Swallowcourt Limited

Trevaylor Manor

Inspection report

Gulval
Penzance
Cornwall
TR20 8UR

Tel: 01736350856
Website: www.swallowcourt.com

Date of inspection visit:
24 October 2017

Date of publication:
20 February 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Trevaylor Manor on 24 October 2017. The inspection was unannounced.

Trevaylor Manor is part of the Swallowcourt group and is a registered nursing home for 81 older people. At the time of the inspection, 73 people were living at the service, some of whom were living with dementia. Trevaylor Manor comprises a main building arranged over three floors. People living on the upper two floors were likely to have higher physical needs. There was a downstairs unit, used for people living with more advanced dementia. In addition, there was a separate building within the grounds, known as the Coach House. The Coach House was part of the dementia unit and accommodated up to eight people who required a safe environment, but were more physically independent.

Trevaylor Manor is required to have a registered manager and there was one 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Trevaylor Manor was last inspected in January 2016 and rated as 'Good' overall. However, the service was rated as 'Requires Improvement' under the caring domain. During that inspection, we found that slings and continence products were communally used and interactions between people and staff were largely task based. At this inspection, we found that slings and continence products continued to be communally used. We continued to observe task based interactions between people and staff.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe, and 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. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

People were not always treated with dignity and respect. Some people were ignored by staff for long periods of time. Staff did not always try to establish why people were calling out, for example if they were in pain, distressed or wanted to move. Some people were left alone for long periods of time, for example in quiet areas which they could not move away from independently People's privacy and confidentiality was not always protected. Confidential information was left on display. People were not always able to alert staff

when they needed help. Some people did not have access to call bells.

People were not always kept safe within their environment. Potentially hazardous items were not securely stored. The sluice room was not lockable and was situated in a corridor where people were independently mobile. We saw a heavy sash window propped open with a cup. This could have caused serious injury if the cup had been moved. This was reported to staff and removed. We saw unnamed items left in bathrooms such as toiletries, continence products and slings. This placed people at risk from cross infection. People were moved using unsafe moving and handling practices.

Areas of the service were not dementia friendly. There was little to distinguish one area of the home from another. This is important for people living with dementia who might not be able to orientate themselves. Seating arrangements were not consistent for people living with dementia. People sat in a circle in armchairs situated around the edge of the rooms. One person's bedroom was sparse and not homely. Action was taken by the service following our visit to address this.

People's health needs were not always effectively monitored. Food and fluid charts were inconsistently completed and did not specify people's target amount. There was no guidance for staff on managing some health concerns, Some people living at the service were at risk from choking. There had been a death at the service following a choking episode, which had in part prompted this inspection. There was no choking protocol or policy in place and people's care plans and risk assessments around choking were basic.

People's medicines were not always managed safely. The medicines room air temperature regularly exceeded 25 degrees Centigrade, meaning the efficacy of the medicines may have been compromised. There was no stock of homely remedies such as paracetamol, meaning people may have had to wait too long for effective pain relief. There were minimal audits of medicines and staff were unclear of what action to take in the event of a medication error.

People's rights were not always protected as the principles of the Mental Capacity Act (MCA) were not followed. Mental capacity assessments were generic and required updating. Deprivation of Liberty Safeguards (DoLS) paperwork was out of date and there was no system for informing the Supervisory Body if restrictions in people's care plans changed. People's consent was not routinely sought. Family members had given consent to elements of people's care and treatment without the correct legal authority to do so.

People had care records in place. Whilst some were detailed and comprehensive, others were not accurate. Some care records contained insufficient guidance for staff on meeting people's needs. Information in people's records did not match what staff told us about them. Some people had life story books in their records which contained details about their background, history, likes and dislikes, whilst other people's life story books had been left blank.

People had access to activities at the service but these were not always personalised. People had personal activity plans in place which detailed their hobbies and interests, but the activities they were offered did not often reflect this. One person's file indicated that they enjoyed fishing, but there was no evidence to suggest staff had tried to help them maintain this hobby, either by actual participation in it, or for example subscribing to a magazine about it.

There were systems in place to monitor the quality of the service at Trevaylor Manor, however these systems had failed to identify or to or address in a timely way, many of the areas of concern identified at the inspection. There were minimal opportunities for people and relatives to provide feedback on the service. There were no residents' meetings or relatives' meetings and there had not been a recent quality assurance

survey.

