Tre' Care Group Limited

Trefula House

Inspection report

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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**

Summary of findings

Overall summary

We inspected Trefula House on 2,3 and 8 October 2018. The inspection was unannounced. At the last inspection, in July 2016, the service was rated Requires Improvement and we issued the service with two statutory requirements about the need to take suitable action when people lacked mental capacity, and treatment of skin damage due to wounds and pressure damage. At this inspection, although we found, overall, suitable action had been taken in these areas, the service was again rated as Requires Improvement due to concerns about the management of the medicines system, concerns about care planning, and quality assurance processes.

Trefula is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Trefula accommodates 44 people across two separate units, each of which have separate adapted facilities. One of the units specialises in providing care to people living with dementia. In the other unit people may also have dementia, but there was also a greater emphasis on nursing care for people who were physically unwell.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection we had some concerns about personal care and skin care for some people. As part of this inspection we liaised with the community tissue viability team. They said staff liaised well with them and they had no concerns about pressure relief and wound care. We assessed the care of people at risk of pressure damage. We had no concerns about care delivered by staff. Overall records demonstrated suitable care and treatment for people with these needs although there was still some inconsistency how these records were kept in respect of this aspect of care.

At the last inspection we also had some concerns about whether people's rights to consent to their care, and measures taken if people could not, were suitably managed within the boundaries of the Mental Capacity Act 2005. At this inspection we found people had a fully completed mental capacity assessment, and where necessary applications had been submitted to the local authority where the registered persons' had assessed a person lacked capacity. However, we did have concerns there was not suitable information to readily demonstrate any conditions of any authorisations to deprive someone of their liberty were being acted upon. Also, we had concerns that nursing staff within the care home were signing treatment escalation plans, which served to say people should not be resuscitated should this be medically necessary, and the person lacked capacity. These should have been signed by external professionals. Some people had behaviour which challenged the service. As a result these people sometimes required staff to use physical behaviour techniques to prevent them from harming themselves or others. Where this was necessary guidance, about individuals needing this support, was limited. For example, there was a

photocopy of what physical holds should be used but this was generic and not person centred.

People, and their representatives told us they were safe. For example, comments we received included: "There's just a nice safe feeling about the home." Suitable policies and procedures were in place to ensure people were protected if there were any allegations of abuse. Staff had received safeguarding training. Due to concerns about how two people were looked after we did put in two safeguarding referrals following this inspection.

The service had suitable policies and procedures about risk assessment to monitor any risks to people (such as poor nutrition and hydration, and falls) or others (such as aggression). Risk assessments were satisfactory, but the process of review was not always completed.

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

Staffing levels were adequate. Concerns were expressed to us about staff sickness levels particularly at the weekends which resulted in staff shortages if agency staff could not be provided. Although there was usually a registered mental nurse on duty, during part of each day, this was not always the case. People who used the service sometimes had a high level of need due to their mental health needs. We were assured by the registered manager suitable processes were in place to monitor staff sickness and take appropriate action to minimise excessive sickness levels. We have made a recommendation about staffing levels.

Staff induction processes were in place. However, we did have some concerns about the brevity of formal induction in place. Staff undertook a day's formal induction with a trainer. This covered an extensive number of areas. We were concerned if this was the only formal discussion which took place it may result in staff being overloaded, and not taking in appropriately required information. The registered manager said staff completed the Care Certificate if they previously did not have experience in the care sector. Staff told us they subsequently completed shifts with experienced staff. One member of staff we spoke to said this was over a two week period. There was no documentary evidence, in personnel files, to state when staff did undertake shadow shifts.

Staff were appropriately trained to carry out their jobs although there were some gaps in the receipt of some training received by some staff. There were limited records of staff supervision for staff members although there were always more senior staff on duty who care staff could approach if they needed help and advice.

We had concerns about some aspects of the medicines' system. For example, we found there was many instances where medicines had been signed for but remained in blister packs. No reason was provided on medicine administration records as to why these medicines had not been given. There were some medicines, within medicine cabinets, where there was excessive stock, and had not been returned to the pharmacist. There were concerns about administration records not being completed for the administration of creams and lotions.

The service was generally clean and hygienic, and staff received training about infection control. However, we did have some concerns about how the service minimised the risks of risk of infection. For example, how some rubbish and contaminated items were stored.

There were suitable pre admission assessment procedures, to check if people's needs could be met. Everyone had a care plan and these were regularly reviewed. We witnessed an assessment being completed. This was completed in one of the lounges, with private and confidential information being discussed, where

other staff, and people who used the service, were present.

People's care plans were not always up to date, and information within them was not always reflective of people's current needs. Care plan review was inconsistent. Some care plans were being reviewed on a monthly basis, whereas other care plans had either not been reviewed at all, or had not been reviewed for several months. Some people were considered to be at the end of their lives. The registered manager provided us of a list of people who were designated as requiring 'End of Life' care. This was not accurate and we found more people requiring end of life care. None of these people had a specific care plan outlining their specific needs or wishes about this stage of their lives. These people's care plans were also not reflective of their current needs.

People were happy with the food. The meal times we observed were pleasant and unrushed occasions. People had a choice of meals. Someone told us: "There is a good choice and you can always have something else if you let them know," and "The food is always lovely and hot." Some concerns were expressed about the presentation of soft and pureed diets. For example, some of the catering staff prepared these foods well whereas others presentation skills were less developed. There were some concerns that food and fluid charts were not being maintained correctly which meant that management were not able to satisfactorily monitor the food and drink consumption of more vulnerable people at the service.

There were good links with external professionals. People could access relevant external professionals such as GP's, community matrons, chiropodists, dentists and community psychiatric nurses. External professionals were positive about the care provided at the service. However, there were limited records in people's care plans about when people had last seen some medical professionals such as a dentist or an optician.

The building was suitable for the people who lived there. Most people could walk around the service, and had access to a garden having to ask staff to accompany them or access different areas. The building was satisfactorily maintained, warm and comfortable. However, some of the areas were looking a bit worn and in need of redecoration and renovation. We have made a recommendation about the suitability of the premises.

People, their relatives and external professionals thought the service was caring. Relatives said, "Some staff go above and beyond," "They are absolutely wonderful….there is a community or a family atmosphere," Care practice we observed was to a good standard. Staff did not rush people and were patient. People could see visitors when they wanted, and visitors said they felt welcome.

