Cornwall Care Limited

Trengrouse

Inspection report

Trengrouse Way
Helston
Cornwall
TR13 8BA
Tel: 01326 573382
Website: www.cornwallcare.org

Date of inspection visit: 15 October 2014
Date of publication: 13/04/2015

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This was an unannounced inspection which took place on the 15 October 2014.

Trengrouse is registered to provide care with nursing for up to 41 people. The service provides care with nursing for people with nursing needs and people living with dementia. The service had a manager registered in post. 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 and associated Regulations about how the service is run.

The deputy manager and staff members were clear about their roles and responsibilities and were committed to providing a high standard of care and support to people who lived at Trengrouse. However people's views about their experience of the service were not being sought which meant the service was limited in how they measured the standards of care and treatment.

Summary of findings

We found staffing levels were not always adequate to provide the support people required. We saw the staff members on duty did not have time to spend socially with the people and could not undertake tasks supporting people without feeling rushed. For example people were not assisted with their meals in a dignified way because staff were assisting more than one person at a time. Some people told us they had to wait a long time for staff to respond to them. One person told us they had been waiting a long time before a member of staff assisted them.

Staff supervision and appraisal had not been taking place for a six month period. Staff told us there

was access to the manager should they wish to report anything but they were not having support to talk through their roles or individual training needs.

We observed staff supporting people were caring and respectful. People responded positively to staff interventions. Staff acknowledged people's privacy and dignity when delivering personal care and support. However, by not having enough staff to support people with meals meant their dignity was compromised.

Activities were not taking place to meet the needs of people living with dementia. Time constraints for staff meant they did not have the time to deliver suitable activities designed for people with dementia. Staff were not familiar with activities specifically designed for people with dementia. We have made a recommendation about staff training on the subject of dementia.

There was no formal process to seek people's views in relation to the running of the home. People told us their views about the service had not been sought through surveys but that they could express what they thought by speaking with staff and managers.

Suitable arrangements were in place to protect people from the risk of abuse. People told us they felt their relatives were safe and secure. One person told us, "I feel confident when I leave that (My relative) they will be well looked after and safe until I get back." Safeguards were in place for people who may have been unable to make decisions about their care and support.

We found medicine procedures in place at the service were safe. Staff responsible for the administration of medicines had received training to ensure they had the competency and skills required. Medicines were safely kept and appropriate arrangements for storing were in place.

The service met people's nutritional needs and there were good links with other health and social care professionals. A number of health and social care professionals told us the service worked with them and responded to recommendations and guidance provided.

There were suitable systems in place to ensure people's rights were protected and appropriate 'best interest' assessment took place where necessary. Other agencies told us the service made appropriate referrals to ensure restrictive practices did not occur without a Deprivations of Liberty Safeguard (DoLs) taking place.

People had access to a concern/complaints system which people thought was responsive. People told us they felt listened to and their concerns had been acted upon. They told us this gave them confidence to raise issues when they needed to.

We found a number of Breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the end of the full version of the report.

Summary of findings

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 because staff did not have the time to carry out their roles to meet people's needs.

Staff were not always available in areas where people required support at mealtimes.

Support plans included risk assessments to safely manage care and nursing needs.

People were receiving their prescribed medicines on time and medicines were being stored safely.

Is the service effective?

Requires Improvement

The service was not always effective in meeting people's needs.

Staff did not receive regular supervision or appraisal for development in their roles.

People's dignity was not always respected when they were being supported at mealtimes.

People had access to a range of health and social care professionals.

Is the service caring?

Good

The service was generally caring.

Staff told us they were sometimes rushed but always tried to make time to meet people's needs.

People told us staff were kind and attentive.

Staff knew the people they were caring for well and communicated with them sensitively.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were not always responded to in a person centred way because care was task driven. This was because of time constraints on staff.

The service did not provide planned activities to people, most of whom required activities designed for people with dementia.

Staff told us they did all they could to make sure they were responding to people's needs but that staff time was restricted to carry out basic care tasks.

Is the service well-led?

Requires Improvement

The service was not well led.

Summary of findings

People's views were not being actively sought in order to measure the standards of care being delivered.

Staff were not confident action would be taken when raising concerns or complaints.

Accident s and incidents were being monitored by the organisation to ensure any trends were identified

Trengrouse

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating of the service under the Care Act 2014.