People were supported by staff who had received an induction. Staff who were new to care undertook the Care Certificate, a nationally recognised set of standards for staff working in the health and social care sector. Staff received training in subjects identified by the provider as mandatory and there was a system to remind them when it was due to be renewed or refreshed. Staff told us that they did not receive regular supervision or appraisals and did not always feel supported by management. Morale amongst staff was generally low.

Staffing levels on the day of the inspection were suitable. There had been a successful recruitment drive and there were few vacancies. Staff however told us they felt pressured and short staffed. During the inspection we saw that there were sufficient staff on duty, however they did not always interact with people.

People using the service told us they felt safe. People were supported by staff who received training in safeguarding adults and who knew how to make a safeguarding alert. People were supported by staff who had been safely recruited and had undergone all of the required checks to ensure they were safe to work with people who were vulnerable.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Hazardous items were not securely stored and the premises were not always safe.

People were moved using unsafe manual handling techniques.

Procedures for staff to follow in the event of a person choking were not robust.

People's medicines were not always appropriately stored.

Infection control practices were not always robust.

Is the service effective?

Inadequate

The service was not effective.

People's rights were not always protected because the principles of the Mental Capacity Act were not followed.

People's consent was not routinely sought by staff.

The environment was not dementia friendly.

People's health care needs were not effectively monitored.

Is the service caring?

Inadequate

The service was not caring.

Interactions between people and staff were not always caring.

People were not always treated respectfully.

People's privacy and dignity was not protected.

Staff did not always know the needs of the people they supported.

Is the service responsive?

Requires Improvement

The service was not entirely responsive.

People were not always able to alert staff when they needed help.

People's care records were not always an accurate reflection of their needs.

People had access to some activities, however these were not personalised.

There was a system in place for receiving and investigating complaints.

Is the service well-led?

Inadequate

The service was not well led.

Systems to monitor the quality of the service were not effective.

The service had not notified us of important events in line with their legal obligations.

There were minimal opportunities for people and relatives to offer feedback.

Lessons had not been learned following significant events.

Trevaylor Manor

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.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a further investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of choking. This inspection examined those risks.

This inspection took place on 24 October 2017 and was unannounced. The inspection was undertaken by two adult social care inspectors, a specialist advisor (SPA) with a background in nursing and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before visiting the service we reviewed information we kept about the service such as previous inspection reports and notifications of incidents. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern.

During the inspection, we looked around the premises. We observed the lunchtime experience and interactions between people and staff. We spoke with eight people who lived at the service and observed others who could not communicate their wishes and feelings verbally. We also spoke with three relatives. Throughout the inspection, we spoke with 13 members of staff. Following the inspection, we made follow up phone calls to six further staff members and made contact with three professionals who knew the service well.

We looked at eight records relating to people's individual care, training records for all staff, three staff personnel files, policies and procedures and a range of further documents relating to the running of the

service.

Inadequate

Is the service safe?

Our findings

We found concerns relating to the environment. We observed a cleaning trolley which was situated in one of the corridors, which contained COSHH (Care of substances hazardous to health) items. We noted that the trolley remained in the corridor throughout the day and was not always attended by staff. People living on the unit were independently mobile and some were living with dementia. The accessibility of the cleaning products meant people were at risk of harm. For example people could have drunk the substances or picked them up leading to products coming into contact with their skin or eyes. In another area of the home, there were keys left in clear sight in a cabinet in a nurse's office. The office door was open and not always staffed. The keys included keys to the COSHH and chemical cupboard.

There were unnamed items left in one bathroom, including undergarments and shared toiletries such as soaps, shampoo and a hairbrush. Moving and handling slings were also being shared between people. The sluice room was not lockable, meaning people could access this room and potentially come into contact with unsanitary items This placed people at risk from cross infection and the increased risk of illness or transmittable disease being spread through the service. The home appeared generally clean and was free from adverse odours.

There was a heavy, sash window in the dining room on the dementia unit. This window was propped open with a cup. This could have caused a serious injury had the cup been removed causing the window to fall on somebody. This was highlighted to staff who removed it. These issues were highlighted to staff on the day of our visit so that they could be addressed promptly.

Some people living at the service needed assistance in order to move. We observed staff using unsafe manual handling techniques to assist people. We saw people being moved by staff placing their hands under their armpits. This placed people and staff at risk of injury.

