Quantum Care Limited

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

Summary of findings

Overall summary

We inspected this service in March 2016 and rated the home as Good. When we inspected the service on 14 and 15 February 2018 we rated the service as Requires improvement overall. This is the first time Trefoil House has been rated as Requires Improvement. This inspection was unannounced.

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.

Trefoil House provides personal care and accommodation for older people. Many people living at the home were living with some form of dementia. Trefoil House is registered to provide care for up to 70 adults. At the time of this inspection 60 people were living at the home. Trefoil House comprises of a building offering accommodation over two floors.

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

We found some issues relating to fire safety when we visited the home. The fire service had visited eleven months ago. They had advised the provider and the registered manager that the home was not fully legally compliant. No action was taken to rectify this issue until we identified this issue on our visit.

Staff recruitment checks were not fully completed. This is important to ensure people are safe among new staff. A safeguarding event had occurred and the correct process to ensure people's safety had not been followed. This situation had not been reviewed to ensure lessons were learnt and this situation was not repeated in the future.

We identified and observed shortfalls in staff practice in relation to always treating people with respect and in protecting people's private information in the home. There were times when staff did not respond to people's needs in a person centred way. Staff's knowledge in certain important areas was not complete. There was a lack of sufficient competency checks to monitor staff knowledge and practice was effective.

There was either insufficient staff or a poor deployment of staff, to enable staff to spend time with people in a social way, chatting, and engaging with people. This is an important part of day to day life. Staff were busy with other important care tasks to give people this time. The provider and registered manager had not considered this issue.

The services' quality monitoring processes were not always effective or robust as they had not identified these issues and taken action to resolve them.

These issues constituted a breach in the legal requirements of the law. There were breaches of Regulation 17, 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People had risk assessments in place which identified their needs and the risks they faced. We could see action had been taken to respond to these risks and to meet people's needs. Although people's care records did need updating in places and there were some occasions when people's care plans lacked details, to support staff to meet people's needs.

People received their medicines as prescribed and most medicines were stored safely. However we found that people's topical creams were not stored in a safe way, which could have undermined the effectiveness of this medicine. People received medical support when they needed this involvement. Referrals were made to specialist health professionals and their guidance was followed.

Staff received training and induction to their work. However, we found some shortfalls in staff knowledge and understanding which did not have a significant impact on people, but it could do if left unaddressed in the future. We have made a recommendation to improve staff competency checks and training in certain areas.

People spoke positively about the food and drinks they were provided with. People were given real choice on a daily basis to try and ensure people had food and drinks which they liked and enjoyed. People who were at risk of not having enough to eat and drink were being supported and monitored. Although it was not always clear if this information was being analysed effectively, to ensure people's hydrations needs were being fully met.

Despite the issues we identified in relation to always treating people with respect, we found that the staff were caring and kind towards the people they supported. Staff showed a commitment and willingness to support the people at the home.

There were planned events and activities at the home. The staff associated with this made real efforts to arrange events which people would enjoy. Relatives felt part of the home and the service responded to suggestions and ideas made by people and their relatives. However we found that outside of these events and activities people had limited social stimulation.

There was an open, friendly, and inviting culture at the home. Staff felt confident about approaching the registered manager. The registered manager was committed to ensuring people led positive and happy lives at Trefoil House.

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.

The service was not adhering to a legal fire safety requirement.

The correct procedure was not followed in relation to a safeguarding event.

Staff did not have full recruitment checks in place.

People's prescribed topical creams were not stored correctly.

There was enough staff to meet people's care needs.

There were various safety checks which were completed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff competency checks were not robust.

Staff training and knowledge was not always effective.

People's health needs were responded to.

People were supported to have enough to eat and drink.

Staff promoted people's choices.

People's liberties were not being unlawfully restricted.

Is the service caring?

Requires Improvement

The service was not always caring.

There were times when people were not treated in a respectful way.

People's private information was not always protected.

People said they were treated in a caring way.

People's independence was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were not always met in a timely way.

Staff did not have time to sit and chat with people.