Some activities were on offer. For example, we were told staff organised ball games, painting, knitting and other activities. There were also various entertainers who visited the service. We saw a drumming session taking place which people participated in and appeared to enjoy. We were told a full time activities organiser was employed, but was currently on maternity leave. The registered manager said they had introduced a shift from 2pm to 7pm each day where the staff member was scheduled to assist with activities. However, we saw no evidence that staff members assisted people with activities, and very limited records of activities taking place.

The service had a complaints procedure. Records were kept of any complaints made. People and their relatives who we spoke with said they could talk to staff if they had any concerns. The people we spoke with said they felt if they had any concerns and complaints these would be appropriately responded to. However, one person's representative said they had been unhappy with the service and the slow response to the concerns they had raised.

There were mixed views about the management of the service. Staff told us management were as supportive as they could be but often seemed stretched and unable to provide much practical help. Some concerns were expressed by nursing staff about how a pay dispute had been resolved, and this had resulted in some of the nursing staff resigning from their posts. The dispute had left some staff feeling aggrieved by how they perceived they had been treated.

Several staff, and the registered manager said morale was low among the staff group. We were told some of the established staff, including senior carers, nurses and the deputy manager, had resigned from their posts and this had caused uncertainty. We were not informed of what action was planned to raise staff morale.

It was sometimes not clear about the accountability within the service. On a day to day basis there was always a nurse in charge of the dementia unit, and another nurse in charge of the general nursing unit. Although nurses were responsible for the supervision of shifts, and for completion of care records, the nurses we spoke with often did not think they were kept informed about some staff management issues such as sickness monitoring. When we discussed concerns about care planning, the registered manager was not aware of the issues of concern, for example that some care plans were not being completed or reviewed.

The service had a range of audit systems in place, for example to check the management of medicines, accidents and incidents, training, and peoples representatives were happy with the service. For example, an annual survey was completed, for which the published results were positive. However, we had concerns about the effectiveness of audit and quality assurance systems in place. This was because current systems had failed to identify the problems we found at this inspection, and ensure suitable action was taken to make necessary improvements. The Director of Operations of the registered provider told us there was a plan to improve systems in place.

We found breaches of regulations. 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?

Requires Improvement

The service was not safe.

Staffing levels were mostly satisfactory and people received prompt support if they needed help. We have made a recommendation about this.

Arrangements to minimise the risk of infection were not always satisfactory.

People did not always receive their prescribed medicines and accurate medicine records were not kept.

Is the service effective?

Requires Improvement

The service was not effective.

Records did not demonstrate suitable action was taken to meet people's needs if they were restricted in line with the Mental Capacity Act 2005.

People liked the food, had a choice of meals, and received suitable support at mealtimes. However pureed food was not always presented in an appetising way.

Staff training was mostly satisfactory, although training opportunities for nursing staff were limited. Induction processes were adequate.

Supervision and appraisal arrangements were not satisfactory because staff did not receive formal opportunity to discuss their work and receive formal feedback about their performance.

Suitable links were in place with external professionals, but care planning and records of medical interventions were not satisfactorily maintained.

The premises were not entirely suitable for people's needs.

We have made a recommendation about this

Is the service caring?

Good

The service was caring.

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

People's right to privacy and dignity were respected.

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

Is the service responsive?

Requires Improvement

The service was not responsive.

Although everyone had a care plan, these did not always accurately reflect people's current needs and were not always comprehensively reviewed.

Activities provision was not satisfactory and people did not always receive appropriate stimulation.

The service had a satisfactory complaints procedure.

Is the service well-led?

Requires Improvement

The service not well led.

Morale among staff was low and the registered persons' had not been effective in improving this.

The service did not have an effective quality assurance system, placing people at risk.

The service worked well with external healthcare professionals.

Trefula House

Detailed findings

Background to this inspection

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

This inspection took place on 2, 3 and 8 October 2018 and was unannounced. The inspection team consisted of a lead inspector. On the first day of the inspection there was a specialist advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience used had experience of caring for an elderly relative. The specialist advisor was a registered nurse and had experience of working with people with dementia.

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

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

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

Before, during and after the inspection we spoke with three people who used the service and communicated by email or telephone with seven relatives of people who used the service. We spoke with five staff. We also communicated with three external professionals including specialist nurses and GP's. We spoke with the registered manager, the director of operations, and two directors of the registered provider.

Requires Improvement

Is the service safe?

Our findings

Most people, their representatives and external professionals told us they felt safe. People told us, " There's just a nice safe feeling about the home." Relatives said, " My wife feels safe because the staff are so patient and understanding. "External professionals said, "The team at Trefula work hard to maintain safety."

The service had a satisfactory safeguarding adult's policy. The majority of staff had received training in safeguarding adults, although all staff were also provided with an overview of the key issues during their formal induction. Information was on notice boards about who could be contacted, and what action they should take if they had concerns about somebody being subject to abuse. Staff demonstrated they understood how to safeguard people against abuse. Staff told us they thought any allegations they reported would be fully investigated and satisfactory action taken to ensure people were safe. Where necessary the registered provider had submitted safeguarding referrals to the local authority, and good records were kept about any referrals which were made.

Risk assessments were in place for each person. For example, to prevent poor nutrition and hydration, skin integrity, falls and pressure sores. Risk assessments however were not being consistently reviewed monthly. Health and safety risk assessments were completed for all areas of the building, as well as tasks which may present a risk.

The registered manager said the majority of people who lived at the service did not have capacity. External doors and some of the internal doors (for example to access stairways) were locked, and could only be opened by using a code on a key pad. The registered manager described the building as a 'secure unit.' The registered manager and other staff said, where possible the service minimised restrictions where possible. For example, if people were physically and mentally able, they could walk around the building, spend time in their bedrooms and were encouraged to make a range of choices such as what to wear, what to eat and how to spend their time. Some people were funded to have one to one support so they were monitored closely. There was a secure garden area which people could safely use and this had a seating area.

