Tre' Care Group Limited

Trefula House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:
Trefula is a care home that provides personal and nursing care for up to 44 people, all who are living with dementia, and / or have other mental health issues. At the time of the inspection 41 people lived at the service. All of the people lived there permanently. The service primarily caters for people aged 65 and over, although at the time of the inspection some younger people were accommodated. The service was divided into two restricted units; 'St Mawes' / 'Restormel', and 'Pendennis' / 'Carn Brea'. Pendennis / Carn Brea provided a higher emphasis on general nursing care. Both accommodated people with dementia and/or other mental health care needs.

People's experience of using this service:

● Steps taken to minimise the risk of unwelcome visitors going into other people's bedrooms were not always effective. This caused some people anxiety. Suitable steps were not taken to safeguard people.

● Risk assessment processes were not always safe for example, in the case of specific individual's: regard to the use of bedrails, emergency evacuation plans in the case of a fire; pressure sore prevention.

●The lack of suitable recruitment checks put people at risk from staff who were not fit to work with vulnerable people. Staffing levels and deployment was not always sufficient to meet people's needs.

● Medicines were not always managed safely. The management of external preparations, such as creams and lotions, was not effective. The service did not have an effective audit system. People's medicines such as skin patches were not always managed safely. The gaps between medicine rounds were often not satisfactory which could result in medicines being given too closely together.

● Infection control procedures were not always effective. For example, we had concerns about the storage of some infection control products, and the cleanliness of some areas within the service.

● Assessment processes, before people came to live at the service, were not always satisfactory, and led to the service agreeing to admit some people who were not suitable to live there.

● Staff induction, training, supervision and appraisal systems were not always satisfactory. This meant staff were not always equipped with the right skills, knowledge and support.

● People did not always receive the correct support with eating and drinking. For example, this put some people at risk of choking. Records kept were not always sufficient.

● Health care records were not always comprehensive and did not detail what treatment people had

received, or when this was next required.

● People's rights were not always maintained in line with the Mental Capacity Act 2005. For example, when conditions were applied to Deprivation of Liberty Safeguard agreements, there was not always sufficient evidence these were being met. Staff training and knowledge about the Mental Capacity Act 2005 was not always effective.

● People did not always have access to a call point to summon staff in emergency

● People did not always have regular opportunity to have a bath or a shower.

● Care planning and guidance for staff to provide good quality care was not always satisfactory. Care plans were not always reviewed regularly and therefore were inaccurate.

● There were not sufficient planned activities available to people on a regular basis.

● End of Life care planning was not satisfactory and did not give staff guidance about people's wishes and needs.

● Management was not effective, and had not provided person centred high quality care.

● Governance arrangements were not satisfactory. For example, there were inadequate audit and quality assurance arrangements to assess service quality, and bring about improvements when required.

● People said they liked the food, were provided with a choice, and were offered regular drinks.

● People said they liked the staff, and staff were kind and respectful.

● Staff said training was good, and they had received comprehensive training in relevant areas such as moving and handling.

●People and their representatives said they felt confident if they made a complaint it would be dealt with quickly.

Rating at last inspection: Rating at last inspection: 'Requires improvement.' (published on 11 January 2019.)

Rated 'Requires Improvement' in the two last inspections. At this inspection we found the service had deteriorated and is rated as inadequate overall.

Following the last inspection, asked the provider to complete an action plan to show what they would do and by when to make improvements to the service. We also met with the provider to discuss our concerns and receive assurance about planned improvements.

Why we inspected: We completed this inspection to check whether suitable action had been taken, following the enforcement action we took following the last inspection. We also received concerns from the local authority and the clinical commissioning group about the operation of the service. Concerns were also received from whistleblowers and members of the public. Subsequently a full comprehensive inspection

was completed

Enforcement During the inspection we identified 6 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in regard of person centred care, consent to treatment, safe care and treatment, good governance, staffing, and fit and proper persons employed. Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

People were at risk from harm because the provider's actions did not sufficiently address the ongoing failings. There has been ongoing evidence of the provider to sustain full compliance since 2016. Our findings do not provide us with confidence in the provider's ability to bring about lasting compliance with the requirements of the regulations.

Follow up: During the safeguarding process the service is being monitored through a combination of visits by health and social care staff, as well as multi-disciplinary safeguarding strategy meetings.

We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.
The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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. We will have contact with the provider following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Trefula House

Detailed findings

Background to this inspection

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

We also wished to check that suitable action had been taken following two warning notices issued by CQC after the last inspection. This enforcement action was due to concerns about the registered persons not providing person centred care, and also not ensuring suitable procedures were in place about consent to care for people in line with the Mental Capacity Act 2005.

The inspection was also prompted in part by information shared with CQC about potential concerns about inappropriate referrals to the service and unsatisfactory care practice.

Inspection team:
The inspection team included three inspectors (two inspectors each day,) a specialist advisor (who had experience of dementia care), an expert by experience, a person who has personal experience of caring for someone who uses this type of care service.

Service and service type:
Trefula is a care home with nursing. The majority of people have dementia and / or other mental health needs. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced.

What we did:

We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse; and we sought feedback from the local authority, and other professionals who work with the service. We assessed the information we require providers 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 used all this information to plan our inspection.

