Cornwall Care Limited

Trengrouse

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**

Summary of findings

Overall summary

Trengrouse is a care service which provides accommodation for up to 41 people who require nursing care. At the time of the inspection 40 people were living at the service. People who live at Trengrouse require general nursing care due to physical and mental health needs. Most people were living with dementia. Trengrouse is a purpose built single storey building with a range of aids and adaptation in place to meet the needs of people living there.

We previously carried out a comprehensive inspection of Trengrouse on 23 February 2016. At that inspection we identified a breach of the legal requirements. This related to the way the service was being staffed. We issued one requirement and told the provider to take action to address the breach of the regulation. We also found the service was not always effective because there were not enough staff supporting people with their lunchtime meal where they required help. The provider sent the Care Quality Commission an action plan following the publication of the report. We checked to see if the service had made the required improvements identified at that comprehensive inspection.

We carried out this focused inspection in response to anonymous concerns that the service was not adequately staffed to meet people's needs. This included staff not having time to respond to people's complex needs. It was also alleged the way staff supported people to move was not safe. People's continence needs were not being met.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Trengrouse on our website at www.cqc.org.uk

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 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.

During this inspection we found the way the service was staffed had been reviewed and changes made to shift patterns. Dedicated staff were available in the communal areas of the service during the day to oversee people who may be at risk due to their complex needs. There was a reliance on the use of agency staff. However a recent recruitment drive had employed six care staff. These staff were not yet working in the service as they were currently undergoing checks to ensure they were safe to work with vulnerable people.

Some people displayed needs which challenged others. Where this occurred staff responded in a calm and professional manner. The instances we witnessed resulted in staff managing the situation's to ensure the person and others were safe. However, not all staff had received formal training in how to manage these situations. The registered manager confirmed this had been recognised and they were currently arranging

the training with the organisations training department. The training was planned for in forthcoming months.

Where people required help to move around the service there was a range of suitable equipment to support staff to do this safely. Staff had received training to ensure moving people was carried out using approved techniques. Staff told us, "They (Cornwall Care) make sure we are up to date without moving and handling courses" and "There are times when we have to act immediately to keep the person safe."

Where pressure mats were being used to monitor people's movement in their rooms they were all in working order and people who required them had been assessed using 'Best Interest' meetings and the service had applied for authorisation under Deprivation of Liberty Safeguard (DoLS).

The design of the service had been improved by making changes to the way seating was provided in lounge areas. This meant people had more choice of where to sit without restricting their movement around the service.

Where people required support to manage their continence needs there were suitable products provided and this was monitored by a named staff member. There were clear records in place demonstrating how people were assessed for help to manage their incontinence. All products were ordered for the person and there was no evidence of continence products prescribed for the person being used for other people.

During the previous inspection of February 2016 we found some people were having a late breakfast followed by lunch in a very short timeframe. During this inspection we found action had been taken to address this by informing kitchen staff of late breakfasts so that they knew the person may not want lunch at the time it was served and accommodated this by providing a later lunch if necessary. Where people required support to eat their meals they were being supported by enough staff to ensure there was one to one support. This was an improvement from the previous inspection when some people were left with their meals in front of them without suitable assistance.

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 mainly safe. Improvements had been made to ensure staffing levels were in place to meet the needs of people using the service but there was currently a heavy reliance on agency staff.

Staff had received training in moving and handling people and there was suitable equipment available to them to ensure this was carried out safely.

We could not improve the rating for safe from 'requires improvement' because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service effective?

Requires Improvement

The service was mainly effective. Not all staff had received training to effectively support people whose behaviour may challenge.

Staff were available to support people who needed help with eating their meals.

Where people needed to have their movements monitored for their safety, equipment was in working order and those people had assessments in place to justify why their movements needed monitoring.

People's continence needs were being met and managed effectively.