The service had a whistleblowing policy if staff had concerns. We were concerned that one member of staff told us they did not have confidence in the process. This was because they had previously raised a concern with senior staff in the office. We were told that subsequently the member of staff they had complained about had allegedly been told by senior staff who had raised the complaint and this had made the person feel very vulnerable. The person was informed if they had further concerns they could raise these with the local authority or with the Care Quality Commission if they did not think their confidentiality would be maintained. The registered manager said staff had raised concerns about some colleagues inappropriately using mobile phones. This matter had subsequently been resolved through the organisation's disciplinary processes.

Where concerns had been expressed about the service, for example if complaints had been made, or there have been safeguarding investigations; the registered persons had carried out, or co-operated fully with investigations. Suitable action had been taken where there had been investigations, for example by

improving documentation, renewing equipment and improving facilities available to people.

Equipment owned or used by the registered provider, such as specialist chairs, adapted wheelchairs, hoists and stand aids, were suitably maintained. Systems were in place to ensure equipment was regularly serviced, and repaired as necessary.

Health and safety checks on the premises and other equipment were carried out appropriately. The boiler, gas appliances and water supply had been tested to ensure they were safe to use. Portable electrical appliances had been tested and were safe. A current gas safety certificate was in place. The electrical circuit had been tested and was deemed as 'satisfactory'. Appropriate systems were in place about the prevention of Legionnaires' disease.

There was a system of health and safety risk assessment in place. There were smoke detectors and fire extinguishers on each floor. Fire alarms, emergency lighting and fire extinguishers were checked by staff, the fire authority and external contractors, to ensure they worked. The service had a fire risk assessment.

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

There were enough staff on duty to meet people's needs. People told us, "There's always somebody around to help me if I need it." On the first day of the inspection, in both the nursing and the dementia services there were six care staff on duty in the morning. In the afternoon, evening and overnight, there were four staff on duty in each service. In addition to these staff, there was a registered nurse on duty, in both services, throughout the 24 hour period. At the time of the inspection the service received additional funding to support some people with one to one staffing. This was due to these people demonstrating behaviours which the service found challenging. The service also employed cleaning, kitchen, laundry, maintenance and administrative staff to help ensure the service ran effectively. The registered manager said a 2pm until 7pm duty was introduced, in both units, to assist with activities. The registered manager said agency staff were always used to cover shifts if there was absenteeism or vacancies. From the rota it was difficult to find out which staff worked on each unit. This was because there was one rota and it did not differentiate where staff worked. Staff said that a copy of the rota was only kept in the main office, and not in each of the units. This made it hard for them to know who was working and when they were next on shift. The main office was only staffed during office hours. A staff allocation sheet however was maintained in each unit, but this only detailed who was on shift for the specific day.

Some staff commented that staff sickness could be a problem, particularly at the weekends. For example we were told, "(Staffing at) weekends can be horrendous." Staff said agency staff were obtained to cover absence, but this was sometimes not possible at weekends or at short notice. One relative said at weekends it could seem that, "There is hardly anyone here."

A concern was raised that on the first floor of the nursing unit there could be limited staff. For example, we could not find a member of staff on several occasions. A relative expressed concerns that there, "Was not

always a member of staff up here," and when they visited there had been times when they "Had not seen anyone." The registered manager said there was always a member of staff allocated to work on the first floor, although at times they may have to assist someone to go downstairs. The registered manager said staff may also be behind closed doors assisting people with personal care.

We received comments from staff that insufficient action was being taken to resolve the problem of high absenteeism by some staff. We received similar concerns when we inspected the service in November 2017. This matter was discussed with the registered manager. We were told staff sickness was monitored. We were told when staff had been sick, back to work interviews were conducted. We were told following professional advice suitable action was taken to minimise excessive staff sickness. However, nurses we spoke with said they did not know if any action had been taken, or whether a 'back to work' interview process was in place. This was despite them being in charge of the day to day running of each of the units. We did not see any documentation of back to work interviews in personnel files we inspected.

The registered manager said staff on duty had a suitable mix of skills, experience and knowledge. However, we were concerned whether there were satisfactory numbers of mental health nurses on duty. This was a particular concern considering the significant mental health needs of people, particularly in the dementia unit, where some people could have very challenging needs. We assessed rotas for the period of one month. Rotas showed a mental health nurse was usually, but not always on shift during the day. Rotas showed there was seldom a mental health nurse on duty at night. We were told currently five mental health nurses were employed, although it was being prioritised that more were employed as part of the current nursing recruitment process.

We recommend the registered provider reviews current staffing levels to ensure there are always enough suitable qualified staff available to meet people's needs.

The service had a suitable recruitment procedure. Recruitment checks were in place and demonstrated that people employed had satisfactory skills and knowledge needed to care for people. Staff files contained appropriate checks, such as two references and a Disclosure and Barring Service (DBS) check number. No records were available however to confirm that staff did not have a criminal record, or police warning. The registered manager said a risk assessment would automatically be placed on the person's file if there had been any issues of concern. Information was provided, after the inspection, to confirm registered nurses were considered by the Nurses and Midwifery Council, the professions regulator, as fit to practice as nurses.

The registered provider has a suitable policy regarding the operation of the medicines system. Nurses and the registered manager were responsible for the administration of medicines, and had received training from a pharmacist about the administration of medicines. Suitable medicine administration records were kept. We were concerned that there were at least 15 instances where medicines were signed for but they remained in the blister pack. This included medicines for pain relief, mental health issues, Parkinson's Disease, and urinary tract infection. We also found excessive stock of some medicines. This included inhalers which were dispensed in January 2017, and were marked as not appropriate to use after October 2017. Systems about the storage of creams, eye and ear ointments were satisfactory. Charts were in place to confirm prescribed creams and ointments were applied. However, the forms were not being completed on a daily basis. For one person there was no completed record since July 2018.

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

At the time of the inspection nobody was self-administered their own medicines. Suitable systems were in

place for medicines which required additional security. The service had systems in place to order medicines and ensure they were stored securely in locked, purpose built cabinets. There were occasions where some people needed to have their medicines administered covertly (disguised in food or drink). Medicines which required additional security were stored appropriately and suitable records were kept. Similarly medicines which required refrigeration were stored appropriately, and refrigerator temperatures were monitored. The service had appropriate procedures about this. These medicines were only ever given this way with the authorisation of external medical professionals. There were records that medicine audits had been completed. For example, the last one was completed covering August to early September 2018.