During, or after the inspection we spoke or had written contact with five people and two relatives to ask about their experience of the care provided. We spoke with seven members of care staff, the deputy manager, the nominated individual, and one of the director's of the company. During, and after the inspection we spoke or had contact with seven visiting professionals from health and social care.

We reviewed a range of records. This included thirteen people's care records, and medicine records. We also looked at eight staff files around staff recruitment. We also looked at other records in relation to training and supervision of staff, records relating to the management of the service and a variety of policies and procedures developed and implemented by the provider.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

At the last inspection this key question was rated as 'requires improvement' as the service was not consistently following safe practice in relation to medicines management and we had concerns about the management of infection control. At this inspection the rating had deteriorated to inadequate due to a number of failings.

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse

- The provider had a suitable safeguarding policy and all the staff we spoke with had a good understanding of safeguarding processes
- The service is currently subject to a systemic safeguarding process due to multiple safeguarding referrals. The referrals had been submitted by the service and external professionals. The local authority and health care trusts have currently suspended referring people to the service. The registered persons have cooperated with ongoing safeguarding enquiries.
- One person expressed concerns that the pass code for entry into the home was well known to visitors, and was concerned that an unwanted visitor could gain entry to the service. The managers denied that the pass code was routinely given out to all visitors.
- We received concerns about people going into other people's bedrooms, and also observed this occurring. This caused subsequent anxiety for some people. We were informed by the nominated individual that there are monitoring systems, such as pressure mats, to help prevent this. However these measures were not always effective. We were told "I am not sure about (my relative) being safe because other residents are allowed to wander round and often come into (my relative's) room, and "I don't feel safe as people keep coming in my room."

The lack of suitable steps to mitigate the risk for people from unwelcome visitors placed people at the risk of harm. This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risk assessments were mostly in place to reduce the risks to people and guidance was provided. However clear and current guidance, in relation to at least one person's behaviour, was not in place, and subsequently there was insufficient information how staff could minimise any risks which were apparent. After the inspection this person left the service.
- One person required bedrails to minimise the risk of the person falling out of bed. One of the bed rail cushions was half off the bed. There was no evidence a bed rail assessment had been completed.
- Emergency plans were in place to ensure people were supported in the event of a fire. One person was situated on the first floor. Information in their fire evacuation plan referred to another person, and was therefore inaccurate. It was not clear, if the person needed to leave the building in the event of a fire, how

evacuation would occur.
● The environment and equipment was generally safe and well maintained. There was evidence electrical, fire, heating, cooking systems and manual handling equipment were serviced and safe. However, we were concerned there was a lack of risk assessment about the use of free standing heaters, and concerns about the temperature in some of the communal lounges.
● We were told more robust auditing has been introduced about pressure care since the last inspection. Pressure relieving mattresses inspected were found to be set at the correct weight to minimise the risk of pressure damage. However, we saw that pressure ulcer prevention records, for one person, were not completed frequently. After the inspection, an external professional expressed concerns that there had not been appropriate action regarding two people at risk of pressure damage, for example, these people had not been provided with pressure relieving cushions. We were informed that since the inspection, additional pressure relieving cushions have been purchased.

The lack of appropriate risk assessment procedures placed people at risk at harm. This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were not always recruited safely to ensure they were suitable to work with people. For example, when a person had previously worked in a caring capacity references were not always obtained from the person's previous employer.

The lack of suitable recruitment checks put people at risk of being cared for by staff who are unsuitable to work with vulnerable people. This demonstrates a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staffing levels were not always sufficient to meet people's needs. In communal areas we observed there was not always a member of staff present. Some of these people were very confused, required assistance with personal care, and / or had mobility issues. On the first floor, there are a number of highly dependent people for example people who were immobile, and one person who was categorised as requiring end of life care. Some of these people could not use the call bell system. On the four occasions we checked, there were no staff present on three occasions. Similarly people were left alone in communal areas for periods up to 10 minutes.
● We received several concerns about staffing. One person said, "Some people need more help than me. I have to wait my turn because I know they are short staffed." Relatives told us, "Staff do an excellent job but they are really stretched," and, "Staff are brilliant, but they need more of them. Sometimes you can tell they are struggling." An external professional told us, "There does not seem to be any nurse observed areas, and often residents are left in lounges without a member of staff…(today) residents looked agitated and needed the toilet. Once informed the carers took action. Without constant supervision how is this monitored?"
● Staff members expressed concerns about staffing levels and said at times the service was "Understaffed." Staff also said some colleagues were taking what was perceived as too much sick leave, "Particularly at the weekends." Other staff said staff sickness had got less, although there were concerns management were not taking enough action to reduce this. This matter has been expressed to us at the last inspection.
● Management of the service have informed us there is always an afternoon shift to provide additional staff support with activities. We were also informed of this at the previous inspection. However according to rotas staff had only been provided for this shift on 25 out of 70 occasions since the end of January.
● We did not see any audit tools in use to determine how many staff members were needed on each shift. There was also no system to determine when a registered mental health nurse must be on duty. There were times when only a registered general nurse was on duty. This is a concern as some of the people

accommodated has significant mental health needs, and there were times when non-clinical staff needed specific guidance.

