoring people's needs. It also demonstrated that staff routines and preferences took priority over consistent care and people's preferences. These examples occurred at different times of the day and therefore showed that staff were not vigilant in their caring responsibilities throughout the day.

We observed two agency staff being kind, respectful and speaking with people considerately. For example, they were trying to encourage a person to change from their night to day clothes. They did not rush the person, spoke to them gently and gave verbal and physical reassurance. the person after some time agreed to let staff assist them. We also saw a member of staff deployed from another service provide physical comfortable to a person who was not well and blow kisses to people across the lounge which were received by the person smiling and waving back at them.

Some care plans contained very little detail about people's personal histories or background. This is important information as it can help staff to ensure people receive care in the way they wish and help them to engage with people by providing them with areas of interest for them to use in conversation.
People were not given information in a meaningful way. People did not have access to their care plans.

People's confidential information was not stored securely. People's care records were in a unlocked room with the door open so that it was accessible to all in the service. At our request they moved people's care records but left people's confidential mail in the room. At the end of the day we requested for this to be placed in a secure area. We were assured this would be addressed immediately.

People were not treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service responsive?

## Our findings

People's care plans, which provided guidance and direction to staff about how to meet their individual needs, were not updated to ensure they were reflective of people's current care needs. For example, one care plan stated that the person used a wheelchair to mobilise: '[Person's name] becomes very frustrated with not being able to walk as she feels she can still walk and go outside freely on her own' and '[Person's name] will sometimes push herself around the corridor in her wheelchair.' This was inaccurate, they were no longer mobile and were in receipt of palliative care and needed all caring interventions to be provided whilst being supported in bed.

We also found that other care plans were not updated as referred to in the Effective section of this report. People's care needs in respect of their dietary needs were not specified in care plans, therefore staff were not informed, guided or directed in how to assist people with their meals and drinks safely. Some people had moving and handling assessments but they had not been reviewed to ensure their needs were accurate and up to date. Other people had no assessments in this respect. Therefore, staff had limited or no information in how to meet people's needs safely and appropriately.

The service provided end of life care to one person. The service had arranged for medicines to be held at the service to be used if necessary to keep people comfortable. However there were concerns in the level of staff skill and knowledge in how to administer them. The person did not have an end of life care plan which would have outlined their preferences and choices for their end of life care.

Commissioners reviewed some people at this service and identified that people's care needs were not identified accurately. Five people's health needs had changed significantly and Commissioners made the decision for them to be moved to alternative placements where their needs could be met. This demonstrated that people's health needs had not been reviewed by the service to ensure they could continue to meet the person's current health and care needs.

Staff told us that they did not have access to the care plans. We received comments such as they are "locked away, we don't have access to them". Agency staff told us that they hadn't seen care plans and so asked Trecarrel care staff what care a person needed. Agency staff said that as they undertook more shifts at the service they then got to know the people they supported, but still had no access to care documentation. Staff deployed at the service said, "I know how to provide personal care I'm just not sure what I am meant to be doing, it's all a muddle." We concluded that care plans were not always accessible to staff and that they did not reflect people's current health and social care needs. Therefore, staff had no or limited guidance or information to provide care that would meet people's current care and health needs.

The interim manager had developed a new handover system as they were aware that, due to the lack of accurate care plans, staff had limited guidance, information or direction in how to meet people's needs. The aim of the daily handover sheet was to provide staff with specific information in how the person needed support and what monitoring was required to be undertaken. As the senior management team were getting to know people and due to a lack of information in people's care records, they acknowledged that the

handover sheet remained "in progress" as they got to understand people's care needs.

Staff kept daily records detailing the care and support provided each day and how people had spent their time. Records showed that some daily care and monitoring records were not completed in a timely manner, for example gaps in repositioning charts were found. The interim manager was aware of this and was reviewing the daily and monitoring sheets regularly to ensure they were completed. The information recorded was very task orientated and the interim manager was aware that this needed to be developed further.

A visiting health and social professional was aware of some of the new systems put in place such as the handover sheets, food and fluid logs and more emphasis on monitoring sheets. They told us "Things are definitely improving but there is still a long way to go. They have got to start from scratch."

There was a lack of accurate care plans and records of care provided. This placed people at risk of receiving inappropriate care. This contributed to a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since August 2016 all organisations that provide adult social care are legally required to follow the Accessible Information Standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss. We found people were not given information in a meaningful way. People did not have access to their care plans.

People had access to activities at the service. An activity co-ordinator was employed and a programme of weekly activities were displayed. There were no weekend activities. On the day of inspection an entertainer came to the home. Music was playing and we saw one person completing a jigsaw. There was no evidence people's preferences were taken into account when organising their routines or activities.

People had call bells in their bedrooms to alert staff if they required assistance. There were pressure mats to alert staff if people were out of bed, should they be assessed as needing support to mobilise. Throughout the inspection, we saw that if bells or alarms were triggered these were answered promptly by staff.

There was a system in place for receiving and investigating complaints. People and relatives said they knew how and who they could complain to and felt their compliant would be listened too.

Inadequate

# Is the service well-led?

## Our findings

The service was last inspected in November 2016 and was rated as Good. In July 2018 we received serious concerns from health and social care professionals about the care that people received. The concerns were in relation to, personal care needs not being met, care plans and risk assessments were not in place for some people, medication, nutrition, staffing levels, staff culture, staff training, moving and handling concerns, infection control practices, lack of confidence in record keeping, and concerns regarding leadership of the service. Due to these concerns we brought our inspection forward.