People's medicines were not always managed safely. We found that the air temperature in the medicines room regularly exceeded 25 degrees Centigrade. Medicines should be stored below this temperature to ensure their efficacy is maintained. On the day of the inspection, the room was warmer than 25 degrees Centigrade despite the window being open. We also found that the service did not have a stock of 'homely remedies'. Homely remedies include items which are available without prescription, such a paracetamol. This meant that if a person living at the service had a headache or other minor illness, they would not have access to these medicines quickly. Staff would have to contact the pharmacy to have them prescribed and delivered. This meant that people in pain may not have had access to quick pain relief. We found that staff who were involved in administering medicines were not aware of what action to take if there was a medication error. For example, what the reporting procedure was. This meant that learning from errors might not take place. There were also minimal medication audits meaning that errors might not be quickly identified.

Some people living at the service required pressure relieving mattresses to ensure their skin integrity was maintained. We found that there were no audits of pressure mattresses. This meant they were not routinely

checked to ensure they were set correctly for each person. This placed people at risk of developing pressure areas.

One person had bedrails to prevent them falling out of bed and injuring themselves. We found the person twice in their bedroom with their legs stuck between the bedrails. This placed them at risk of injury or skin breakdown. There was a crash mat on the floor to the side of the bed, in case the person climbed over the bedrails and injured themselves, but this was not in the correct position should they fall from the bed.

The service did not have a policy or protocol in place to inform staff of what action to take should a person living at the service experience an episode of choking. A choking incident had occurred at the service which had in part prompted this inspection. Despite this, there were no clear procedures for staff to follow in the event of a choking incident. One staff member told us; "I know about the choking event, we have not had any specific guidance provided since or any meetings about it." People had risk assessments in place where they were considered to be at risk from choking but these were generic and basic. One person had been assessed as needing a soft diet due to choking risks. We found they had a care plan which stated they enjoyed eating crisps. This could have placed the person at risk, particularly if new or agency staff saw this information and provided the person with crisps. This information was highlighted to the registered manager. After the inspection, we raised a safeguarding alert to the local authority safeguarding team regarding this person.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw examples where people living at the service were controlled or restrained in a way that was not proportionate to the risk of harm posed to them. One person was sent back to their bedroom because we were told they displayed episodes of aggression. Staff told us they had decided on this course of action, however we saw no evidence of a best interest process to ensure this was proportionate or necessary, or evidence of consultation with the person's representatives. Another person repeatedly tried to get up from their chair and was repositioned by staff and sat back down. Staff did not help the person to mobilise or interact with them to try to comfort or reassure them.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Some people living at the service could become agitated and distressed due to their dementia. People had care plans and risk assessments in place around this issue. However some of the documents we reviewed contained minimal guidance for staff on how to identify triggers or how to ensure a consistent and personalised approach. One person's records directed staff to manage their anxieties through developing an understanding of them through their life story book. However, we noted the book was blank.

Throughout the inspection, we observed suitable staffing levels. The registered manager told us that there had been a successful recruitment drive over the summer leaving few vacancies at the service. Whilst we noted there were sufficient staff on duty, they did not always engage with people. On one occasion, there were five staff members stood in the lounge, but not interacting with people.

Staff had received training in safeguarding adults and told us they would have no hesitation in reporting signs of abuse or mistreatment, however following the inspection we made safeguarding alerts about practices we observed relating to two people living at the service, which staff had not reported.

People had personal, emergency evacuation plans in place (PEEPS) to advise services of the level of support they would require to leave the building in an emergency, however we noted that these were out of date. This meant first responders to an emergency might not have had the information required to support people from the building safely and quickly. We informed the registered manager of this and action was taken immediately to update them.

A maintenance person was employed full time at the service and they carried out daily checks to help ensure any defects were attended to. There were regular checks by this staff member to ensure the building was safe such as checks on the boiler, fire extinguishers and lighting.

Inadequate

Is the service effective?

Our findings

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 people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

People had mental capacity assessments and requests for authorisations under (Deprivation of Liberty Safeguards (DoLS) in place but these were generic and out of date. Where people's needs had changed, requiring a greater level of restrictive practices, the DoLS supervisory body had not been informed. This is important as the supervisory body operates a triage system, meaning that those with higher levels of restrictions in their care plans may be seen more urgently.

The service had its own Facebook page. Facebook is a social networking site. People living at the service had their photographs and images on this site. We looked in people's care records and found that relatives without lasting power of attorney had given consent to these images being used. Without LPA agreements (Lasting Power of Attorney) in place, these relatives did not have the correct legal authority to give consent.