The lack of suitable staffing puts people at risk of inappropriate care. This demonstrates a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

●Nurses received updated training on safe management and administration of medicines, and further refresher training had been booked to take place over the next few weeks. Competencies were checked to make sure they gave medicines safely. We were told any incidents were reported and reviewed to try to reduce the risks of them happening again.

●Some people were prescribed sedative medicines to be given when required. There was information in their care plans to guide staff as to how to manage episodes of anxiety or agitation, but this did not include when it would be appropriate to give doses of the medicine. This meant staff might not be able to administer medicines to each person consistently.

●Medicines were stored securely, however some medicines for disposal were stored in a locked office that was accessible to staff not authorised to access medicines. The deputy manager told us that they had started creating two new storage rooms for medicines to separate them from the office areas, which would address this issue.

●Nurses completed daily checks on medicines. However no formal medicines audits were being completed at the time of our inspection. The deputy manager told us they were planning to implement a regular medicines storage and Medicine administration record (MAR) chart audit to help identify areas for improvement.

●Creams and external preparations were recorded on separate charts. We checked three people's records. Two were well completed when preparations were used but the third person had no record of cream applications.

● Peoples medicines were not always managed safely. Skin patches were not always administered correctly. Two people had missed their patch being replaced at the correct time interval. However, these errors had been identified and reported by staff. Nurses were not aware that one medicine box contained two types of patch that needed applying in order, leading to a risk that these could have been applied incorrectly. We found that these had been used appropriately but records didn't show which strength had been administered or was due next.

● The temperatures in the medicines refrigerator were recorded as lower than the minimum recommended range in one fridge, and higher than the recommended range in the other. No action had been taken for the low temperature, although we were told that the higher range had been like this for some time and had been reported to the supplying pharmacy. However, it appeared that the minimum and maximum range was not being reset. This meant it was not possible to be sure that medicines were always stored at the correct temperatures and would be safe and effective.

● We were concerned about the timing of medicine rounds. We were concerned there was not safe time intervals between doses. We saw that the morning medicines rounds took up to 1pm to be completed. We were told this is because it can take nursing staff additional time to administer medicines, if people initially refuse them. This led to a risk that multiple daily doses of medicines could be given too close together. Times of administration were not recorded on the MAR charts, and nurses told us delays were not always reported at handover. However the nominated individual told us nursing staff are aware of required interval times between dosages of medicines.

● A GP raised concerns that although prescriptions had been sent to the pharmacist there were often unreasonable delays before administration commenced, and also dosages of medicines had not changed following instruction from a doctor's visit.

Inappropriate management of the medicines system puts people at risk of inappropriate care. This is an ongoing breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
●We did not notice any malodours.
● We had health and safety concerns about infection control practices. On one occasion a basket of cleaning products had been left on a person's bed; a staff member on more than one occasion was seen walking around the service wearing gloves resulting in a risk of cross infection; some rooms such as the laundry, store rooms, and some bathrooms, had areas which were visibly dirty; a hand sanitiser container fixed to the wall was empty.
● Staff were provided with gloves and aprons. However, these were stored in corridors. Due to people's behaviours there was a risk these could be ingested or misused by some of the people at the service. The nominated individual said storage of these items would be reviewed.

Inappropriate practice to minimise the risk of infection control puts people at risk of cross infection. This is an ongoing breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The service appeared clean and we saw staff used protective equipment such as gloves and aprons.
● Suitable laundry procedures were in place, for example for washing contaminated and soiled laundry.
● Staff received training about infection control and food hygiene.
● Cleaning staff were employed and were deployed seven days a week.

Learning lessons when things go wrong
● Incidents and accidents were recorded with action taken to reduce the risks of incidents reoccurring.
● We were concerned lessons were not learned when things go wrong. Despite significant concerns being expressed, at the previous inspection, the registered persons had failed to take appropriate action. For example, as expressed elsewhere in this report, there has been insufficient action taken to address breaches in the regulations, and this inspection has highlighted further concerns.

The inability of the registered persons to learn when things go wrong means people are at risk of unsafe and inappropriate care. This is a contributory factor in the breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At the last inspection this key question was rated as 'requires improvement'. This was because we had concerns about pressure care, people's rights being maintained under the Mental Capacity Act 2005, and the maintenance of health care records. After this inspection the rating has been downgraded to 'inadequate,' as insufficient action had been taken about previous regulatory breaches, and we had additional concerns about the assessment procedures.

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Inadequate:□The effectiveness of people's care, treatment and support did not achieve suitable outcomes for people.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Written assessments detailed that senior staff assessed people before a decision was made for the person to move in. People and their relatives could visit the service before a decision was made about moving in.
- We were concerned about the appropriateness of some people admitted to the service. This was due, for example, whether staff had the skills and knowledge to meet these people's needs, that the service did not have the correct facilities and equipment to meet the needs of one person, and the impact of one person's behaviour, and the risks they subsequently presented to other people.
- The service had an assessment policy although there were no written criteria to assist staff to assess whether the service can meet an individual's needs.
- Staff told us there could be delays from the time when people come to live at the service, to the time when management provide them with assessment information. We were told this had resulted in staff not having information about someone's needs when the person was admitted to the service. An external professional also added, "X was discharged from hospital, and needed urgent review. (consultation about a healthcare need.) X was at Trefula for 24 hours and was only brought to my attention when I was visiting someone else. I had no idea about X's (care needs), there was no documentation...I felt the standard of care and communication was poor."