This inspection took place on 15 October 2014 and was unannounced.

The inspection team consisted of two inspectors. Before our inspection we reviewed the information we held about the service. This included previous inspection reports and information supplied to us by the provider. 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 improvements they plan to make.

During this inspection we looked at care plans for four people, two staff files and documents in respect of the services quality assurance systems and how the service safely managed medicine processes. 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. This involved observing staff interactions with the people in their care on several occasions throughout the day.

We spoke with a quality assurance manager for Cornwall Care and the deputy manager for Trengrouse. The registered manager was not on duty on the day of the inspection. We also spoke with three people using the service, seven staff on duty as well as two relatives. Prior to and following the inspection we spoke with four professionals who provide services at Trengrouse. They included healthcare professionals and social workers.

Requires Improvement

Is the service safe?

Our findings

People's needs were not always being met because staff said, "always busy" and "rushing about". Staff were not always available to provide support to people. We observed people in the lounge and dining areas between 9:30am and 11am. During this period of time people were being assisted to the lounge and dining area for breakfast. One person, whose care records showed they regularly displayed behaviour that challenged, was wandering amongst other people without any staff available to support people. Another person began shouting for attention but a member of staff in the vicinity was busy doing something else and was unable to respond. One person was sitting alone in a lounge area. After eating their breakfast they remained on their own for over an hour. One person said, "It's always like this in the morning".

Four staff members told us they were always rushed especially in the morning. Comments included, "We just have to get on with the job in the morning getting people up. There is no time to stop and do anything else". Another told us, "I would love to have the time to spend with people but we don't get finished until lunchtime". Staff told us overtime was a regular feature on the staffing rota. One commented, "It's to plug the gaps, but some of the shifts are long". Others said they were often tired but felt they did not want to let people down.

Some people chose to stay in their rooms. We saw staff called into the rooms and engaged in conversation in most instances. However in one instance a person in their room away from the main lounge area, was shouting for staff for over five minutes. Staff were only made aware of this by us drawing their attention to this person. Staff told us they tried their best to protect people from the risk of social isolation but that they could not be in all areas of the home all the time.

We spoke with the staff and looked at staffing rotas to see how the service was being staffed. The deputy manager told us a recent recruitment drive was currently underway to employ additional staff. Records we looked at confirmed this and it was anticipated newly recruited staff would soon be completing the induction programme to join the staff team. This meant steps were being taken to address issues of staffing team numbers within the service. However there was no information to show how more staff would be utilised during the day or night time periods.

We found that the registered person had not ensured there were always sufficient numbers of staff employed. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems in place for care planning and support, took account of risks to people using the service. Records we reviewed contained processes that identified risk associated with peoples care. Risks assessments were in place for falls, nutrition, mobility, tissue viability and supporting people who displayed behaviour which may challenge others. Where risks had been identified the information was in place to inform staff of what was required to keep people safe. Staff told us they felt risk management was an essential part of delivering care safely but that staffing levels sometimes meant people were not being observed as much as they should be.

To maintain qualified staff for each shift, agency nurses were contracted on a regular basis. In general the same agency was used to ensure continuity. People told us they "knew the staff well and rarely saw new faces".

The design of the building meant people had space to move around without restriction. Staff told us they liked the way the home was laid out as it gave them space to work without restriction. There were a range of aids and adaptations in place to meet the needs of people using the service. For example staff used mobility equipment knowledgably and safely to transfer people from wheelchairs to lounge chairs. However there was an unpleasant incontinence odour in the lounge and dining area of the service. The deputy manager acknowledged carpets required replacement and that this was included in the business plan for the home. Ancillary staff we spoke with told us carpets in the area were cleaned weekly but the odour remained.

Staff were familiar with the services safeguarding policies and procedures. They were able to describe to us what action they would take if they witnessed bad practice. Staff members told us they would not hesitate to report any concerns they had about incidents they considered to be abuse. We were provided with an example where this had occurred. The documents were completed and appropriate action had been taken to safeguard the person.

Requires Improvement

Is the service safe?

We looked at four people's medicine administration records (MARs). They showed people were receiving their medicines when directed and in doses prescribed. There were instances where some people required 'covert' administration of their medicine. This is a method of administering medicines in a way which meant the person would not necessarily know they were taking it. Records confirmed risk assessments had been carried out and consent by the General Practitioner (GP) and family member had been sought, due to potential restrictions to the person's right to choice as defined within the Mental Capacity Act 2005.