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

The service had a suitable infection control policy. However, we were concerned the door to the sluice room was unlocked all day. This meant that people could enter the room if they were not being supervised. This matter was also reported on at our previous inspection. Cleaning staff were and had clear routines to follow. Staff received suitable training about infection control practices. and staff understood when it was necessary to wear protective clothing such as aprons and gloves. However, plastic aprons and gloves were left in corridors. Due to the needs of the people at the service this could present a choking risk if people tried to ingest these items (which was a possibility due to the level of confusion that some people had.) Similarly toiletries were left by wash hand basins in people's bedrooms. These could also present a health risk to people if they ingested them. In the laundry there was a bucket with powder in next to the washing machine which we were informed was washing powder. The COSHH file was not available (this should give detail of actions staff should take if someone ingested any specific cleaning or laundry product.) There was no visible instruction how to use the washing machine for example what temperature to wash any of the laundry at. A dirty bowl had been left in one of the baths. In one of the sluice rooms there were no peddle bins and just a black bag. We saw that a yellow peddle bin in another bathroom did not work and had to be opened by hand. These matters constituted infection control risks.

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

Suitable procedures were in place to ensure food preparation and storage meets national guidance. Catering staff had received suitable training. The local authority environmental health department has judged standards has to a high standard.

The registered manager said the team tried to learn from things which went wrong. For example, since the last inspection, the registered manager said the team approach to working with people with wounds or pressure damage had improved significantly. The registered manager said photos were always taken of wounds. Referrals were promptly made to the tissue viability team when this was necessary. Records we looked at, during this inspection, showed however what the registered manager told us was not always applied in practice. The registered manager said there were regular meetings with the tissue viability nurse. We contacted the tissue viability team and they said they had no concerns about this aspect of care at the service.

The service did not keep monies or valuables on behalf of people. When people needed to purchase items such as for toiletries and hairdressing items the person's representatives were invoiced for any expenditure. Records of invoices were kept at the registered provider's office. Where necessary the registered manager said she would provide families with receipts and invoices for any expenditure. The registered persons did not act as appointee for any people who used the service, and staff did not have any access to people's financial accounts. No personal possessions had been reported missing by any of the people we spoke with.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we had some concerns about personal care and skin care for some people. We assessed the care of some people at risk of pressure damage. We had less concern about care delivered by staff, and records generally demonstrated suitable care and treatment for people with these needs. As part of this inspection we liaised with the community tissue viability team. They said staff liaised well with them and they had no concerns about pressure relief and wound care.

However, we did have a concern about one person. Staff made a referral for the person to the tissue viability team due to a pressure wound on their buttock. However, the change in need, and what care the person required was not reflected in the person's care plan, for example the need to regularly turn the person. Care notes stated photos were taken of the pressure damage but these were not on the person's file. There was however a record the person was actually being repositioned by staff. We saw for another person that they had an airwave mattress on their bed (to assist in minimising the risk of pressure damage), However, the pump was against the wall so staff would not be able to see or check that the setting was correct.

This contributes to a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the last inspection we also had some concerns about whether people's rights to consent to their care, and measures taken if people could not, were suitably managed within the boundaries of the Mental Capacity Act 2005.

At this inspection we found people had a fully completed mental capacity assessment, and where necessary applications had been submitted to the local authority where the registered persons' had assessed a person lacked capacity. Where necessary there was evidence that 'best interest' meetings had occurred when a person lacked capacity to make decisions for themselves. The registered manager said none of the people using the service had mental capacity. She said DoLS applications had been submitted for everyone at the service.

We did have concerns there was not suitable information to readily demonstrate conditions of authorisations to deprive someone of their liberty were being acted upon. For example, when the service

was authorised to lawfully restrict someone's liberty, there can be conditions applied and the service have an obligation by law to meet these conditions, for example someone must have activities arranged for them, the usage of any restrictions must be regularly reviewed and so on. When we requested information about which people had conditions applied to their DoLS authorisations, the registered manager said there were, "Very few." Although we were given the names of two people, we found there were at least another three people who had conditions applied. One of the nurses, who we spoke with, who was in charge of one to the two units, informed us that none of the people at the service had conditions on their Deprivation of Safeguard authorisations. This raised concern as both the nurse and the registered manager had key responsibilities for ensuring any legal conditions were adhered to. This evidenced a clear risk that any conditions would not be met as a senior staff member was unaware some people had DoLS authorisations.

We were concerned that the records we saw did not easily demonstrate that the conditions applied were being acted upon. For example, one person was meant to go out each day but there was nothing in their care records to show this was happening. We discussed this with the registered manager and we were told the person was not able to go for walks anymore due to their mental health needs. This however was not outlined in the person's care plan, and the care plan stated the person should go out twice a day. Another person also had a condition which stated they should have regular activities. An activities profile had been created, which outlined what the person enjoyed doing. However, there was limited evidence in records we saw, to confirm the person was provided with regular opportunities to participate in activities, or a record if any offers were refused. For example, for the limited number of occurrences which were noted, the duration of activities was recorded as between five and thirty minutes a day. These activities included throwing a ball, chatting, looking at a book, colouring or reading a poetry book. There were other examples of conditions which were put in place for individuals but care plans did not demonstrate how, and whether they were being met.

We asked the nurse in charge of the dementia unit about where we could find information about how conditions as part of DoLS authorisations were being met. The nurse in charge said this information was kept in the registered manager's office. However, when this was discussed with the registered manager we were told the information was kept in people's care files as part of the care plan In the unit. Although care plans were in place there was unsatisfactory information to confirm conditions had been met. The absence of knowledge in relation to the location of people's DoLS authorisations further evidenced the poor management of the DoLS authorisations.

We were concerned about the completing of treatment escalation plans. These forms outlined whether the person had capacity or did not have capacity. When the person did not have capacity, we were told the service consulted with people's representatives about whether they should be resuscitated in an emergency. Two signatures were required from medical professionals to authorise the decision. We were concerned that there were some cases where there was just one signature for example from a GP, and several others where a nurse at the service had acted as the signatory. The signatory should be from external medical professionals. This evidenced a risk that emergency treatment may be administered against the person's wishes or of those lawfully acting on their behalf.