Failure of the registered persons to have suitable assessment processes puts people at risk of ineffective care which does not meet their needs and wishes. There is an ongoing breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- A one day session included an over view of safeguarding, health and safety issues, and principles of care. Staff told us after the introductory day they would then work "up to two weeks supernumerary," depending on whether they had previously worked in care or not. We were informed by the nominated individual staff complete the Care Certificate. The Care Certificate is a nationally agreed set of induction standards which care providers are strongly recommended to follow with staff new to the care sector. However, not all staff, who had not previously worked in health and social care, had evidence of completing the Care Certificate.

● After induction staff complete formal training in a range of health and safety related matters, safeguarding, mental capacity, dementia, recording, and dignity and respect. Staff also completed training to minimise, and manage aggressive behaviour (MAPA). Most staff had completed required training, although computerised records were not available for some staff who started work from November 2018. Some staff said observations were completed for example to check competency with manual handling. Some of the staff we spoke with had limited knowledge of the mental capacity act, and its consequences, despite there being records they had received training in this area.
● Nursing staff were not always provided with satisfactory training. For example, we were informed of two incidents when there were not enough nursing staff trained in catheter care to assist people. Some external professionals recommended that staff should receive more training about tissue viability.
● The staff we spoke with all agreed that training provided was "good." A relative said "Staff are knowledgeable and well trained."
●Although there was always a senior care assistant, or registered nurse on duty, there were insufficient records to demonstrate staff received regular one to one supervision. Some records referred to brief discussions about a particular matter or were classed as 'informal.' Only a few records outlined lengthy discussions about care practice, performance, support and training. One staff member, who had been in post several months said, "I have not had supervision since I started," and another said, "I have had two supervisions in five years." (The last one occurred in November 2018). There were no recent records to show staff received an annual appraisal. We were told the in house trainer carried out spot checks for example, regarding personal care and manual handling practice.

Failure to provide staff with suitable formal induction, training, supervision and appraisal puts people at risk of inadequate and unsafe care. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● Food and fluid charts were not always correctly completed. For example, on fluid charts there was a tick box stating if the person required thickened fluids. On all forms assessed this information had not been completed. Particularly as the service used agency staff, who would not be aware of what type of fluid consistency people required, this could potentially be a choking risk if a person required thickened fluids and was given normal fluids.
● There was no likes and dislikes in care plans reviewed

Failure to provide satisfactory care records puts people at risk of inadequate and unsafe care. This is a contributory factor to the breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●One person had a gluten free diet. They raised concerns food provided may not always be according to their dietary requirements. For example, we witnessed the person asking a member of staff if their dessert was gluten free, and the staff member replied, "I don't know it is the same as everyone else's."
● People were supported to be independent. People ate at their own pace. Some people chose to eat their meals in their bedrooms. People were served promptly. Where necessary we observed people receiving suitable support to eat, for example to have food cut up, or one to one support with eating. However, we were informed one person had a care plan which said food should be "cut up small," due to a health condition. However, the person was observed eating their main meal where food had not been cut up.

Failure to provide safe support with their meals puts people at risk of inadequate and unsafe care. This is a contributory factor to the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

● Other people were supported to receive meals, in a timely manner, which met their dietary requirements, this included the texture they needed to reduce the risk of choking.
●People we spoke with told us they liked the home cooked food. They told us they were offered two choices for their lunchtime meal each morning and that if they did not like either choice they could request something else. However, we observed that one person's meal, which was eaten in their bedroom, was lukewarm. The person said this was a regular occurrence. There were regular drinks rounds.
● People were positive about the food. We were told, "It is lovely, very tasty," and "The food always looks hearty and there is plenty on the plate." A relative said, "The food looks appetising and there is good variety and choice each day. (My relative) enjoys (their) food."

Staff working with other agencies to provide consistent, effective, timely care
●Visiting professionals, had mixed views about care. Several health professionals, such as GP's had no concerns, for example "We are positive" (about the service) and, "Staff are keen to get our input and advice and have always appeared willing to carry out the advice and treatment regimens recommended." However, others expressed concerns such as: "In the last three months standards have significantly dropped," "Not all of our recommendations are followed." "There are increased times when reviewing a patient the nurse has little idea of the current state of play which makes reviewing them medically more difficult."
● Referrals had been made to a range of health care professionals when that area of support was required. For example, occupational therapists, tissue viability nurses, speech and language therapists and physiotherapists.

Adapting service, design, decoration to meet people's needs
●Decorations, particularly in the older part of the building were in places shabby and in need of redecoration. Furnishings and carpets generally looked clean. However, we saw, and received some concerns from relatives, that some furnishings were scruffy. For example, bedside cabinets had handles missing. The nominated individual informed us the service has a rolling maintenance programme, and informed us the registered provider recognises that the older part of the building needs some attention.
● The majority of accommodation was on the ground floor. Some accommodation, in the older building, was on the first floor. There was a passenger lift, but due to size, this was difficult to use for some people, and was not possible for at least one person who was accommodated on the first floor and could not get downstairs without several people supporting them. Some facilities were adapted for people with physical disabilities and / or who were frail; for example there were specially adapted bathrooms and toilets which people could use. Signage however (which would help people who were confused or had dementia) was very limited. The muted colours of doors throughout the building made it challenging for someone with visual or cognitive impairments to navigate.