We looked at a record where pain relief was prescribed as PRN (when needed). We saw additional locked storage was in place and records were current and signed by two senior staff whenever administered. In addition stock control was monitored for each dose administered. This demonstrated the home was working within pharmaceutical guidelines. The quality assurance manager showed us recent audit information identifying internal medicine management requirements where omissions had occurred. This demonstrated the service had systems in place for the safe management of medicines.

Requires Improvement

Is the service effective?

Our findings

During the morning period we observed some people were not receiving breakfast until after 11am with lunch served at 1pm. Due to the short timeframe between the two meals, some people may not be ready for the lunchtime meal. Most people did not have capacity to make this choice and relied on staff to manage their mealtimes. At lunchtime most people were encouraged to eat at dining tables and tables in front of their chairs. Staff were rushed and we saw two staff assisting four people with their lunch at the same time. This was because other staff were assisting people in other parts of the service. Some people lost interest in their meal due to the lack of personal attention by staff. This demonstrated people were not being supported in a dignified way.

Staff told us they had not received supervision for a long period of time. Supervision is a system to ensure staff are properly supported in their role to provide care and treatment to people who use services. Those we spoke with told us they had access to the manager should they wish to report anything but they were not having support to talk through their roles or individual training needs. Staff records we looked at confirmed this. There were no supervision records completed in the previous six month period. The deputy manager told us a number of senior staff were receiving training to undertake staff supervision. Staff told us, "Appraisals are probably an area where we are not functioning very well". "It's been difficult and busy especially for the last six months".

We found that the registered provider was not ensuring staff were being appropriately supported. This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff told us they had good access to a range of training applicable to meeting the needs of people living at the service. Mandatory training included fire safety, first aid, food hygiene and safeguarding) training. Training to support people with a diagnosis of dementia and behaviours which challenge staff had been limited until recently when it had been included in the induction programme for new staff. One staff member told us they felt they had the knowledge and skills to manage people's dementia care needs. In one instance we saw a member of staff respond in a calm and relaxed way to diffuse a conflict between two people. They responded positively and the situation was managed successfully. Two other care staff we spoke with told us they had not received any updates in dementia care for a long time but felt they had the knowledge and skills to manage situations that arose. Staff had various levels of knowledge and understanding of best practice in dementia care, which might affect how people's dementia needs were responded to.

People told us meals were enjoyable. A relative said, "(the person) has a special diet which the staff are familiar with and (the person) seems to like the food presented". Also, "The meals are OK and they know what I like and don't like". A menu board was in the lounge area so people could see what was available. Mealtimes were flexible and choice was available. Some people required special diets and this information was available to the catering staff. For example one person had a risk of choking. This had been identified and they had been referred to a Speech and Language Therapist (SLT) for a swallowing assessment. By doing this staff being informed of the need for a soft diet and to supervise the person when eating and drinking.

We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the quality assurance manager. They demonstrated an understanding and knowledge of the requirements of the legislation. Records we looked at showed the service had taken action to carry out Mental Capacity Assessments and best interest decisions were being recorded where necessary. The majority of people living at Trengrouse had a diagnosis of dementia which affected their capacity to give consent. The home was reliant on the response of the local authority to hold best interest meetings and a number still needed to take place.

We found the provider was meeting the requirements of the DoLS. We looked at training records for the staff team and saw all staff had received training in the MCA and DoLS. Staff told us they had a basic understanding of the principles underpinning the legislation. Records we looked at demonstrated where DoLs applications had been made. A healthcare professional reported to us the service made appropriate referrals to assess peoples best interest where it was identified.

Trengrouse worked with other providers of healthcare to ensure continuity of care. For example people said, "The doctors come in all the time as well as social workers and

Requires Improvement

Is the service effective?

Community Psychiatric Nurses (CPN)." Visits were recorded in individual records, or if urgent in the daily records. We spoke with three professionals associated with the service. They included healthcare workers and social workers. They told us they worked well with the manager and staff and felt their recommendations and instructions were listened to. One person told us they felt involved in any decisions about their relatives health needs. They told us, "They contacted me straight away when (the person) had a medical emergency".