Some people had behaviour which challenged the service. As a result, these people sometimes required staff to use physical behaviour techniques to prevent them from harming themselves or others. Necessary guidance, about individuals needing this support, was limited. For example, there was a photocopy of what physical holds should be used. However, guidance was generic and not person centred. For example, there was limited information about what actions staff took, for that person, to de-escalate a situation and minimise or negate the need for physical intervention, and how staff tailored any holds to the person for example to minimise distress and injury. This could put both people and staff at risk if techniques used were

not appropriate, not consistently applied and/or not regularly reviewed

This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, and also contributes to the breach in regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Records showed most staff had received training about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff also received some basic information about these issues during their initial induction session.

The service had suitable processes to holistically assess people's needs and choices. Before moving into the home the registered manager told us they went out to assess people to check the service could meet the person's needs. People, and/or their relatives, were also able to visit the service before admission. Copies of pre-admission assessments on people's files were comprehensive. We were concerned that we witnessed, as part of an initial enquiry by a family, an assessment completed with relatives in one of the communal lounges. Private and confidential information was discussed in an area where both people who used the service and staff were coming and going. The inappropriateness of this was discussed with the registered manager

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

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

Overall, staff had appropriate skills, knowledge and experience to deliver effective care and support, although as outlined earlier we did outline our concerns about the lack of registered mental health nurses on some shifts and have made a recommendation in the safe section of this report.

Staff received an induction. This included a one day session with a trainer which covered a wide range of issues such as an introduction to the company, and an overview of important matters such as safeguarding, fire prevention, infection control, and principles of care. However, we did have some concerns about the brevity of formal induction in place. We were concerned if this was the only formal discussion which took place it may result in staff being overloaded with information, and not having the necessary time to take in required information. We did understand staff were subsequently required to complete full courses on the subjects discussed, but there could be a gap between the induction and the training of up to several months.

The registered manager said staff completed the Care Certificate if they previously did not have experience in the care sector. The Care Certificate is an identified set of national standards that health and social care workers should follow when starting work in care. Staff told us they subsequently completed shifts with experienced staff. One member of staff we spoke to said this was over a two week period. There was no documentary evidence, in personnel files, to state when staff had undertaken shadow shifts. There was however a record that staff had completed an induction on all files.

Records showed staff received relevant training which enabled them to carry out their roles. For example,

files inspected showed care staff had a record of receiving training about techniques to manage behaviour which challenged the service. The majority of staff had received training about first aid, fire safety, infection control, moving and handling, safeguarding and dementia awareness. There were some gaps in receipt of training which were discussed with management. The majority of staff, where there was no evidence of training, had started working at the service in the last six months. However, there was no evidence a minority of established staff had received training in food handling, safeguarding and dementia.

Nursing staff had received training about anaphylaxis, buccal midazolam (administration of medicine for people with epilepsy), catheterisation, flu vaccination, and first aid. However, some of the nurses we spoke with said, apart from training about syringe drivers, they had not received any specialist nursing training recently.

A member of staff said training was "Brilliant, (the trainer) makes things enjoyable" and (we are) "provided with regular updates." An external professional said, "I feel the skill mix is outstanding. I have been very impressed and talking to the trainers the training feels very organized."

Staff told us they felt they could go to a senior member of staff if they had any concerns or needed any help. There was always a senior member of staff on duty to provide day to day supervision for staff members. There were some records of individual formal supervision with a manager. Supervision is a process where members of staff sit down with a supervisor to discuss their performance, any goals for the future, and training and development needs. However, evidence whether staff members had received supervision, its frequency, and if staff had received it recently varied considerably according to records inspected. There was evidence in only three of the staff files we inspected that these people had received any formal supervision in 2018. Staff we spoke with said they had not received supervision, for example one staff member said, "I have not had supervision for two years." There was also no evidence staff had received an annual appraisal.

It is recommended that the registered persons ensure staff receive regular, one to one formal supervision, and an annual appraisal. The registered persons should also have a system to ensure the system is operating effectively.

The service had a four week rolling food menu. At lunchtime people had two choices of meal. People were not involved in developing the menu. The cook told us if people did not like what was on the menu people were always offered an additional choice of meal. In the evening people were offered sandwiches or a hot snack such as soup, eggs or quiche. Currently there were no people who used the service who had specific cultural or religious preferences about the food they ate. The service had some people who were vegetarian who the service catered for. Some people required 'soft' or pureed meals. The different parts of the meal were pureed separately. There were some comments that some of the cooks' presentation of these meals were better than others. We discussed with the registered manager about whether suitable training and guidance could be given to ensure presentation of meals was consistent whoever prepared them.

Meals were appropriately spaced and flexible to meet people's needs. For example, people could have their breakfasts in their bedrooms. All meals we saw looked appetizing.

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

We continued to have concerns about records kept for people who were monitored about what they ate and drank. Everyone had a food and fluid chart but these were not always completed regularly. There was no

process of staff deciding who needed to have these aspects of their lives monitored, and ensuring the monitoring was subsequently done well. The matter was discussed with the registered manager who said this matter would be addressed.

One relative said they worried that if they did not come to assist the person they cared for, staff would not feed the person correctly. This was because the assistance took "up to an hour," and the relative thought staff did not have this amount of time to assist one individual. This was an example of a person who did need suitable monitoring so management could check the person was being supported correctly, and suitable staffing could be provided accordingly.

We observed the support people received during one lunchtime. People chose to eat in the lounge areas or in their bedrooms. The meals were served from a hot trolley and covered to reduce cross contamination. The menu consisted of either Chicken Casserole or Steak and Kidney Pie with mashed potatoes and vegetables. The food was well presented, hot and looked appetising. Dessert was rice pudding or yogurt. Some people were seen to be helped by staff members to eat their meal in a dignified manner. Staff mixed with people while they were helping them to have their meals. Staff appeared caring and supportive. People appeared to enjoy their meals. The occasion was unrushed and appeared pleasant. However, we were concerned that none of the people in one of the communal lounges was asked if they would like to eat at a table and their food was served to them at individual tables over their armchairs. There were very limited facilities for people to be able to sit at a table. Comments about meals were mostly positive and included; "The food is average," There's always a good choice and you can always have something else if you let them know," "The food is always lovely and hot," " My wife eats everything they put in front of her," "Our sister eats really well, the meals look lovely," "I can have a meal with my relative as well if I want."