It is recommended that the registered persons seek advice, from a reputable source, in respect of design of buildings, and suitable signage, for people with dementia.
● There were mixed comments about the building. One external professional said the older part of the building was "cramped," (in respect of the lounges, and being able to manoeuvre people in wheelchairs within corridors and bedrooms. We noted at times corridors were blocked with trolleys and hoists. Wheelchair access is available throughout the main building and ramped down to the extension. However, the incline of the ramp is too steep to allow independent wheelchair access. The downstairs extension is fully accessible with modern facilities and full access to the outside garden areas, although people with mobility issues could not access upstairs office facilities.
● There were some free standing heaters in people's bedrooms. We were told this was due to the heating

not working in these bedrooms. Management did not seem aware of their use. A relative also expressed concerns about the temperature in one of the lounges. We were told, "I was told they check the heating but the thermometer is up there (at the top of the doorway). It is cooler down here, where people are sitting. (My relative) gets cold, and that is why there is a blanket." There were no risk assessments about these issues. Earlier in the report, we have stated this needs to occur.
● People could choose to personalise their bedrooms with photographs, televisions and other personal possessions.

Supporting people to live healthier lives, access healthcare services and support
● People told us that they received health care support when needed, for example they could see a doctor if they were unwell.
● At the last inspection we found records to demonstrate people saw a range of health care professionals were poor. At this inspection records demonstrated some relevant health and social care professionals were involved with people's care such as the GP. However, there were insufficient records to demonstrate people needed, and saw other healthcare professionals such as dentists, opticians and chiropodists.
● A short time after the inspection, concerns were expressed by external professionals, about the service's failure to appropriately assess several people's health and personal care needs, and ensure they received suitable care from external services such as community psychiatric nurses and GP's.

Inadequate record keeping puts people at risk of inappropriate care. This is a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). Some DoLS have conditions applied for example such as a person being provided with an opportunity to participate in activities.

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
●The registered manager had applied for DoLS on behalf of people and kept clear records of which were awaiting authorisation and when they needed renewing.
●Where people did not have capacity to make decisions, staff involved them in making some decisions about their care for example what they wanted to wear and choices of what they wanted to eat and drink. Managers told us staff worked to support people to have maximum choice and control of their lives and were supported in the least restrictive way possible.
● Care staff explained to people what they were about to do. For example, when assisting people to move around during the day. We saw staff patiently explain to people that it was lunch time and they were going to assist them.
●Staff had received training in the MCA and DoLS. However, some of the staff we spoke with had limited awareness of the act and its consequences. This brought into question the effectiveness of the training provided.

● Each person had a mental capacity assessment, and if DoLS were in place there was a record of authorisation on their files.
● There were insufficient records to demonstrate conditions, which were given as a consequence of any DoLS authorisation, were always being met. We found conditions in respect to 'one to one' staffing were complied with. There were records in place in regard to conditions about 'skin integrity'. However, we had concerns about the service complying with conditions about activities with people. For example, a condition was in place for a person to have regular activities. Staff had completed a thorough assessment which said the person liked music, baking, poetry and other activities. Although records were kept of activities, there was no evidence most of the activities on the assessment had been attempted. Records gave examples such as "declined to see singer," or "visited by family." We found similar evidence with a second person.
Not adhering to conditions of DoLS authorisation means the service is not ensuring people's rights are maintained. This is an ongoing breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Requires Improvement: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity

● When care staff were present, we observed them responding to people, and answering call bells promptly. One relative said that although a person could not use the call bell, "Staff understand that and make regular checks." Most people, and their representatives, we spoke with told us when they used their call bell care staff came within a reasonable time. However, we did receive some concerns. We were informed of one person who spent significant periods of time in their bedroom, but did not have access to their call bell. Similar concerns were expressed by relatives and external professionals.

Not providing people with the means to access staff help promptly puts people at risk of unsafe and inadequate care. This is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People looked clean and their nails well manicured. However, we were concerned there were insufficient records that people had a bath or a shower. There were records however that people received support to have a wash. There was no record that another person had been assisted to have a bath or shower since mid January. One person said, "I have not had a bath or shower since I got here because they don't have the equipment and I have to bed bath." Another relative said, "When (my relative) first came here they were not doing it (providing a shower /bath), but I complained and now it's every three days."

Not providing people with the opportunity to have a bath or a shower means people's personal hygiene needs are not being satisfactorily maintained. This is a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We observed people were treated with kindness. We received positive feedback from people and relatives. For example relatives told us, "Staff are approachable," "On the whole carers are good," and "Staff are extremely caring and helpful…I have observed on many occasions how kind and helpful they are," "Staff are lovely," "They are very caring," and "The staff are fantastic, really caring and professional." An external professional said, "Some staff are amazing." On the whole we observed many positive relationships between people and staff. We did however witness some incidents which raised concerns about some staff approaches. We observed one person slumped precariously in the chair. Two members of staff checked the person but others ignored them. We heard another member of staff refer to people who needed help with their meals as "feeds", and judged this language to be undignified. These matters were discussed with senior staff and management.