Staff did not routinely seek the consent of the people they supported prior to assisting them with tasks. For example, we saw staff members moving people without their consent. One staff member said to a person; "I am going to put you here, next to [another person's name]." The staff member did not ask the person where they wanted to sit. We also saw staff clearing items away such as table cloths whilst people were still sitting at the dining tables finishing their meals and drinks.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment did not always meet people's needs. For example, one person's bedroom was not personalised with belongings, such as soft furnishings and photographs. There was little within the environment to distinguish one area of the service from another, for example, different areas painted in different colours. There were also few sensory items such as rummage stations or reminiscence items for people living with memory impairments. Seating arrangements at the service were not consistent with good practice for people living with dementia. People sat facing each other in chairs, arranged in a circle around the lounge.

We recommend the service seek advice and guidance from a reputable source about how to organise and decorate the environment to suit the needs of people living with dementia.

There was a large garden to the rear of the property which staff told us was used regularly in the warmer weather.

We found that monitoring records were inconsistently completed so that it was not always possible to understand the care that was being provided and whether people's health concerns were being addressed appropriately. For example, food and fluid monitoring forms were used, but they were not totalled at the end of the day and the recommended daily intake was not always recorded. This meant staff might not have been aware if people were not getting sufficient food and fluids to keep them well.

The registered manager told us that if there were concerns around a person losing weight, food and fluid charts would be kept, the GP, dietician, Speech and Language Therapist (SALT), would be notified, fortified drinks and full fat drinks would be offered, and a MUST (malnutrition universal screening tool) assessment would be completed. We checked one person's records and found they had lost 20kg over the course of 2 years. There was no evidence in the person's records to explain this. For example, there was no record that they had been on a controlled diet to lose weight or any record the weight loss was due to illness. The person had declined to have their weight checked since August 2017 meaning there were no up to date weight recordings for the person. In addition, the person's nutrition care plan and fluid charts did not demonstrate that they were receiving a fortified diet. The person's fluid charts did not specify what the person should be having as a minimum per day. There was no evidence of a SALT referral. This meant the person had not been protected from a highlighted risk of potential malnutrition.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were supported by staff who had received training in order to carry out their role effectively. Newly employed staff were required to complete an induction before starting work. This included familiarising themselves with the organisation's policies and procedures. Staffs who were completely new to care were required to complete the Care Certificate. The Care Certificate is a nationally recognised set of standards for health and social care workers. Staff had received training in areas identified by the provider as mandatory, such as safeguarding, moving and handling, fire safety and infection control and there was a system in place to remind them when it was due to be renewed or refreshed. Staff received training in dementia awareness. One staff member said; "I had the dementia awareness training as part of the induction."

Not all staff we spoke with felt supported in their role. Staff told us they were not receiving regular supervision or appraisals. When asked if they had regular supervision, comments from staff included; "I could not tell you"; "I have not had supervision since I started";" There is a definite lack of support from management"; " I had supervision with [staff member's name] recently, it's not sufficient" and "Supervision is not regular". This meant staff did not have formal opportunities to raise any concerns they might have, highlight gaps in knowledge or make any suggestions about how care was delivered.

We observed the breakfast and lunch time experiences. The food appeared plentiful and appetising and people confirmed that they were offered a choice of what they ate. Comments from people were mixed and included; "I couldn't grumble about it; the kitchen always looks clean. I sometimes don't like the food, but they'll always give me something else. There's plenty of tea and drinks"; They try and help everyone. The food is plentiful and the chef is good. We have biscuits and cakes with our cups of tea"; "The food is ok, the menu is not particularly challenging, you can predict what you're going to have each day". We noted that staff were not always available to help people during mealtimes. One person had placed their cup in the middle of their bowl of porridge and was sat in front of it for some time. Staff had not noticed this. Another person had removed their false teeth and was sitting looking at a full bowl of porridge, with two cold drinks and a hot drink, untouched in front of them. Despite this, there was enough food for people generally and there was adequate choice available.

Inadequate

Is the service caring?

Our findings

People's privacy was not respected. One person had received a letter from a relative. Staff read out this letter to the person in front of the other people and staff who were sitting in the lounge area. The staff member then helped the person to write a letter back to their relative. The person dictated the letter to the staff member whilst sitting in the lounge. Staff did not ask the person if they would prefer to move somewhere confidential to do this. People's personal information was not confidentially stored. We saw white wipe boards which were visible in the open door office to anyone visiting the service with personal information about people written on them.

We saw examples where people were not interacted with for long periods of time. One person was sitting in the lounge. A foot rest which was raised was placed in front of their chair to prevent them from getting up. Throughout the inspection, we saw the person repeatedly trying to stand up and move. Staff would reposition the person back in the chair and place a blanket over their knees. Staff did not interact with the person to ask whether they wanted to move or to establish if they were in pain or discomfort. At times, the person appeared distressed. Later in the day, an arranged activity was taking place in the lounge. Singers were engaging with people and some people were dancing. Throughout the activity, the person continued to try to stand up. They were seen gesturing to staff in an attempt to get their attention. At one point, five staff were standing in the lounge and none of them acknowledged the person. People were then handed a song sheet so that they could join in the activity. This person was not given a song sheet and not included in the activity.