We recommend that the service finds out more about training for staff, based on current good practice, in relation to the specialist needs of people with dementia.

Good

Is the service caring?

Our findings

Our observations indicated staff knew what people's likes and dislikes were. For example, one person was asked by a staff member if they would like their usual for breakfast. The person responded positively to this by laughing and saying "You always know what I like it's lovely". Another person told us, "The management are good. They do their utmost to help you as much as they can".

Where staff were assisting people to move from wheelchairs to lounge chairs we saw they took time to explain to the person what was happening. They were patient and spoke to them personally throughout which put them at ease. They completed tasks like this in a caring and compassionate way. To make sure people's privacy and dignity were being upheld staff closed doors for personal care tasks.

We observed staff talking with people in a light hearted and jovial way where they responded positively by laughing and smiling. In one instance two staff had used this approach to distract a possible altercation between two people. They told us, "We do this on a daily basis and it usually works. It's a good way of focusing resident's attention".

Staff were observed speaking with people with respect and they had a good knowledge of individual needs. One person told us, "The staff are very caring, they take their time with me". We observed a carer spending time with a person who was upset. They sat with them and spoke in a calm and reassuring way. The person responded positively to this approach.

Our observations showed that staff were very patient when dealing with people who repeatedly asked them the same question in a short space of time. We observed that one person appeared agitated. A member of staff demonstrated patience and understanding of the person's condition to diffuse the situation safely in a caring and compassionate way. This showed both concern for people's well-being whilst responding to their needs and an awareness of supporting people to remain independent whilst ensuring their safety. However staff said it was difficult to spend the additional time with people due to the staffing levels and meeting the presenting needs of people using the service.

Care plans were in place which included evidence of involvement from people being supported, their families or advocates. Some relatives told us they had been involved in the care planning and review of their relatives support plan. "Staff always explain any changes with me". Also, "I have been involved but it's lapsed a little lately". When we spoke with the deputy manager and some staff, they told us recent changes in staffing had resulted in some families not being involved in reviews however this was being addressed by delegating personal care plans to individual senior staff for review.

Care planning records were individual and took account of the person's likes and dislikes. There were personal profiles taking account of life history events. One person told us, "When we were putting my relatives plan together it was important to tell them what things were important to (the person), and the staff talk to (the person) about those things now which I think is wonderful".

Requires Improvement

Is the service responsive?

Our findings

There was no evidence of a programme of activities taking place. Staff told us, "Entertainers come in every few weeks. People enjoy that". Other people told us, "Nothing goes on, people are bored".

The majority of people living at Trengrouse had some form of dementia diagnosis. However there was no evidence of activities designed for people with dementia. Staff told us they had little time to engage in activities. Their understanding of appropriate activities for people living with dementia was limited. This meant people did not have the opportunity to take part in activities which might benefit them.

Staff were seen to complete care file records after lunch. They did this in lounge areas so there was a staff presence. However, there was no positive engagement between staff and people using the service during this time frame. We saw people sitting in chairs. Most were sleeping or dozing. Others were seen to be wandering around the lounge areas. Staff told us this was the only time they had to complete paperwork resulting in no time for activities.

A visitor told us they thought the staff provided good care but that there was little activity going on. There was evidence of a private agreement for a member of staff to provide additional one to one support for a person. This included looking at photographs and going for a walk. It would be expected this activity would be available to people as part of person centred care and support rather than as an additional individually purchased activity.

We found that the registered person had not ensured people had access to a range of activities suitable to meet their individual needs. This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 (3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed prior to them being admitted to the service. The information was then used to complete more detailed nursing and support plans which provided staff with information to deliver responsive care and support. We saw there had been changes made to the care planning and support records to reflect a more person centred approach. This is a method to plan personalised support. There was evidence that plans had been supported by contributions from the family as well as the person. For example efforts had been made to assist a person to engage in an interest they had prior to coming into a supportive environment.

People's involvement in reviews was not always taking place. A relative told us that they continued to be informed of any changes in their relatives care but there had been no formal reviews since July. Responsibility for reviews had been allocated to specific staff members who confirmed a revised review programme had begun. Records we saw confirmed this.