Planned activities and events regularly took place.

The service responded to complaints and suggestions made.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service's quality monitoring processes were not always effective and robust.

There was an open culture at the service.

Staff felt confident about approaching the registered manager.

Trefoil 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.

The inspection site visit started on 14 February 2018 and ended on 15 February 2018. This inspection was not announced.

The Inspection team consisted of two inspectors, a specialist advisor who was a nurse, and two Experts-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. In this instance the experts-by-experience had personal experience of caring and supporting an older person who was living with dementia.

Before the inspection we made contact with the local authorities' contracts team and safeguarding team. We asked them for their views on the service. We looked at the notifications that the registered manager had sent us over the last two years. Notifications are about important events that the provider must send us by law.

During the inspection we spoke with 16 people who lived at the service, 11 people's relatives, six members of care staff, a member of staff supporting the management of the service and the registered manager. We looked at the care records of seven people, and people's medicines records. We looked at the recruitment records for three members of staff. During our visit we completed observations of staff practice and interactions between people at the service and the staff. We also reviewed the audits and safety records completed at the home.

We received a Provider Information Return report. This is information we require the provider to send us at least once annually to give some key information about the service. What the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in the report.

Requires Improvement

Is the service safe?

Our findings

When we last inspected Trefoil House in March 2016 we found that the service was safe. When we visited in February 2018 we identified some areas related to people's safety, which required improvements to be made.

In March 2017 the local fire service visited and completed a fire safety assessment of Trefoil House. They said that the result of their assessment was that the service was "Adequately safe." However, the fire service had identified that the service was not compliant with the associated legislation, because the service did not have enough fire extinguishers. This was raised with the provider and registered manager, but no action was taken. We spoke with the registered manager about this who confirmed this issue had not been resolved. This was eleven months after the fire services visit. This could have had a negative impact on people's safety had there been a fire. The provider should have responded quicker than this. On 23 February 2018 we received an e-mail confirmation saying that more extinguishers had been purchased. However, we had needed to prompt this action. No investigation followed as to why swift action was not taken.

The above issues constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were various safety checks being completed in relation to the equipment which people used. This was to ensure it was safe to use. The service tested for Legionella which is a water born virus and can cause people to become unwell. There were, other fire safety checks completed which included a weekly test of the fire alarm. However, there had not been an evacuation drill in the last twelve months which involved people who lived at the home. We also noted when looking at people's emergency evacuation plans, that these did not contain a photo of the individual people. Even though the home supported up to 70 people.

When we visited the home we looked at how staff protected people from experiencing potential harm and abuse. We could see that appropriate referrals had been made to the local authority safeguarding team when concerns had been raised. However, records showed that an allegation had been made, in relation to a person experiencing potential abuse on 15 July 2017. This was reported to the acting manager by a member of staff. It was not until 17 July 2017 that this was reported to the local authority. The management team started to investigate the allegation and waited this time, until they reported it to the local authority. This was not good practice as it could have interfered with a potential safeguarding investigation led by the local authority. This could have also potentially meant that the person could have experienced further harm during this time. The registered manager said this occurred when they were away from the home, by a manager brought in by the provider. This situation had also involved a member of the provider's senior management team. The registered manager and provider had not taken action to prevent this from happening again.

The above issues constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the accidents and incidents which had occurred in the last four months. We found that appropriate action had been taken on individual cases. However, we noted a high figure of bruising and redness to people's skin. We spoke with the registered manager about this. They advised us that the local authority did not require certain types of bruising to be reported. The management team had no regular system of discussing these types of incidents with professionals. Considering the potential risk identified here, we would expect to see further action taken, to make sure that these people were safe. Given the high number of bruising we advised the registered manager to review this situation and create a process to monitor this issue.