We could not improve the rating for effective from 'requires improvement' because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Trengrouse

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 inspection took place on 30 June 2016. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. The inspection team consisted of two inspectors.

The inspection was the result of receiving anonymous concerns about how people were being cared for at Trengrouse. We also looked at what action had been taken to meet the breach in regulation identified during the comprehensive inspection of February 2016.

Before the inspection we reviewed the action plan provided by the service following the last inspection, previous inspection reports and other information we held about the service. We also looked at notifications we had received from the service. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection people using the service were not able to express their views of living in the service. We spoke with one visiting relative. We looked around the premises and observed care practices. We spoke with a health care professional during our inspection visit. We used the Short Observational Framework Inspection (SOFI) during the visit which included observations at meal times and when people were seated in the communal lounge throughout the day. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eleven staff who worked as care staff, senior carers, domestic and catering staff, plus the operational manager, registered manager and deputy manager. We looked at three records relating to the care of individuals, staff duty rosters and staff training and supervision records. We spoke with a visiting professional.

Requires Improvement

Is the service safe?

Our findings

At our inspection in February 2016 we found the deployment of staff around the service was not ensuring people's needs could be met or that the safety of people could not be assured. Staff were not always available in areas of the service where people required supervision for their safety and welfare. This was in breach of Regulation 18 of the Health and Social Care Act 2008
(Regulated Activities) Regulations 2014.

We recently received anonymous concerns about the service not having enough staff available to meet people's needs. Moving and handling techniques were not being carried out safely. Where people required individual support because of their complex needs they did not always have the supervision they required.

At this inspection we looked at staffing rosters, identified people who required one to one staff supervision, looked at accident and incident reporting and made observations to determine how staff supported people to mobilise and how equipment was used. In addition we observed how staff were supporting people.

Rosters showed the service had recently introduced a new shift system which meant there was more flexibility in how shifts were managed. For example shift times were staggered, meaning there was more continuity in the levels of staff especially at the busiest times. During the previous inspection there were concerns staff were not always available to support people in communal areas when they needed it. At this inspection we found a dedicated member of staff was rostered to be available from 10:30 to 6pm working specifically in the lounge areas. Our observation confirmed at least one member of staff was visible in the lounge and dining areas throughout the day but in most instances there were other members of staff available as well. There were examples of staff supporting people when they became agitated. For example when a person was anxious the staff member spoke with them in a calm and sensitive way and diverted the persons attention to another activity. In another instance a person who was distressed and displaying behaviour which had the potential to affect their dignity, was being supported by two staff members encouraging the person to leave the communal area to a place which was private.

While there have been changes to improve how the service was being staffed we were told of recent constraints in staffing the service resulting in a depletion of five care staff. Action had been taken to address this. The registered manager told us six care staff had recently been interviewed and were currently going through recruitment checks followed by induction. During this period agency staff were being used. On the day of the inspection there were five agency staff on the roster. The registered manager acknowledged this did not always help with continuity in care, but told us the same agency staff were used wherever possible.

We had received anonymous concerns one to one care staff were not always available to support people. When we looked at the staffing rosters, spoke with the registered manager and three staff members they confirmed there had been a specific problem on 19 June 2016. On this date three agency staff employed to support people requiring one to one support did not work, giving only short notice. The deputy manager arrived to support the staff team and staff were contacted to work additional hours or extend their shift. Staff told us, "It was a difficult day but we managed by juggling staff around" and "There are sometimes

problems with agency not arriving but this was the most difficult day." In order to address this issue the operational manager had discussed the difficulties with the contracting organisation and an alternative agency, already used by the service was commissioned.

At this focused inspection we found that the provider was continuing to make improvements in staffing and had met the shortfalls in relation to the requirements of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 as described above.