The registered manager said the service had good links with external professionals. The registered manager said the service had strong links with the elderly ward at the psychiatric hospital where many of the people who lived at the service came from. The home was also part of a wider group of services, and people came also to live at the service from the provider's other locations, for example if a person's needs could no longer be met at these services. The service worked closely with a wide range of professionals such as community psychiatric nurses, social workers, dementia liaison nurses, community matrons, dentist, opticians and general practitioners to ensure people lived comfortably at the service. An external professional said, "When we have had communication issues Trefula are willing to meet and consider collaborative problem solving methods. We have no concerns."

Records about consultations with GP's, and external mental health services were mostly good. However, we were very concerned about one incident when staff allegedly failed to follow GP advice appropriately. The GP had allegedly said to staff that a person, who was very ill, should stay in bed, and the person was happy to do so. The GP had also informed staff the person required palliative care. However, on one occasion night staff assisted the person to get up and the person was placed in the lounge. The person's representative complained about the matter to senior staff and the person was assisted appropriately back to bed. We were also concerned that records did not state the GPs directions and that these were clearly not communicated appropriately to staff. The care plan had also not been rewritten to reflect the person's palliative care needs. CQC made a safeguarding referral about this matter following the inspection.

Records about support received from chiropodists, opticians, dentists were poor. From reading care plans it was not possible to check what individuals' needs were in these areas, whether they needed external support from these professionals, and if so, how these needs were met. It was difficult to check when people last saw these professionals.

This is a a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010

The service was situated in a large building divided into two parts; a service which focused on the needs of people with severe dementia, and a service which provided care for people with dementia but also physical nursing care needs. Both services had suitable communal lounges. People could walk around the building as long as they were physically and mentally able to do so. External doors were locked. There were several outdoor areas which people could use, including one in the centre of the building which people could use unsupervised. Nurses offices were not locked which could present a risk to people using the service and could present a risk that unauthorized persons could access confidential information.

The buildings decorations were or beginning to look worn. For example, some of the stairways and corridors particularly in the physical nursing unit looked tatty on some of the carpets on staircases. The registered manager said there were plans to redecorate the dementia unit. Access for people with physical disabilities was satisfactory.. The dementia unit was on one floor. Although access was possible, wheel chair access was more challenging in the nursing unit, in the older part of the building. There was a small lift to the first floor of the nursing unit. The layout of the building could be quite confusing and there was limited signage. Bathroom doors were generally painted yellow, the muted colours of doors throughout the building made it challenging for someone with visual or cognitive impairments to find their way around.

We recommend the service seek advice and guidance from a reputable source, about interior design and signage to assist people with dementia.

Good

Is the service caring?

Our findings

We received positive comments about the attitudes of staff. People and their relatives said people were treated with kindness, respect and compassion. People told us, " The staff are so relaxed and calm," "Some of the staff are absolutely brilliant, " and "The staff are very loving and caring."
Relatives said, "The staff are one big smile," "The staff are very pleasant, you can ask them to do anything," and "The care from the home has given me my dad back." Care staff told us; "Care is pretty good," and "I love being here." External professionals told us, "Staff are warm and friendly and will go out of their way," "All families are happy with their loved one's care at Trefula…. Families have fed back outstanding reports to myself and have shown they have built close relationships with staff at the home," and "Nursing staff are pleasant professional, kind, caring and knowledgeable. Care assistants are lovely kind and caring. There is a feeling that every member of staff cares about the patients."

We observed staff sitting and talking with people in lounges in a respectful and friendly manner. We observed staff in the communal areas, throughout the day, being caring and maintaining people's dignity. Staff did not rush people and took time to listen to them. Staff appeared friendly.

However, we were concerned about some of the 'one to one' support. This was required when people were either at risk of injuring themselves or others. Some staff clearly made effort to discuss or encourage the person to take part in an activity such as reading or completing a jigsaw. However, other staff just sat with the person and there was limited or no verbal communication. Some staff only spoke to the person in response to any questions, or addressed other staff or visitors in the room. Records for some of these people only commented on their behaviour, and not on any other needs or activity.

We observed staff safely using hoisting equipment; for example, when moving people from wheelchairs to more comfortable furnishings. This was carried out according to best practice. Staff talked through with the person what they were doing, and carried out the manoeuvre slowly and carefully. Individuals were provided with their own slings for safety and hygiene purposes.

People and their relatives said staff responded to people quickly if they needed help for example, if people called or pressed the call bell. We did not see any examples where people were kept waiting or staff did not respond appropriately for assistance.

Records were stored securely in the main office or nursing offices. We had concerns about care records not being up to date and not complete and these are outlined later in the report. All care staff had access to care records. The registered manager said there was a plan to introduce an electronic care planning system in 2019. There was information about people's lives in all care plans which we read. This information was either provided, in the form of a life story book, by the hospital (if people had been inpatients before moving to the service), or by the service.

People were encouraged to make decisions about their care, for example what they wished to wear, what they wanted to eat and how they wanted to spend their time. Where possible staff involved people in care

planning and review. However, due to people's capacity involvement was often limited, and consultation could only occur with people's representatives such as their relatives. The registered manager said one person had an advocate.

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

People were generally happy with the laundry service. However, one relative complained that some clothing such as blouses had been returned to the persons room, and stuffed in the persons underwear drawer.

The relatives we spoke with said they could visit the service at any time. The registered manager said if possible relatives were asked not to visit at meal times but otherwise visiting times were open.

Requires Improvement

Is the service responsive?

Our findings

Everyone who used the service had a care plan. The registered manager said only a small minority of people were consulted about drawing up and reviewing their care plans due to people's mental health needs. The registered manager said where possible people's representatives were consulted.

Care plans we read were detailed. They included information about people's physical and mental health care needs. Care plans included risk assessments, for example in relation to people's mobility, eating and drinking. Care plans were written in the first person and where possible outlined people's preferences, interests and aspirations. All staff were able to access people's care plans which were stored in either of the two nursing offices.

The management of care planning was organised by each registered nurse. There was a key worker system but this currently was not working. This was due to a number of nurses having resigned from the service. We were told that a 'resident of the day' system had been introduced where whichever nurse on duty reviewed various aspects of an individual's care. However, nurses we spoke with said they often did not get time to complete this aspect of their work as they needed to prioritise the hands on nursing care provision of the people who used the service.