Supporting people to express their views and be involved in making decisions about their care

● We observed staff listening to people, and asking them about how they wanted their day to day care for example what they wanted to eat and where they wanted to spend their time. Throughout the inspection staff were observed consulting people about what they wanted. A relative said, "Staff take great care to involve (my relative) as far as they can" (in day to day decisions. However, people also told us "I can make choices, but it depends how many staff are on, "and "I ask for things, and staff say they will be right back to help me get up, but then they do something else and don't come back to me. I have to ask again and I feel a nuisance."

● People could get up and go to bed at a time of their choosing, but people said this was however dependant if staff were available to assist them.

● Most people, due to their mental health needs could not participate in the care planning process. However, some people's representatives said they had been involved in care planning.

● Relatives said staff were good at keeping in touch and letting them know if there were any concerns.

Respecting and promoting people's privacy, dignity and independence

● People were treated respectfully and the staff spoken with were committed to provide the best possible care for people. People told us, "They always knock on the door," and "If I don't like something I tell them and they don't do it." A relative told us, "(My relative) responds positively to the attention (they) receive, and in many ways (my relative) is happier than (they) have been in the last ten years".

● A relative told us, "Staff are careful to allow (my relative) as much independence as possible while keeping (my relative) safe."

●We did hear staff talking about people's needs in front of other people for example in the lounges. This was primarily about organising tasks which needed to be completed, but did involve some personal and sensitive information. One person also commented on this and told us, "It worries me that they might be saying things about me that other people hear."

● Otherwise we saw that people's dignity and privacy was respected. For example, staff were discreet when asking people if they required support to the bathroom.

● People were supported to maintain and develop relationships with those close to them. Relatives told us they were welcome to visit anytime and always felt welcome.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection this key question was rated as 'requires improvement'. This was because we had concerns about care planning, activities and end of life care. After this inspection the rating remains 'requires improvement', as insufficient action had been taken these issues.

Responsive – this means we looked for evidence that the service met people's needs

Requires Improvement: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● Although care plans were being rewritten, and we judged them an improvement, they did not always contain relevant and up to date information about people's needs. For example, there was insufficient up to date and detailed information about some people's physical and mental health care. For example, one person had a catheter, but this was not outlined in their care plan; one person was viewed at risk of self harm, but there was no care plan about this; there was a lack of repositioning information for a person who spent most of their time in bed, and irregular record keeping when the person was repositioned. Statements were made such as 'Reduce the risk of Urinary Tract Infection,' but staff were not given person centred information how this should be done. There was no evidence of pain scales being used. This method is used for people who are not able to express their pain.

● Guidance in behavioural care plans was not comprehensive. People who required assistance to de-escalate aggressive behaviour, and may require physical intervention, did not always have clear guidance to assist them for example 'triggers' which caused certain behaviours. Triggers may affect a person's emotional wellbeing, or affect how to de-escalate inappropriate behaviours. One person only had guidance, provided by their previous placement dated June 2018, and there was no evidence this had been reviewed. Care plans referred to 'low' or 'medium holds' required in some situations. However, no person centred guidance was provided to staff to ensure actions were applied consistently, and in a manner to minimise the risk of injury. One person, where guidance said 'low' or 'medium' holds may need to be used, had a record of an incident where a 'high level MAPA' hold was used. This was not what was in the care plan, and there was nothing in the record to state what this involved or how it was authorised. An external professional said staff were not identifying and responding to triggers which caused certain behaviours

● Care records such as fluid charts were not always being completed. These records were sometimes not being stored confidentially. For example, we found some of these records in corridors.

● One person raised concerns about terminology used in their care plan and believed this was defamatory and inaccurate. Although information was removed from the person's bedroom, a copy of the records was in the office. The matter was discussed with management.

●Care plans were not always being reviewed monthly in line with the registered provider's policy. For example, although we saw some care plans reviewed within the last month, some had not been reviewed since December 2018. An external professional said one person had been reviewed with external professionals (verbally) the previous week, but was concerned the care plan had still not been updated.

●External professionals have expressed concerns, in the case of one person, that at multi- disciplinary meetings staff were unaware of the person's needs, even though significant and ongoing concerns had been

expressed about these.
● Due to people's health many people could not participate in reviews of care plans. Relatives had mixed views about whether they had been involved. Some said they had not, but others said they had. For example, "My sister and I were very involved with developing (the care plan)." Care plans did not outline how staff involved the person or their representatives in the person's care.
● Some staff expressed concerns that nursing staff were not routinely reading daily records, except for when care plan reviews were completed. Some care staff said they did not have routine access to care plans, as these were stored in the nurse's office. Others said they did not read records as they did not have the time. Some staff told us they relied on verbal handovers to obtain information. One senior carer said they, "Don't have time," to read care plans, and they were made aware of people's needs through discussion. We spoke to one nurse who said they "Didn't have time to do it," and did not know when they would have time to complete the reviews. We spoke to the deputy manager about these matters, and we were told that all staff were able to access records, and could regularly review them. Nurses were designated protected time to update care plans. External professionals have expressed concerns that care staff have not been provided with detailed information about specific care plans. The staff we spoke with however appeared to know people well.

