Cornwall Care Limited

Trevarna

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 well-led?	**Good**

Summary of findings

Overall summary

Trevarna is a care home that provides nursing care for up to 53 older people, some of whom had a diagnosis of dementia. On the day of the inspection there were 50 people living at the service.

The service is divided into five units each individually staffed. Trevarna is a single storey building.

The service is required to have a registered manager and at the time of our inspection a registered manager was in post. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. However, another service manager was deputising in the registered manager's absence.

We previously carried out a focused inspection of Trevarna on 1 September 2015. At that focused inspection we checked to see if the service had made the required improvements identified at the comprehensive inspection on 10 March 2015. This related to the way the service was staffed. Inspection improvements had been made to the way staff were deployed around the service. However where people required food and fluid monitoring their records were not being maintained to show an accurate record. This resulted in a breach of regulation. The service responded to the breach by providing the commission with an action plan showing what action had been taken to address the breach.

We carried out this focused inspection in response to concerns that the service was not adequately staffed to meet people's needs. This included staff not having time to complete records and people that required supervision not having the support they required at all times. There were also concerns the manager was not responding to information of concern relayed by staff members.

This report only covers our findings in relation to the 'Safe', 'Effective' and 'Well Led' domains covered in this inspection.You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Trevarna on our website at www.cqc.org.uk

At this focused inspection peoples' fluid and nutrition were being managed had been reviewed and changes put in place to monitor them more effectively. Regular reviews were taking place so that the records were effective and meaningful. However, improvement was still required to ensure all staff were informed of who

required monitoring and that the assessed daily amounts of fluid were included in all records, to inform staff and act as a key indicator for them to follow.

There was a deputising manager in post as well as a new deputy manager and they, together with the clinical lead, were continuing to support staff through leadership and operational changes.

People's health needs were being individually managed and staff had the skills to recognise when people may be a risk of their health deteriorating. People had access to healthcare professionals including GP, chiropodist, dentist and optician.

Staffing levels were continuing to increase and the deployment of staff in each unit had increased since the focused inspection in September 2015. There had been a number of nursing and care staff employed at the service who were currently going through an induction process before commencing work in the service.

There was a current review taking place to introduce a different shift pattern. This would increase staff levels into the evening thereby supporting night staff during the early part of the night shift when some people required more support.

Where people did not have the capacity to make certain decisions the service acted in accordance with legal requirements under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Applications had been made for potentially restrictive practice to be authorised, as appropriate.

Procedures were in place to assess and monitor the quality of the service. Meetings and regular audits were taking place and showed people were engaged in the process.

We identified one breach of the regulations. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

We found action was continuing to improve the safety of the service.

Staffing levels were improving and shift systems were under review in order to improve the way the service was staffed.

While improvements had been made we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for safe at the next comprehensive inspection.

Is the service effective?

Requires Improvement

The service was not always effective. Records to monitor people's nutrition and hydration had improved, however staff were not always provided with the information they required to support people with food and fluid intake. .

Management and staff understood the legal requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

Is the service well-led?

Good

The service was mainly well led. There were effective systems operating to assess and monitor the quality of the service provided to people. Where areas that required improvement had been identified actions were being taken to address them. Not all actions had been completed.

Transitional management systems were being overseen by senior managers.

Staff told us they were being kept informed and consulted about proposed changes in how the service was staffed.

Trevarna

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 26 January 2016. The inspection team consisted of two inspectors.

We reviewed the information we held about the service and notifications of incidents we had received. A notification is information about important events which the service is required to send us by law.

During the inspection people using the service did not have the capacity to express their views. We looked around the premises and observed care practices on the day of our visit.

We also spoke with five care staff, the nurse in charge, the deputising manager and clinical lead. We looked at four records relating to the care of individuals, staff duty rosters and records relating to the running of the service.