During our visit we spoke with staff about their understanding of protecting people from potential harm and abuse. Staff were clear with us about what potential abuse or harm could look like. They told us that if they had any concerns they would report it to their manager. Staff were confident that their manager would take action. However, we asked staff about the outside agencies they could also report their concerns to (such as the local authority safeguarding team). Five out of the six members of staff we spoke with did not know who these other organisations were. One member of staff was aware of the local authority safeguarding team. They told us that they had been given the local authorities contact details when they worked for a previous employer. Staff also said that they would go "Higher" within the provider organisation. However, they did not know who they would need to go to, or how they would go about doing this, to discuss or raise their concerns.

We asked these members of staff about their understanding of discrimination. Staff did not have a clear understanding of what this was and how this could be relevant within an older person's residential home. Staff had not heard of 'protected characteristics' for example age, disability, sexual orientation.' One member of staff asked us to explain this to them, which we did.

People told us that there was enough staff to meet their needs. One person said, "I think there are enough staff, and they are not over bearing." A person's relative told us, "My [relative] is safe because staff are always present."

Staff told us that there was enough staff to meet people's care needs. When there was a shortfall of staff they told us that the registered manager resolved this issue quickly. They also said that the management team had also helped with care tasks if replacement staff could not be found at short notice. During our visit we observed on all four units that there was sufficient staff to meet people's care needs.

During the course of the inspection we looked at three staff recruitment files. We could see that new staff had completed Disclosure and Baring Service (DBS) checks in place before they started working in the home. However, out of the three staff records we looked at, two members of staff did not have two references from previous employers. One member of staff had two character references with no attempts recorded to contact their previous employer. In people's applications it asked for the last ten years of their employment history. The service should be asking for people's full employment histories. These are all important checks to ensure people are safe around staff. We were told after our visit that the service now requests full employment histories.

We asked our specialist advisor to complete an audit of people's medicines. They found that people's prescribed medicines had been administered according to best practice including 'controlled' prescribed medicines' at the home. They looked at people's Medication Administration Records (MARs) and completed an audit of people's medicines. They found that people had been given their medicines as prescribed. They found that these medicines were being stored correctly. However, when we entered into people's bedrooms we found some people's prescribed skin creams were not being stored correctly. These medicines should be

stored below 25 degrees. The temperatures of people's rooms were not being monitored for this purpose. People had thermometers to monitor if people's rooms were warm enough. We noted in one person's room who had prescribed creams, the temperature recorded was above 25 degrees. We spoke with the registered manager about this who told us that this issue would be resolved straight away.

At this inspection we looked at seven people's records. People had risk assessments in place but we found that in two people's records some of the key risks which they faced had not been fully explored. For example one person had a diagnosis of a mental health condition. Their plan did not explain how this person could present if they were beginning to experience a period of ill mental health. A further person had a cognitive condition; their assessment did not clearly explore how this affected them in relation to their mobility. People's care records did give staff an overview summary of people's needs. This was aimed at helping staff to know people's needs. However, this information was also not stated here.

When we spoke with people they told us that they felt safe. One person said, "I feel perfectly safe." Another person said, "People treat me well and I get on with staff." A person's relative told us, "I know my [relative] is safe."

People were protected from the spread of infection. We noted that the home was clean and staff wore the appropriate infection protection equipment. We noted that people were supported to wash their hands, if they wanted to, in between meals, snacks, and drinks.

Requires Improvement

Is the service effective?

Our findings

When we visited Trefoil House in March 2016 we found that people were receiving Good effective care. When we visited in February in 2018 we found areas which required improvements to be made.

Staff spoke positively about their inductions to their work. Staff shadowed more experienced staff and most completed the care certificate (this is a set of standards which outlines what good quality care looks like). New staff received induction training in key areas of their work such as emergency first aid, fire safety, food safety, infection control, and moving and handling. However, staff did not receive training on certain conditions which effected individuals who lived at the home. One person was living with Parkinson's disease another person was living with a mental health condition, but no training was provided on these conditions.

Most people living at the home were living with some form of dementia. We were told how some staff had completed a three day dementia course. The staff who had completed this training told us how this course had changed their understanding of dementia. We were told by the registered manager that staff completed a test following any training course they completed. If a question was answered incorrectly the designated senior member of staff would sit with them. They would revisit this question(s) until they were satisfied the member of staff had understood the related area.