Handover time was allocated for nurses and protected time had been identified to ensure information was passed between the staff team. For example changes in a persons care plan for food supplements had been noted and responded to by staff as instructed during handover. Clinical needs including changes in pressure care were also discussed. The records we looked at demonstrated staff were being informed of changes where they were occurring.

Staff made the effort to speak with people and respond to their requests. For example, one person was visibly upset and a staff member sat with them and spoke sensitively until they were reassured. People who required assistance were responded to by courteous staff who informed them of what was happening. However we saw examples of staff saying they would respond to somebody soon but did not return. One person told us, "The wait (for staff) feels like a million years". Staff told us they did all they could to make sure they were responding to people's needs but that staff time was restricted to carry out basic care tasks. For example staff were still assisting people to get up until almost lunchtime. Staff said this was not unusual and impacted on their time to carry out other duties including personal care.

Relatives were aware of the services concerns and complaints procedures. They told us they had previously raised issues with the staff and manager. They told us they felt listened to and action had been taken to their satisfaction. For example one person told us, "I have no problem at all in telling them if I am not happy about something. It always gets sorted out. I have confidence in the manager and staff although there have been lots of changes recently they seem to be for the better".

Requires Improvement

Is the service well-led?

Our findings

There was a limited process to seek people's views in relation to the running of the service. People told us their views about the service had not been sought through surveys but that they could express what they thought by speaking with staff and managers. There were no systems in place to take account of the views of people living with dementia. Manager's told us the organisation was introducing a system which would capture views and opinions so the information could be used to develop the service. The revised system was not available to view.

We found that the registered person was not seeking the views of people using the service or persons acting on their behalf. This was a breach of Regulation 10(2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had attended previous resident and relative meetings but they were not regular. A service audit from April 2014 reported there had been no formal resident meetings although external quality group meetings were held every three months to inform relatives of information about the provider services. It reported relatives were invited by letter to these meetings. People told us they had not attended any of those meetings, but felt management and staff were available whenever they wanted to discuss any issues. Provider supporting information in the PIR told us, 'where possible we involve client's representatives/ advocates to be involved with the service to help drive improvement'. However there was no evidence to support this.

Quality audit processes and quality assurance tool's was an area the provider told us they were developing. The provider used its own in house audit tools to monitor the quality and performance of the service. We saw monthly audit reports were in place. In one instance an unannounced audit visit in July 2014 reported there was no manager, no deputy, no senior nurse, no administrator and no housekeeper on duty. Staff on duty did not know who the nurses on duty were and they had not received a handover. The service responded by providing a senior manager overview. Its findings reported at senior governance level, identified a need for additional staff and improved reporting methods to ensure the situation did not occur again. This inspection demonstrated staff shortages were continuing to have a negative impact on staff being able to respond to peoples' needs.

Staff understood their right to raise concerns using the provider's whistleblowing procedure and told us they would confidently report any concerns using the policy. Some people told us, "It's an open door here and I would not hesitate to report poor practice". However others said, "It's not really worth saying anything as nothing gets done". This showed there were some conflicting views in how staff felt about raising concerns or complaints.

Staff and management were consistent in what they said challenge the organisation. For example managers recognised the need for a more consistent staff team especially recruitment of nurses. Ensuring improved staffing levels was another key area of concern for all grades of staff. Staff were in general more positive about the way the service was running. Comments included, "We went through some difficult times but I feel we have turned the corner", "It hasn't been chaotic but hopefully there is light at the end of the tunnel". However, staff said increased staffing levels remained a concern to them and were needed to improve person centred care and support.

An incident management system was in place showing accident s and incidents were being monitored by the organisation to ensure any trends were identified. For example we saw action being taken following risk analysis of increased falls to introduce a 'pressure mat'. This is a piece of equipment to alert staff before a fall occurred.

Most people living at Trengrouse were living with dementia. There was no evidence of specific dementia care practice to engage more with the individual such as dementia care mapping. A process which enables staff to observe life through the eyes of the person with dementia.

We recommend that the service finds out more dementia assurance tools, based on current good practice, in relation to the specialist needs of people with dementia.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered person had not ensured there were always sufficient numbers of staff employed. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered provider was not ensuring staff were being appropriately supported. This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered person had not ensured people had access to a range of activities suitable to meet their individual needs. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person was not seeking the views of people using the service or persons acting on their behalf. This was a breach of Regulation 10(2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.