The lack of up to date care plans means staff do not have satisfactory guidance to provide people with consistent care. This demonstrates ongoing breaches of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the last inspection, the registered persons had recruited a temporary activities co-ordinator, over a four day week. The substantive post holder is on maternity leave. We saw only very limited activities taking place over the two days of the inspection. For example, we saw a member of staff facilitating a ball game in one of the lounges, an occasion when a staff member offered to paint someone's nails, and for people to complete a jigsaw, and a third occasion when a member of staff was briefly playing with plasticine with one person.
● The person who was covering for the post holder was on annual leave, and there were no arrangements in place in this person's absence. We were told there was a 2pm-7pm shift which facilitated activities, but records showed that since the end of January this had not often been arranged.
● We were told staff facilitated activities such as knitting, baking, a coffee group, exercises, singing and dancing. There was a laminated sheet with suggested activities which staff could facilitate with people. Staff we spoke with said activity provision had "Got better," due to their being an activities co-ordinator. One staff member said, "It is hard to get people engaged, but we try to just sit and chat."
● Some entertainers visited the service. For example, we were told different singers and musicians visited the service, and there was a drumming session which people participated in. We were told these organised activities took place approximately "once a fortnight."
● There was a lack of evidence held both centrally, and individually in people's files, that frequent, suitable and planned activities took place. Records in people's files contained a significant number of entries of individuals not wanting to participate in activities rather than outlining what activities they did participate in. Some entries could not be deemed as an 'activity' for example 'listened to a CD', 'chatting,' or 'watched film.'
● Some people had assessments completed about what activities they would like to participate in, or should be encouraged to do. One person's external assessment said they should be kept 'meaningfully occupied' for example given a 'job tick list' or participate in 'balloon', or 'parachute' games. We only saw this person, over the two days, walking around or sitting with the one to one member of staff they were allocated with.
● Radios and TV's were on in lounges. However, the volume was often very low so it was difficult to hear

programmes. The subtitles on the TV was not switched on. This was discussed with management both on this and the previous inspection. A daily newspaper was available which people clearly enjoyed looking at. There were some old magazines and books which people could look at.
●People told us, "There is nothing to do," "I just watch TV," and "We had a singer, that was nice one day." Relatives said, "They have a few activities like singers," and "I don't think most people want much, just to sit in their chairs and snooze."

Not providing a satisfactory level of meaningful activities results in people not having satisfactory stimulation to live a varied and interesting lifestyle. This demonstrates an ongoing breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a monthly church service and people told us they enjoyed the spiritual occasion.
● Information was not always provided in a format to support people's needs. People with a sensory impairment were not always able to access information in other formats such as menu's, the complaints procedure or the service user guide in a pictorial, audio or easy read format. This is a requirement by the Accessible Information Standard. We were told staff would read out or verbally inform people of relevant information if necessary (for example personal correspondence, menus, service information)

Improving care quality in response to complaints or concerns
● People and their representatives who we spoke with said they all felt confident that if they did make a complaint it would be dealt with quickly.
● We saw that any written complaints had been investigated and addressed providing the complainant with a formal response.
● The complaints procedure was displayed in the home and this was also issued as part of the service user guide.
● A relative said, "I have no reason to complain….I am sure any complaints would be taken seriously."

End of life care and support
● We were told, at the time of the inspection, that one person required end of life care. The person was in bed throughout the inspection. We did not see staff actively providing any care and support to the person.
● We were told that people who required end of life care had end of life care plans. However, there was no evidence these had been developed for the person who we were told needed end of life care. It was therefore not clear what the person's wishes were, what specialist support was required, and how they were being supported with their spiritual needs.

Not providing people with appropriate end of life care contributes to people not receiving suitable person centred care, or treating them with dignity and respect. This demonstrates an ongoing breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were told when people needed end of life care the service involved GP's and other external professionals to ensure suitable care was provided.

Inadequate

Is the service well-led?

Our findings

At the last inspection this key question was rated as 'requires improvement' as governance arrangements had not consistently identified shortfalls in relation to several matters such as the management of medicines, and the provision of good quality person centred care. At this inspection the rating had deteriorated to inadequate due insufficient action taken about the majority of previous regulatory breaches, and also due to additional failings highlighted at this inspection.

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- Leadership and management did not ensure person-centred, high quality care was delivered. The provider had failed to ensure there was sufficient oversight and governance at the service. Systems had not been effective in identifying shortfalls and unsafe practices. As a result, standards had not improved, but deteriorated, since out last inspection. For example unsatisfactory action had taken place in respect of the enforcement action we took in regard to providing effective person centred care, and not fully met in respect of the mental capacity act and maintaining people's rights. The provider was not aware of many of the concerns we raised during the inspection.
- People were at risk because accurate records were not consistently maintained in respect of people's care.
- Relatives had mixed views about the culture at the service. One relative said, "(My relative) has thrived in the atmosphere at Trefula where almost everybody who passes talks and chats to (them)" We were also told, "The most striking thing is that it feels like an extended family and community. That is no small achievement granted the level of disability and disorientation of so many of the residents." However, we were also told, "I am not sure how well managed it is because I don't think the staff are very happy," and "It is a hard job managing a place like this. I feel there are things they could do better especially around staff. If you don't get your staff right you can't provide a good service."