We received anonymous concerns that moving and handling techniques were not safe. At this inspection we observed staff supporting people to move from wheelchairs to lounge chairs using hoists. Staff demonstrated they were competent in how they carried out these tasks. Training records showed staff were up to date with moving and handling techniques. There were sufficient hoists and aids to support staff to mobilise people. The equipment had been checked to ensure it was safe to use. Staff had received training in how to support people safely. Staff told us, "We (staff) are kept up to date with moving and handling" and "We sometimes have to support people to move quickly when they are at risk of getting hurt." We were given instances of where this had occurred recently, for example when a person was on the floor and another person was threatening them. A staff member told us, "It might look a bit dramatic when we have to move someone this way but we only do it so they are safe." Three staff members told us that they felt confident as to respond in an emergency situation in order to protect the person, but that there were no written guidelines to follow.

We recommend the service looks at implementing guidance for staff which reflects current good practice when moving and handling is required as an emergency response.

Accident and incidents were recorded when they occurred and a record of what action was taken to protect people from further harm. All accidents and incidents were assessed to determine if they required being forwarded to senior manages where they may need to be reported under health and safety legislation. For example a fall had occurred resulting in a person receiving a head injury. This had required an ambulance referral and treatment at the service. Records showed the outcome of the fall resulted in care plans being updated to remind staff of the need for additional monitoring of the movement of the person.

Requires Improvement

Is the service effective?

Our findings

At our inspection in February 2016 we found there were not enough staff to help people eat their meals where support was required. Some people were receiving meals with very short intervals between them. There was no communication of when a person had been supported with a late breakfast before another staff member was supporting them with lunch. We recently received anonymous concerns about the service using pressure mats to monitor people's movement and that some of those pressure mats were not in working order. We were told people's continence needs were not being managed to ensure they were being effectively managed.

At this inspection we observed people being supported with their breakfast and lunchtime meal. Also, we observed how people were being supported to take regular drinks. Throughout the morning period people were having breakfast in the dining room and in various lounges. Where a person had received scrambled eggs on toast another person requested eggs and staff brought these to them. Staff were visibly to supporting people with their meals. We observed staff sitting with people and talking with them when they were supporting them. A member of staff talked through what a person was eating and encouraging them discreetly to eat small amounts. Drinks, both hot and cold were being offered throughout the day. In order to ensure people were not receiving meals within short intervals, the service had introduced a system to record a late breakfast or lunch on a board in the servery area. This reduced the chance of a person being provided with food they may not be ready for or wanted. This meant the service had improved how it supported people at mealtimes. A staff member told us, "Meals are focused on especially for people who need support of which there are quite a few."

There were twelve people who needed pressure mats to monitor their movement in the interest of their personal safety. Records showed assessments had been carried out to determine the reasons a persons movement should be monitored. Applications had been made to authorise those decisions were in the persons best interest The registered manager understood the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). All pressure mats were in working order and the maintenance person told us they were checked weekly in each wing and any faults reported by staff.

Most people using the service needed some level of continence support and continence aids. There was a designated member of staff who was responsible for assessing and ordering continence aids overseen by a nurse. Records showed the level of continence for each person and what aids were required for that person. Ordering was regular and people had their own continence aids stored in their rooms. Where people needed staff to support them to change those continence aids there was a system of communication through daily records and staff handover. Five staff discussed with us the frequency of changing continence aids, for example in order to maintain pressure care. One member of staff said, "We know who needs regular changes through handover. It can vary from person to person." Records showed there were no current pressure wounds which would be an indicator for poor continence management.

Five members of staff told us they had good access to training and that topics relating to health and safety were updated regularly. However, a number of people using the service demonstrated behaviour which

challenged. Incidents occurring during the inspection were being managed safely and effectively by staff. However staff supporting the people were agency workers. Staff working in the service told us they had either received training to manage challenges some time ago or that they had gained experience working at Trengrouse. The registered manager told us this had been recognised as a training need and had asked the organisations training department to provide 'Managing conflict' training to staff. This would support staff to respond to conflict in a safe and effective way based on good practice.