The staff who completed this training on dementia and how to administer people their medicines had their competency assessed in these areas. Staff also completed a competency check during their six month probation period. However, when we looked at these competency assessments, these records did not evidence how the assessor had come to the conclusion that the individual member of staff was now competent.

When we looked at staff's medication competency observations, which we were told involved three observations, these records were not dated. New staff did not have a robust competency check when they had completed their induction. Staff's knowledge and their competency was not monitored or checked and evidenced sometime after their training. Supervisions and appraisals also did not ask staff about their knowledge and understanding in key areas.

We found that staff's knowledge in relation to protecting people from abuse was not complete. Staff also lacked an understanding about discrimination. The registered manager and staff had told us that staff had recently completed this training. The staff we spoke with had a limited understanding about mental capacity. Staff could not tell us what a deprivation of liberty was. We observed some other shortfalls in staff practice when they were supporting people. Sufficient and robust competency checks would have identified these shortfalls. This also questioned how effective the training in these areas was.

During our visit we spoke with the registered manager about this. They had not considered on-going competency assessments as a means of checking that the training was effective sometime after staff had had this training. The short falls of the existing documentation in relation to assessing the competency of

staff had not been identified. As a result of this staff were not being fully supported to consistently deliver best practice to the people they supported.

We recommended that the service improve the competency monitoring of staff and consider how they can support staff to improve their knowledge and practice in their work.

People's physical care needs had been assessed and the appropriate support and treatment had been provided and sought to ensure people received effective care. We looked at one person's records who had complex health needs. We could see staff were regularly monitoring their condition and they had the appropriate equipment in place to meet their needs.

The provider had considered the layout of the home to support people to meet their needs. For example there were places for people to spend time alone, in or near communal parts of the home and for people to spend time with their relatives. We saw people sitting on occasional chairs in more secluded areas of the home either by themselves or with visitors. Although there was a lack of accessible signage directing people to other parts of the home which people may have wanted to explore.

The service used technology and equipment to enhance the delivery of care and support which people received. Some people who needed specialist equipment to help them to eat and drink independently had this equipment. The home had a virtual reality headset which was shared across the four areas of the home. On the first day we visited we saw people using this to explore different environments which they would not ordinarily be able to access. These people were smiling and laughing when they did this. One of these people said, "That's marvellous."

People spoke positively about the food and drinks at the home. One person said, "The food is very good, and I get what I want." Another person said, "The food is very good, but there is a lot left." A person's relative told us that, "My [relative] is finicky, but the food is appetising and there are good choices." Another person's relative said, "The food is very good and I can't fault it, more like a restaurant."

During our visit we observed people were encouraged to drink during and in between meal times. People were offered a selection of snacks and drinks throughout the day. On the first day we visited we noted people had mini eclairs and biscuits with their tea and coffee. People were offered soft drinks during lunch and offered a hot drink when they had finished eating. Hot drinks were offered twice later in the afternoon. For people who needed support to eat, we noted that this was provided at the person's own pace. These people were given one to one support and staff tried to positively engage people in the meal time experience. For example, we saw some staff telling people who were living with dementia what the food was they were offering people to eat, per portion of food.

We observed the lunch time experience. Throughout all four dining rooms people were offered a choice for their lunch. Staff would show two plated up options and the person would choose. People had also been asked the day before what they had wanted to eat for lunch. This supported people who may have forgotten what they had chosen the day before. It also gave them the opportunity to change their mind on the day, if they wanted to. The chef had a clear understanding about people's likes and dislikes. People's food preferences were updated twice a year.

All the dining rooms had a social atmosphere to them. Although we did note that people were not asked if they wanted to listen to a popular radio station, which was playing in the background. One person told us that they would like some wine with their meal, but staff did not offer this. We spoke with the registered manager about this, who said they would address this issue. We looked at the dining audits and found these

had responded to issues raised by people having their lunch. We saw documented that two people did not like the type of sausages provided. The chef spoke with these people and changed suppliers.