Due to the systemic safeguarding concerns the manager was no longer employed at the service. The provider initially deployed a manager from one of their other services to manage the home. However, following the inspection, the provider informed us that due to the serious concerns at Trecarrel the organisations operational manager clinical lead would manage the service.

The service is required to have a registered manager. At the time of our inspection the service did not have a registered manager in post. The provider stated the registered manager would be advertised externally.

Trecarrel is owned by Cornwallis Care Services Limited who run a number of services within Cornwall. There is a clearly defined management structure and regular oversight and input from senior management. However, the provider had failed to have effective oversight of the service to recognise the failings others have quickly identified. The communications systems between management had also failed to be effective.

There were organisational systems in place to monitor the quality of the service at Trecarrel, however these systems had failed to identify or to or address in a timely way, many of the areas of concern identified at the inspection. This included concerns with risk management, infection control, staff training, induction and supervision, medicines, MCA and DoLS, people's records and with the way in which care was provided to people who were vulnerable. For example, a health and safety audit in March 2018 identified that 'risk assessments for falls in care plans were not in place', and we still found examples of no risk assessments in this regard: the accident and incident log had not been completed since 17 December 2017 and yet senior managers were aware that incidents had occurred. This meant that the auditing system was not used in a proactive way when new issues had arisen and the provider's own governance and quality monitoring systems were not effective at providing checks of the service and the manager's work.

The provider had an operations manager, who was responsible for the overall monitoring of the safety and quality of the organisation and all its services. The operations manager met with the manager eleven times between March 2018 and June 2018. In addition, the nurse consultant met with the manager on ten occasions. The operations manager said that the visits were part of the managers induction. Whilst the manager met with both the operations manager and nurse consultant regularly the issues of concerns were not identified or monitored. Therefore, checks carried out by the operations manager and nurse consultant, had also failed to identify where improvements were required.

In the six weeks prior to this inspection nine staff had resigned from Trecarrel. The organisation had a

process in place to carry out a voluntary exit interview for staff leaving the service. Staff had not participated in this. Therefore, there was no means of capturing why staff were leaving the service. Staff confirmed that from February 2018 they had not received any formal supervision. There were significant gaps in staff training and the induction process. This meant that staff skill and experience was lacking and staff were unable to provide effective care that met the needs of the people they supported.

The provider's vision and strategy was to deliver 'high quality care and support', however because of the gaps in the provider's overarching governance arrangements, the vision was not embedded within the service.

Staff were positive about the previous managers' personality but felt that "She had a good talk, but nothing happened" and "It was really worrying when [managers name] was here. It was crazy"." This evidenced that the service did not always operate in an open and transparent way.

We received a mixed view from health and social care professionals about how the manager would listen to and receive advice. They told us at times it appeared the advice was listened to and believed that it was being shared with the staff team to ensure people were receiving the right care. However, it became apparent that advice was not acted upon as was evidenced by people's health and care needs deteriorating. For example, the significant weight loss for some people at the service.

We saw senior staff meetings occurred. Minutes of the senior staff meeting on the 13 June 2018 recorded an issue with; 'Seniors not knowing what a MUST is or how to calculate it even though these risk assessments have been in the care plan for years.' This showed that staff did not have the skills or knowledge to undertake their role effectively to ensure people's health needs were met. This demonstrated that when issues had been identified no follow up action was being taken in a timely manner.

Services are required to notify CQC of various events and incidents to allow us to monitor the service. The service had stopped notifying CQC of any incidents as required, for example when incidents occurred at the home, such as falls that required treatment. The previous rating issued by CQC was displayed.

The provider had arranged for a relative meeting to discuss the recent concerns about the service and what actions they intend to take.
During the inspection we spoke with staff, people and relatives. A recurring theme in our conversations was one of a 'chaotic' situation. This was born out by our observations, particularly in shared areas of the service. We found the service was crowded with little room for people to have privacy or quiet time without going to their rooms. Due to the crowded situation staff found it difficult to observe what was happening and we have described occasions when they failed to notice when people needed support. This had not been identified as an issue the provider's own quality monitoring.

The provider did not have effective systems in place to ensure the effective monitoring of the leadership and quality of the service. This a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has implemented an action plan to address the systemic safeguarding concerns. This document is being monitored to ensure that the actions they have stated they will take are complied with.

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 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider was unaware of who had been subject to a mental capacity assessment or DoLS application. There were restrictive control measures in place which had not been adequately assessed for or consent to. Where conditions had been made these had not been met. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>All premises and equipment used by the service must be properly maintained. |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>Service users must be treated with dignity and respect. |

**The enforcement action we took:**

Imposed a condition

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Care and treatment must be provided in a safe way for service users. Including the proper and safe management of medicines, risk assessments and infection control processes. |

**The enforcement action we took:**

Imposed a condition

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered person did not have effective system in place to regularly assess and monitor the quality of the service provided and identify, assess and manage risk relating to the health, welfare and safety of the people who use the service. |

**The enforcement action we took:**

Imposed a condition

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Sufficient numbers of suitably qualified, competent, skilled and experienced personal must be deployed to meet the needs of the people they support. Staff must receive appropriate |

support, training, professional development, supervision and appraisal as is necessary to carry out the duties they are employed to perform.

**The enforcement action we took:**

Imposed a condition