Requires Improvement

Our findings

We received concerns that staffing levels in the service were not always meeting the needs of people. Specifically people who required one to one care. This means a dedicated member of staff supports a person for an agreed period of time. There were seven people identified as requiring one to one support during the inspection visit. Daily schedules identified staff who were supporting people requiring one to one care and the times they were being supported. In general this was occurring. Two units we visited had dedicated staff supporting people. An agency worker told us, "I support (person's name) most days. It's important we support the same people because of the continuity." Another agency worker said, "I cover a lot of shifts here. It seems to work well and I support the same people. I write everything down and that shows the times we support residents". Some staff supporting people were part of the services own staff pool. One member of staff told us, "I am covering this as part of overtime. It's good because I know all the staff and residents well so it's not disruptive". People's daily notes showed there was continuity in staff supporting them. In most cases the records showed people were having one to one support at the times identified on their care planning records. Day staffing levels had increased and people were being supported to meet their needs.

Some people's one to one support carried on into the evening. For example after night staff came on duty and up to 11pm, with one person requiring 24 hours one to one support. Concerns raised with us were that there were times when night staff were responsible for these people without additional staff to support them. Four records showed one to one staff had remained on duty with people until the majority of contracted times. However there were some gaps when one to one staff were not identified as supporting people up to 11pm. We raised this with the deputising manager who said all one to one support was currently being reviewed as it was not felt necessary when most of those people were in bed during the early part of the night shift. In order to discuss this further we spoke with other professionals involved in this process. They agreed this was currently under review with a multi-disciplinary team involved.

Records showed some night staff had been concerned about the impact of supporting people on one to one support in the early part of their nightshift. A senior staff member had advised staff to be distributed in each unit with additional staff to use as a 'float' and used as and where necessary. However, the communication record showed a senior member of night staff had not seen this as a viable or safe option, due to people requiring two staff to support them. Staffing rosters identified the agreed ratio of night staff to be six care staff and a nurse. However rosters showed this had on occasions been reduced due to staff sickness. Records showed where possible the shift would be covered by staff 'stepping in'. However there were eleven nights in January where staffing ratios had fallen below this level.

Staffing shift patterns were currently under review and were going through a consultation process with all staff members. The aim was to improve shift patterns and extend the working day to maximise staff cover. In addition five more care staff had been recruited and were currently going through the induction process to increase the levels of staff in the service. By extending the working day to 10pm there would be some relief of the pressure night staff were currently concerned about.

The way staff were deployed was dependent on the levels of need for each unit. There were two higher dependency units where people required a more intense level of support. Most people were living with dementia. Many were mobile and required more staff to observe and ensure they were safe when moving around the service. Some people had 'pressure mats' in place to ensure staff were alerted to their movement. In all instances people had been assessed for pressure mats in order to safeguard them against the risks associated with their lack of mental capacity.

We observed three of the five units. Staff were available to people when they needed support. For example, three people spent most of their time sitting down for short periods but then moved around the unit they were in. Staff were available to them at all times to ensure they were kept safe and minimise the risk of falls. Accident and incident records showed where these had occurred and how they were managed. There were no patterns or trends to show they were occurring at specific times of the day or night or to an excessive extent for the type and size of service. A staff member said, "It's got better (staffing levels) and we have more time to spend with residents."

Staff were not seen to be rushed in their duties and had time to spend with people and support them. Staff using equipment to move and support people were seen to operate it safely and reassured people they were safe throughout.

This focused inspection showed the service was continuing to develop and improve the way the service was staffed. To improve the rating to 'Good' would require a longer term track record of consistent good practice.

Requires Improvement

Our findings

During the focused inspection on 1 September 2015 we found the service was not maintaining accurate records for people whose food and fluid intake needed monitoring. This resulted in a breach of regulation and we asked the provider to provide us with an action plan as to what they had done to meet this regulation. During this focused inspection we looked at what action had been taken to improve the management of nutrition and hydration.