The chef was involved in reviewing people's nutritional status. They had been informed by care staff of the people who were at risk of being too low in weight and nutritionally at risk. They described to us how they met these people's needs.

We could also see that the management team had made appropriate referrals to enable dietician involvement, to support these people with their nutrition and hydration. These people had food and fluid records. We found that staff had been completing these records daily. However, we found that these records did not always have the target food and fluid amounts stated, but this information was on people's care plans. This would support staff to check that people had had enough to eat and drink on a daily basis. We also noted on one person's fluid chart when they had consumed below the recommended amount it did not show what action had been taken. It stated to "Encourage fluids." There was no analysis to check if a different approach was needed. It did not ask staff to record what, when, and how fluids were being offered to this person. We spoke with the registered manager about this, who advised us this person was no longer on this chart as directed by the GP.

When we looked at people's records we could see that people had been supported to access health services when their needs changed. People were in receipt of specialist health involvement due to their needs. We observed one person inform staff that they did not feel well. We saw that staff took action to respond to this.

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 so that they can 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff told us how they promoted choice when they supported people with their daily needs. We could see that when people's relatives had been given certain legal powers in relation to their care, this was detailed in people's care records.

Some people's liberties were being restricted and they had been placed under a DoLS. When these authorisations by the local authority were close to expiring we could see that the registered manager had contacted the local authority to request a re-assessment. We saw that people were not being overly restricted in their movements. However, when we asked staff about DoLS staff did not have a reasonable understanding about what a DoLS was. Even despite the fact they were supporting some people who had been placed under a DoLS. This could have an impact on how people's liberties were being promoted by the service.

We concluded that the service was compliant with the MCA and DoLS, but staff knowledge and understanding of mental capacity and deprivations of liberties, in relation to their work, needed improving.

Requires Improvement

Is the service caring?

Our findings

When we visited Trefoil House in March 2016 we found that the service was caring towards the people who lived at the home. When we visited in February 2018 we found some areas were improvements were required.

During our visit we observed some positive examples of staff treating people as adults and in a respectful way. For example, we observed two people becoming agitated with one another. A member of staff defused this situation in a respectful and calm way.

Despite these examples we also saw some situations when people were not treated in a respectful way. On some occasions we observed staff referring to people as 'she' or 'he' and talk amongst themselves about the person when they were near in front of them, rather than involve them in the conversation and use their first names. Occasionally staff also made comments such as "Good girl" and "Bless." These comments were not treating people as adults. We saw two members of staff assist one person to transfer in a hoist. As the person was being moved in the hoist one member of staff pulled them into position by pulling on the elasticated waist of their trousers. We also saw that a person had turned the light off in the dining room when people were having their supper. A member of staff said, "Don't do that again." They did not explain to the person why this was not appropriate to do this. This person was living with dementia.

We raised these practice issues with the registered manager. We concluded that staff did not intend to be disrespectful as we had seen many thoughtful and kind interactions between members of staff and people at the home. On balance, these events highlighted a lack of monitoring of staff practice and a training need.

People's private information was kept in a secure way in the home. People's care records were kept in a locked cabinet in the lounges in each area of the home. At the beginning of our visit we saw staff return people's records to the cabinet and lock it. However, as the day progressed in two lounges we found these documents were left on top of the cabinet and on display. At these times this information was not being stored securely.

People spoke positively about how the staff treated them. One person said, "The day carers are really kind and helpful, I know their names." Another person said, "It is very good here, the staff are kind and caring if I'm ill." A further person said, "The staff are wonderful and very caring, we have a good relationship." A person's relative said, "The home is excellent for the care given to my [relative]; it's like a big family."

During our visit we observed staff treating people in a kind and thoughtful way. For example we saw staff ask people if they wanted a "freshen up" in between meals and snacks. We saw that staff gently supported people in this way. Staff spoke calmly and at people's eye level when they supported them. We saw some examples of some people who were living with dementia who became distressed. Staff stopped what they were doing and offered support to these people. We saw that these people responded well to this, looking

physically calmer, as a result of this support.