We were very concerned that many of the care plans we inspected were not up to date and we found the review of care plans was erratic. For example, separate care plans for one person were last reviewed either in July or September 2018, a second person's care plans were last reviewed either in February 2018 and September 2018, and a third person had no record of review since July 2018. Other care plans we read were last reviewed in either August or September 2018.

Some care plans did not reflect current people's needs. For example, one person now spent the majority of their time in their bed due to their changing physical care needs. The care plan for this person reflected a person who was more active and well. Another care plan had sections which had not been completed. We noted in the previous inspection report that some aspects of care plans had not been completed.

We were told some care records were kept in people's bedrooms. However, we were told that nurses only reviewed these on a monthly basis unless there was a particular concern, which then should be brought up at the staff handover. This was a concern as unless nursing staff were informed about a specific issue there appeared a significant risk that they were not informed about a concern, or they were not actively monitoring, on a day to day basis, that important personal care activities were being completed.

Every person had a food and a fluid chart, although all of the ones we reviewed were not completed effectively. For example, boxes were not ticked to state if people required 'normal or 'thickened' fluids, or the type of diet the person was on. Only one of the charts reviewed had an amount of fluids, drank by the person, during the night. It appeared, according to fluid charts, that most people had not been offered or given fluids between 8pm and 7am, and some people had longer gaps of between 11 and 16 hours when no record was kept. On one food and fluid chart it stated, 'No Cheese' had been highlighted, but on other charts

for the same person, this information had been omitted. We saw some people in their rooms, who were in bed, or in a chair, who had drinks readily accessible to them, whereas other people did not. In respect of the latter group it was not clear how they could access fluids or how often staff assisted them to drink. This did not evidence that the service ensured people's care plans were designed with a view to ensuring their needs were met.

Although people all looked clean and well dressed, records of when people were bathed, had their hair washed, or went to toilet were at times limited. For example, one person had a record that they had last had their hair washed in mid August. It was not clear whether this reflected the lack of personal care provided (although this did not appear to be corroborated by how people looked), or poor record keeping. Some people found it difficult to speak for themselves, and/ or they were physically or mentally very unwell. It is therefore important such records were maintained as a means of communication between staff for when people required appropriate help and assistance.

This contributed to a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010

We read the care plans for three people who the registered manager informed us were assessed as requiring 'End of Life' care. Despite the registered manager informing us that "Everybody would," have a current End of Life care plan, we found the three people who we were informed required palliative care did not have one. End of life care plans should outline what people's wishes were when they required palliative care, and specific personal and nursing care needs. Palliative care needs were not integrated into other care plans, for example about pain relief, or spiritual needs. Care plan reviews described people's physical deterioration, but where necessary the care plan itself had not been rewritten as should occur when someone's needs fundamentally change. In respect of one person, GP advice about their care was not recorded in full and was not followed by staff. The person's care plan said they had been very active in their local church when they were well, and had a 'strong faith.'

There was no evidence the service had made contact with the church to state they were very ill and not expected to live. There was a record that in early August 2018, the person had 'screamed in pain,' and according to notes their pain relief was later changed 'due to family concern.' The person's care plan did not reflect this. However, records showed that currently prescribed pain patches were being regularly changed to minimise discomfort. In mid August 2018, a referral was also made to the external tissue viability nurse. However, the person's 'Skin Integrity' care plan was last reviewed in July 2018 and did not reflect current needs. The absence of the creation of an end of life care plan presented a risk people would not receive a dignified death in line with preferences.

This contributed to a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010

We were concerned about the provision of activities at the service. We were told there was an activities organiser but they were on maternity leave. At the last inspection in November 2017, there was a full time and a part time (16 hours) activities organiser. We were not informed about cover arrangements for the activities organiser who was on maternity leave, and there did not appear to be any.

The registered manager said some activities were completed by staff members. These included ball games, competing jigsaws, painting, knitting, looking at the newspaper and bouncing balloons. We were told there was a 'breakfast club,' and a 'gardening club.'

There was a discrepancy about who was responsible for activities. The registered manager said that they had introduced a 2pm-7pm shift on each day to provide activities. We spoke to one of the registered nurses, who was in charge of one of the units about the provision of activities, and asked what activities were planned for that day. The nurse told us no staff were completing activities, and management were trying to "Sort it (staffing for activities) out." The rotas we were provided with did show there some 2pm-7pm shifts allocated. However, there was nothing in the services' diaries, allocation or handover sheets what was organised, or what one to one activities took place during these periods. During the periods of time we spent sitting in lounges, in both units, on the first two days of the inspection, we did not see staff organising any activities for people either on a one to one basis or in groups.

However, there were some activities organised using external entertainers. This included a drumming session which we saw on the first day of the inspection. The activity facilitator got people involved in drumming, and people appeared to enjoy the activity. One person told us, "I enjoy the music people that visit so I can play the drums." There was also a calendar which outlined sixteen activities were scheduled during the month of October 2018. These included massage (five sessions), a breakfast group run by staff (3 sessions), singers (5 sessions), a tea dance (1 session) a drum group (1 session), and a church group (1 session). Other months showed some variety of activities offered, for example a visit from farm animals, a coffee group, baking sessions and craft sessions. The service did not have any transportation, such as a minibus, which limited opportunities for people to go out.

The registered manager said the library currently did not visit as people were not interested or unable to read books. People could order newspapers and magazines if they wanted. The registered manager said they downloaded a periodical, on a weekly basis, for people with dementia called 'Daily Chat,' which staff could use with people as a means to stimulate discussion about current news and historical events.

When we spent time in the lounges, for a lot of the time there was no music, radio, or TV. It was not clear if it was people's choice whether music or TV was switched off or on. On one occasion a staff member put on the radio, but this was turned off when the telephone rang, and was not put on again. One of the lounges in the dementia unit did not have a television. The television was on in the other lounge but the volume was too low for anyone to hear, and there were no subtitles.