Five people were being monitored for nutrition and hydration. We looked at four of those records to see how they were being managed. The service had provided us with an action plan following a full review of people's food and fluid monitoring. They had identified where some people had no clinical reason for continuing with monitoring their food and fluid intake. In other instances they had continued with the records but changed how they were being reviewed, so reviews were more frequent and the information was being more effectively managed.

Improvements included reporting how decisions had been made to determine why people required monitoring with nutrition and hydration. These decisions were based upon clinical guidance and GP support. For example where people had been identified as losing weight or losing their appetite to eat or drink, referrals had been made to their GP. Staff were following advice from the GP including administering prescribed food supplements and setting up food and fluid charts where this had been recommended. Review records were up to date. However, one review record did not identify why a person's diet was being monitored. The information had been recorded in general multi-disciplinary notes. The deputising manager recognised this needed to be improved and agreed to ensure all staff recorded decisions in the necessary areas of the care planning document, so the decision making process was clear.

Records showed food and fluid being recorded as taken or refused. However some records did not show the amount of food or fluid taken which was a necessary indicator to senior staff monitoring the records. For example one chart recorded what food was offered but not actually taken by the person. Two peoples care records recorded the necessary calorific intake and daily fluid intake but this was not on the chart to assist staff in knowing what the daily target was.

Two staff members were asked about a person's food and fluid monitoring. Both were unaware the person had commenced a monitoring chart. Both staff had been off duty for five days and had not been given handover information on their return that day. Staff told us changes had been made for staff handovers. Senior care workers were now responsible for cascading handover information to other care staff. This had

not occurred by the time we spoke with two staff members. By not knowing this person required their food and fluid to be monitored meant they would not have completed a chart when supporting people with food and drinks. We shared our concern with the deputising manager. They agreed to ensure staff at all levels had the essential information relating to people's current care and support needs.

The recent audit of food and fluid charts had resulted in revised management systems for the recording and monitoring of people nutrition and hydration. Whilst improvements were in evidence the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had not been fully met at this focused inspection.

Good

Our findings

At the time of this focused inspection the service was going through a process of transitional change. This included changes in management structure and revising management systems. Staff told us, "There is a lot of change going on, but I think it will be better with the new shift patterns" and "We have regular meetings and things get fed down to us. We are having meetings with the manager about the new shift patterns and how it will affect us."

There were systems in place to support all staff. Staff meetings took place regularly. These were an opportunity to keep staff informed of any operational changes. For example, changes in using more 'in house' staff for one to one support. Staff were asked to bring any staffing issues they may have to the manager for discussion. These meetings also gave an opportunity for staff to voice their opinions or concerns about any changes.

Senior care workers also had regular team meetings. These gave more senior staff an opportunity to meet up, share ideas and keep up to date with any developments in working practices. Managers from services within the group of Cornwall Care Services regularly shared good practice ideas and discussed issues which had a negative impact on the service. The aim of the meetings was to improve quality within the organisation.

These meetings also shared the outcomes of internal audits. For example an audit for November 2015 highlighted areas where improvements were required by all staff for example laying all tables for meals with table cloths and ensuring cutlery was available to people.

Meetings were held for relatives every three months. The most recent one was attended by twenty-two relatives. The meetings provided up to date information about the service in general. For example new nurses starting to work in the service and how staffing levels at week-ends were being looked at so they could be improved. Some relatives asked about specific topics including staff competencies and how staffing ratios were worked out. The minutes of the meetings clarified these areas for people.

Records showed audits were taking place regularly. For example the last audit looked at the areas of caring and effective. The outcome was shared at the most recent team meeting. Accident and incident audits were taking place as part of the governance overview of the service and to ensure any patterns or trends were being focused on to ensure the safety of people using the service. The most recent staffing audit had been conducted to look at how best to meet people's needs and had resulted in the proposed new shift pattern.

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance We found that the registered person did not always have the necessary information to accurately monitor the nutrition and hydration needs of people using the service.