We also observed people coming out of the hair dressers at the home and staff commented to individuals how nice they looked. Again people responded positively to these interactions. On the first day we visited it was Valentine's day. The chef went round to each area of the home with a large bowl of heart shaped chocolates. The chef knew people's names and gave people lots of compliments. The registered manager was seen visiting and chatting to people throughout the home. These were natural interactions and people appeared familiar with the registered manager and responded well to these moments.

Some people were living with advanced dementia and no longer communicated in ways we could understand. Staff were seen talking softly and gently to these people. Giving them choices and making suggestions about elements of their daily needs. There was information in people's care records which explained how people wanted to be supported each day and what their routines were. We concluded that as far as possible people were being involved in making decisions about the care they received. However, there was no information about the home for people to access and the home did not actively use or promote the use of advocacy services.

People told us that they were treated with dignity and respect by the staff. One person said, "I'm treated with respect." A person's relative said, "[Relative] knows the staff and they knock on [relative's] door."

When some people who were living with advanced dementia had moved to a position in their chairs which looked uncomfortable and awkward, staff responded to this. Practical action was taken to help them reposition themselves. During this process staff explained what they were doing and spoke gently to them.

One person told us that they were encouraged to maintain their independence. One person said, "I like to be as independent as I possibly can be, and I like the way they [staff] allow me to keep my independence, and let me do what I want." During our visit, we saw people (who were able to) make their own decisions about their daily needs and where they wanted to be, and staff responded positively to this.

The relatives we spoke with all said they felt welcomed and they could visit when they wanted to. During our two day visit we saw relatives being involved in activities and supporting their relatives. Relatives and staff were seen to chat openly and easily with one another. One relative told us how they had asked to be part of a project in the home, and this was agreed. They said, "I feel I am helping [relative's name] integrate into the home when [relative] sees me around."

Requires Improvement

Is the service responsive?

Our findings

When we visited the home in March 2016 we rated Responsive as Outstanding. However, when we visited in February 2018 we found that this had not been sustained. Instead we found areas where improvements were required.

During our visit we observed positive examples of staff responding to people's needs. However, we also observed some occasions when staff did not respond to people's needs in a person centred way.

One person had told staff that an item of clothing they were wearing had holes in it and they wanted this changed. This person was very expressive about the issue. We saw a member of staff say they would do this. We then heard them tell another member of staff that they were going on their break. When they returned to the lounge they had brought the replacement clothing and suggested they went to the person's bedroom to help them change. They had also announced to the room, that they had this item of clothing. The person did not respond positively to this. The person later returned with the member of staff explaining that the new item of clothing also had holes in it and they did not have a clean replacement for them. They said they would get these to the person as soon as possible. This did not happen. When we left on our first day at 18:00 this person was still wearing the clothing with holes in. Throughout the day and at this point this person was clearly expressing that they were not happy with this. No one had resolved this issue. We spoke with the registered manager about this who agreed with us that this situation could have been easily resolved.

When we observed lunch we saw that three people who needed assistance with eating their lunch sat together at a table. Two members of staff were supporting two people to eat lunch. One person sat between them waiting for their lunch from 12:30 to 13:19 and had not been given anything to eat. At this point this person started saying repeatedly in a loud voice, "Where's my dinner, where's my dinner." No member of staff responded to this. Eventually after this person kept saying this a member of staff re-assured this person that they would be having something to eat soon. This situation was not managed effectively. This person waited a long time for their lunch and became distressed. We looked at this person's care records. Their relative had advised the service that their relative does not like spending too much time in communal spaces and being around too much noise. These factors had not been taken into consideration when supporting this person. This person was unable to mobilise without equipment and support. They were seen trying to stand up when they spent their day in the lounge. Staff had also not considered if this person had in fact wanted to spend the morning and afternoon in the lounge or wanted to be somewhere else.