A member of staff said, "Activities are non existent. We cannot spend a lot of time with them (people who used the service). "

Overall we judged activity provision was insufficient. This was because throughout the inspection there were significant periods of time when people did not appear to get any stimulation from activities, and records did not demonstrate what we saw was an aberration from general practice at the service.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010

The service had a complaints procedure. This was part of the service's user guide, which was issued to people when they moved in. Most people and their relatives, who we spoke with, said if they had any concerns or complaints, they felt they could discuss these with staff and managers without fear of discrimination. They felt any concerns and complaints would be responded to appropriately. However, one representative said they had "Lost faith," in the home at trying to sort out problems. We were concerned that communications with this complainant were poor, and it was only after CQC became involved that suitable action was taken to ensure matters of concerned were addressed. The service had a record of any complaints made, and a record of how these had been responded to. An external professional said "Management are responsive and quickly try to resolve any concerns." Since the last inspection some

anonymous complaints about the service have been made directly to CQC. These were referred to the provider and responses were received to the concerns raised.

Requires Improvement

Is the service well-led?

Our findings

We received positive comments about the registered manager. For example relatives told us, "She is as good as gold," and "You can talk to her." An external professional said, "Management are approachable and sympathetic."

The registered manager said morale had been low at the service over the last few months. The registered manager said it is "Not a good situation at the moment." They said there had been a dispute about nurses pay which had resulted in several nurses leaving, and some of the remaining nurses feeling upset, and "very angry," about how they perceived they had been treated. The registered manager said they had not felt supported, and their previous manager had not visited the service, and assisted her, as she felt would have been appropriate. The registered manager said as a consequence the situation had "Knocked me for six." The registered manager said there had been "Poor communication," with the general manager, for example the general manager had "Not passed on concerns to the owners", about staff morale and issues how the service was running. We were very concerned about the deterioration in the standards of service as has been illustrated in this report. Although the registered manager was able to describe the service had some significant problems, they did not appear to have a plan for improving the current situation.

Care staff also raised concerns about the culture at the service at the moment. One member of staff said, "Care has gone downhill. Clients have been left soaking wet, and personal care not done properly. Some staff are here just for the money, and others are here because they care," and "Morale is low…I don't know why…;there is a lot of backbiting…nobody seems to be happy. Everybody is miserable." Another member of staff said, "There are some wonderful carers who go over and above. But we can be short on the floor due to sickness. I am not sure how sustainable it is in the longer term." We received two comments from different staff that "Management don't listen." There seemed a particular concern when staff said they would be best suited due to their skills and experience, in one or other of the units, but management wanted to ensure staff rotated so they could work anywhere in the service. The matter was discussed with management so they could give consideration to the idea of increasing the core group of staff based in each unit, while also ensuring staff were flexible to work in both units as needs arose.

The service had a clearly defined management structure. The registered manager reported to a director of operations who oversaw the group of three services on behalf of the registered provider. The director of operations was new in post and had worked for the organisation for less than a month. The registered manager had a deputy manager. However, we were informed, during the inspection, the deputy manager had resigned. We were informed the registered provider was actively seeking a replacement. This person would also act as the clinical lead for the service, as the registered manager was not a registered nurse. After the inspection, at our request, the nominated individual informed us of interim arrangements, for who would act as the clinical lead, until a new deputy manager was appointed. There were always two nurses on duty, one in each unit of the service. Senior care assistants were always on duty throughout the 24 hour period, and assisted with the day to day supervision of care and ancillary staff.

There were handovers between shifts so information about people's care could be shared, and consistency

of care practice could be maintained. Handover sheets outlined a summary of staff observations about each person on the previous shift. However, handover and staff allocation sheets did not outline duties which staff needed to perform on the forthcoming shift, and we did not see any documentary evidence how shifts were planned. The diary only outlined if people had appointments.

External professionals were positive about the management of the service. Comments received included, "Communication is good and staff are friendly and helpful," "Care has remained to a high standard and they are consistent in their approach to care. The management team are strong and organised which enables the home to have a very organised feel." Another professional said, "Trefula is well run and responsive."

The registered persons had ensured all relevant legal requirements, including registration, safety and public health related obligations, and the submission of notifications had been complied with. The previous rating issued by CQC was not prominently displayed as is now required by the regulations. The registered persons said they would ensure the rating of the service was displayed.

The registered provider had a quality assurance policy. The service's approach to quality assurance included completion of an annual survey. The results of the most recent survey had been positive. There was a system of audits to ensure quality in all areas of the service was checked, maintained, and where necessary improved. We were told audits completed included bedroom checks, maintenance checks, monitoring care plans were to a good standard and regularly reviewed; monitoring accidents and incidents; auditing the medicines system, and checking property standards were to a good standard. We did see evidence of some of these systems in place. However we were concerned about standards how the care planning system was operating and also how the medicines system was operating; therefore we have concerns about the effectiveness of quality assurance systems in place. In respect of care planning it was concerning that care plans did not always reflect people's current needs, and review was inconsistent. This was a significant concern due to the vulnerability of people who lived at Trefula. People could not always communicate their needs, and staff were dependent on written information to ensure people received good and consistent care. The evidence collated during the inspection shows current systems are ineffective and are placing people at the service at risk of unsafe or inappropriate care or treatment.

The registered manager said the previous general manager had not visited the service, "for many months," which raised concerns to us about how the registered provider had ensured the service had been monitored, and what governance arrangements were in place if the general manager had not been doing their job correctly. The absence of oversight by the provider did not evidence effective systems were operated to monitor the health, safety and welfare of people using the service.

As a consequence of our concerns we have requested the registered provider send us a monthly action plan to evidence improvements made since this inspection.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

The registered manager said they thought it was important to, "Ask, talk, and be open with staff. They said she would "Walk around, a minimum of twice a day," to check standards and monitor the service was running smoothly. There were regular staff meetings, and meetings with relatives took place.

The registered manager said she though relationships with other agencies were positive. Where appropriate the registered manager said they ensured suitable information, for example about safeguarding matters, was shared with relevant agencies.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed appropriately. Infection control prevention measures were not sufficient

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance arrangements were not satisfactory. For example care plans were not up to date, did not always reflect people's current needs, and were not always being regularly reviewed. Audit and quality assurance systems were not satisfactory to bring about suitable improvements to the service and placed people at risk of receiving unsafe or inappropriate care or treatment..

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Care records and care plans did not always outline people's current needs. There was insufficient evidence that some care plans were satisfactorily reviewed. Activity provision was not satisfactory. Arrangements to ensure appropriate end of life care were not satisfactory

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Records to outline how care was provided, when people were subject to restrictions under the Mental Capacity Act (2005) were not always sufficient.

The enforcement action we took:

Warning notice issued