The shortfalls in governance and failure to implement improvements was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager was not available at the time of the inspection. An acting deputy manager had been recruited since the last inspection, and was in charge of the service on the days of the inspection. Another nurse acted as the clinical lead for the service, but it was not clear how this role was performed. We were concerned there had only been either limited, or no action about the regulatory shortfalls highlighted

at the previous inspection.
● The nominated individual had provided an action plan to outline actions taken following the last inspection, and concerns raised about care standards by the local authority. This was last updated in March 2019. As outlined within this report we did not always judge there was sufficient evidence to conclude appropriate action had been taken about previous regulatory shortfalls.
● The registered manager, and deputy manager had several audit systems. These included about infection control; incontinence aids; pressure care; staff training, and accidents and incidents. We were told there was no system to audit the medicines system despite there being an ongoing regulatory breach highlighting problems in its operation. Audits completed did not highlight any significant shortfalls.
● Staff we spoke with had mixed views about the management of the service. For example, we were told "They are ok," and "It is a good place to work…I feel supported by the management team." Another member of staff said, "I can go and rant if I need to." Others felt they could not approach managers and would get support from other carers. For example, we were told there could be better leadership from "the top down" and staff were "barked at" by management. We were told staff were leaving because of the attitude towards them. Just after the inspection we received an anonymous concern, expressing concerns about the management of the service. Relatives and external professionals told us "The manager is very approachable but lacks management skills. Recently things have felt chaotic." Other relatives were positive about the attitudes of management. For example, one relative said they are, "Very friendly and open to feedback."

The shortfalls in governance and failure to implement improvements was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The deputy manager said there had been meetings with relatives to discuss the operation of the service and to give the opportunity for relatives to contribute their views of the service.
confirmed they attended regular meetings and were asked their views on the running of the service. A relative said, "Managers always stress how helpful our feedback is and frequently invite us to let them know about any problems."
● Staff were involved in daily handovers. These helped to ensure good communication between the team and consistency of care.
● Surveys were sent out each year to relatives, external professionals and staff. The results of the survey conducted in 2018 was positive.

Continuous learning and improving care
● Incidents and accidents were recorded, and we were told action had been taken to reduce the risks of these reoccurring. We were told management analyse accidents and incidents at least on a monthly basis.
● There were mixed views about whether morale within the team was acceptable. Some staff told us it had "improved," whereas others felt this was not the case. We were also told "It could be improved. There is a lot of stress." An external professional told us: "Staff seem stressed and morale is low. The feedback is they are always short staffed and staff sickness is high."
● Some staff meetings took place for management and staff to discuss service developments and improvements that needed to be made. For example, there were two meetings scheduled for each grade of staff; nurses, senior carers and carers in January and March.

Working in partnership with others
● Health professionals had mixed views about working relationships. We were told "care staff are very helpful and informative, and they are a close team." External professionals said, "Nobody knows what is

going on," and, "I have worked with Trefula for (many) years and have found care to be largely excellent. More recently some standards have dropped."

●The service had some ongoing links with the local community. For example, the local church visited on a monthly basis. Some external entertainers visited the service.

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 Failure of the registered persons to have suitable assessment processes puts people at risk of ineffective care which does not meet their needs and wishes. Not providing people with the opportunity to have a bath or a shower means people's personal hygiene needs are not being satisfactorily maintained. The lack of up to date care plans means staff do not have satisfactory guidance to provide people with consistent care. Not providing a satisfactory level of meaningful activities results in people not having satisfactory stimulation to live a varied and interesting lifestyle. Not providing people with appropriate end of life care contributes to people not receiving suitable person centred care, or treating them with dignity and respect.

The enforcement action we took:

We imposed a condition on the registration of the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Not adhering to conditions of DoLS authorisation means the service is not ensuring people's rights are maintained.

The enforcement action we took:

We imposed a condition on the registration of the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

The lack of suitable steps to mitigate the risk for people from unwelcome visitors placed people at the risk of harm.
Inappropriate management of the medicines system puts people at risk of inappropriate care.
Inappropriate practice to minimise the risk of infection control puts people at risk of cross infection.
The lack of appropriate risk assessment procedures placed people at risk at harm.
Failure to provide safe support with their meals puts people at risk of inadequate and unsafe care.
Not providing people with the means to access staff help promptly puts people at risk of unsafe and inadequate care.

The enforcement action we took:

We imposed a condition on the registration of the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The inability of the registered persons to learn when things go wrong means people are at risk of unsafe and inappropriate care. The lack of up to date care plans means staff do not have satisfactory guidance to provide people with consistent care. Inadequate record keeping puts people at risk of inappropriate care. There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

The enforcement action we took:

We imposed a condition on the registration of the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The lack of suitable recruitment checks put people at risk of being cared for by staff who are unsuitable to work with vulnerable people.

The enforcement action we took:

We imposed a condition on the registration of the service

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The lack of suitable staffing puts people at risk of inappropriate care Failure to provide staff with suitable formal induction, training, supervision and appraisal puts people at risk of inadequate and unsafe care.

The enforcement action we took:

We imposed a condition on the registration of the service