We also observed a member of staff rushing into the dining room saying to a person that they are needed, as the visiting nurse had arrived to see them. This person who had mobility issues responded by getting up quickly and starting to walk quickly. They appeared to struggle and looked out of breath. Then this member of staff asked them to walk slowly with their stick. Due to the speed in which this person stood up, this member of staff needed to support their balance. This member of staff's initial actions, were not responsive to their needs. They had not taken into consideration this person's mobility needs.

One person was watching TV in a lounge. Two members of staff started to transfer this person into a wheelchair without talking to them about why they were doing this or if the person wanted to be moved. The staff then left this person in the wheel chair at a position so they could not see the TV. These members of staff then helped other people to move to another part of the home to take part in an activity. There was no conversation at this point with this person. This person was left in this position until everyone else had gone to the activity, who wanted to go. Another person kept pointing to their leg for about an hour. Later their relative came to visit them. They responded to this 'pointing' and asked a member of staff for assistance. This person's catheter bag was full.

When we looked at people's care records we could see that people and their relatives had been involved in the planning of their care. The service had gained information about people's backgrounds, interests, and their past achievements. People's backgrounds and what was important to them had been explained in detail. Specific information was given about people's interests. For example what types of films individuals liked watching. What newspapers they liked to read. What genre of music they enjoyed listening to. The staff we spoke with were able to tell us elements of this information.

We looked at people's reviews. It was not clear from the information recorded if the person or their relative(s) had been involved in this process. We noted on one person's review that their relative had been involved. They had raised an issue about how their relative was being supported. This was not addressed by the member of staff reviewing this person's care. There was no explanation of what action was taken to address this issue.

The service employed two activity co-ordinators who were rostered to work together and separately which ensured there was always at least one activity co-ordinator at the home seven days a week. Recently one activity co-ordinator had been away from work. The registered manager told us that this member of staff had been temporally replaced, to ensure people had this support. We saw this was in place. There were activities planned daily and events which regularly happened.

On the first day we visited the home a Valentine's day music event took place, which involved a performer coming to the home to sing. We observed that this was well received. On the second day the service had a special Chinese meal to celebrate Chinese New Year. During that day a pub quiz was held in an area of the home styled on an Irish pub. These were all planned events. We noted that there was a real upbeat and boisterous atmosphere at the home during these times. We could see from looking at 'residents newsletters' that there were other events that had taken place, this included a 'hen party' and a 'gastro meal out experience.' Some of these events were re-occurring. We could see time and thought had gone into these activities. We also noted that these events had involved people from different parts of the home.

Despite these positive experiences during our visit we did not observe staff sitting and chatting to people. Staff told us that they tried to do this about thirty minutes a day when they were completing their paperwork tasks. However, when we saw staff completing their paper work over our two day visit, staff were not chatting to people. Both activities are important and it would be challenging and unrealistic for staff to be doing both at the same time. The management of the home had not incorporated time for staff to do this.

There was also a lack of activities during the day in the lounges. People sat not talking with one another. The TV was often on but people were not seen to engage with what was on the TV. In one lounge there were various vintage magazines picturing European royalty. No one engaged with this material. No one had considered if it needed replacing. Music was being played but this was on a repeat. We saw staff asking people if they wanted music playing, but they did not ask what music they wanted to listen to. Staff were seen to press the repeat button and not change the CDs. On one occasion we saw one person watching the

TV in the lounge alone with the sound off and subtitles on. We asked if they wanted the sound on they said, "Do you mind, I can't read that from here."

We concluded that there were positive elements to how the service tried to meet people's social needs and respond to their individual needs. However, we found there were areas where improvements were required.

The service had a complaints process in place. We looked at the complaints made and we could see that the appropriate action was taken and in a timely way. We also saw what action was taken when relatives and people who lived at the home made suggestions to improve the home.

In September 2017 we received a complaint by a person's relative who had lived at the home. At this inspection we referred to the issues raised in this complaint during our two day visit. We did not find any repeated concerns which had been raised in this complaint.

When we looked at people's care records we could see that people had end of life plans in place. However, often this information was limited. Some stated that people wanted to remain being cared for at the home. But there was little detail about how this care should be delivered. Or what should happen if a person needed to be admitted to hospital when they were in the end part of their life. Also, there was no reference to what would be important to the person at this time. In some cases the plans deferred to people's relatives. Good practice would have been to have had a discussion with the person and their relatives, involving key workers, about making these plans, if people wanted to. If people did not want to engage with these plans, this should have been documented and potentially revisited at another time. We spoke with the registered manager about this who said they would review these plans.

Requires Improvement

Is the service well-led?

Our findings

When we inspected Trefoil House in March 2016 we found that the home was well led. During our recent visit in February 2018 we found some areas where improvements were required. This has therefore changed the rating in this area.

We found some issues relating to the safety of the home. The fire service had visited and explained the service was in breach of the relevant legislation, because the home did not have enough fire extinguishers. The provider and registered manager had known for eleven months and not taken action. It was our visit which prompted action to be taken. This had the potential to put people at risk. This highlighted a failure in the services governance systems, as this had not been resolved.

An alleged safeguarding event was not processed according to best practice and was not managed in a transparent and open way. Staff security checks were also not fully completed.

Staff did not have robust competency checks which evidenced how the member staff was competent in all areas relevant to their work. We needed to explain what a robust competency assessment looked like. We identified short falls in staff's understanding and knowledge of protecting people from harm and abuse, discrimination, and in depriving people of certain liberties. We also observed short falls in staff practice in terms of protection of confidential information, always treating people with respect, and responding to people's needs. This also questioned how effective the training was in these areas.

We found some shortfalls in people's risk assessments, reviews, and end of life plans which had not been identified as part of people's care records audits. In how the service evidenced their response to supporting some people's hydration needs. People's prescribed creams were not being stored in a safe way.

There was insufficient time given to staff to enable them to engage with people on a social basis as part of their day. We observed some incidents when people's needs were not responded to in a person centred way.

As a result of these issues we could not be confident that the quality monitoring and governance systems at the service were robust.

We looked at the services quality monitoring checks. During our review of these audits we could see from the registered manager's monthly audits and the provider audits that when issues were identified action was taken to quickly resolve these issues. However, the issues which we found had not been identified by the home's quality assurance audits and systems.

The above issues constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management of the service did not always take advantage of learning opportunities. Staff training and staff practice was not fully analysed and monitored to see if this could be improved. It was not evidenced if complaints were fully used as an opportunity to improve and do better next time. The registered manager had not challenged the provider regarding the unresolved fire safety issue or how a safeguarding incident was managed in their absence.

The service regularly had relatives visiting the home and during our visit a Catholic priest came to the home to see people who identified with this faith. However, there was no other evidence of how the service involved the local community or key organisations relevant to people's needs.

The staff and the registered manager presented in an open way during our visit. The service responded positively to feedback they received about the service. People and their relatives were asked about their views of the home. The registered manager and all the staff we spoke with showed a commitment and interest in ensuring that people that lived at Trefoil House were happy and well cared for.

The registered manager was present and involved in the running of the service. We observed the registered manager engaging with people and staff on a regular basis during our visit. The staff we spoke with all spoke positively about the registered manager. They felt that they could approach them, ask questions and make suggestions. One member of staff said, "I've been here for [said period of time] and I feel part of the team here. You can mention anything to the manager, and they are very nice, and they don't mind if you ask the same question twice."

We found that the registered manager had a good understanding of the important events that must notify the CQC about by law.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The provider had not ensured that care and treatment was provided in a safe way. They had not responded appropriately and in a timely way to all the risks effecting people's safety. Regulation 12 (1) and (2) (a) (b) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA 2008 (RA) Regulations 2014: Safeguarding service users from abuse and improper treatment The provider had not ensured that people were protected from the potential risk of experiencing abuse or harm. Regulation 13 (1) and (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance

The provider had failed to have effective systems and processes in place to monitor and improve the safety and the quality of the service provided.

Regulation 17 (1) and (2) (a) (b) (d)