We saw another person in their bedroom. They were distressed and calling out. They were not able to alert staff using the call bell due to their cognitive abilities. We saw the person was sitting, with their bare legs stuck in the bed frame, on a bare, plastic mattress. They had removed their bed sheets. The bedroom was sparsely furnished and not personalised. We alerted staff and they came to the bedroom to help the person. We asked staff why the person was there. Staff told us they had been put in their bedroom as they were aggressive. We saw written in the person's care plan; "if [person's name] displays aggression physical or verbal, ensure site is safe and leave to calm in her room for 10 mins, then return, repeat as necessary". We expressed concern at the approach, especially given the person's distress and inability to alert staff. In addition, the person had been there for longer than 10 minutes. We left the staff member to help the person to free their legs from the bed frame and make the bed. Approximately one hour later we went to see the person again. They were still in their bedroom, and their legs were through the bed frame. They were again sitting on a bare mattress. A table had been pulled up to the bed with the person's dinner on it. It was late in the afternoon by that point and it had gone dark. The person was sitting in the darkness eating their meal. Staff had not switched the light on. Following the inspection we raised safeguarding adults referrals about both of these people.

Another person was left in a quiet lounge on their own all day. Staff did not always acknowledge the person as they passed through the room. At times the person was distressed. Staff told us they were unable to use the three steps to leave the room to join the rest of the people on the unit without support from staff. The person's care plan stated they challenged staff and others and was aggressive. We were concerned that

people whose health conditions could lead them to act in a way which could be difficult for staff to manage, were not being supported appropriately or in a caring way.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always know in detail the needs of the people they supported. One person's care plan indicated that they had periods of agitation which impacted on those around them. The care plan highlighted that the service was struggling to meet their needs and that they might need to move. Incident forms and behaviour charts indicated that they required a high level of involvement from staff to meet their needs. We asked staff about this person and they told us there were no particular issues in providing care to them.

People were not given information in a meaningful way. There was little signage around the building to support people to move around independently and be confident about where they were. This is important for people living with dementia as the condition means people can easily become disorientated.

People were not asked for their views of the service or given an opportunity to express their ideas and suggestions. There were no arrangements for residents' or relatives' meetings in place.

Requires Improvement

Is the service responsive?

Our findings

People did not always have adequate means of alerting staff if they required assistance. Some people living at the service were unable to operate call bells to alert staff if they needed help. We saw one person who's bedroom was situated along a quiet corridor, shouting out for staff to help them. They could not operate the call bell which was in their bedroom. Due to the location of this person's bedroom staff did not promptly respond to their requests for assistance. Other people had pressure mats in place to alert staff if they got out of bed. In some cases, we saw pressure mats were placed in people's bedrooms who could not mobilise independently, or who required a hoist to move. Some of these people also did not have call bells within reach. This meant that in order to alert staff they would have to activate the pressure mat, but they were unsafe to do this. One person we spoke with said; "I don't have a call alarm, I have to try and get out of bed and press the alarm button [situated on the other side of the room], I'd be happier if there was one plugged in". One relative said "[person's name] has a pressure mat on the floor, so if he tries to get out of bed that's set off. He can't go to the toilet himself and due to his condition, needs to go quite often". This meant the person's means of alerting staff was to get out of bed to activate the pressure mat, which they could not do safely.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had care records in place, however the quality of these records varied. Some were detailed and comprehensive where others were not always accurate and contained insufficient guidance for staff. One person's care plan stated that they had leg ulcers. However we met this person and saw that they did not have ulcers. We checked with staff who confirmed that the person's skin was intact. Another person's care record said they had a DoLS authorisation in place, when they did not. Some records contained minimal guidance for staff on how to meet people's needs. For example, one person's care plan stated; 'Support [person's name] with her care needs'. There was no further guidance on how staff should do this. Another person's record stated that they were at risk of injury as their movements could be unpredictable and for staff to consider permanent bed rest for the person 'If the above does not work', However there was no guidance on how to reduce the risk of injury to this person. The level of personalised information in people's records was also variable. Some people had comprehensive life story books in their records which provided information on their background, history, likes and dislikes. Other people's life story books were left blank. People had daily notes in their records which were generally detailed.

People had access to activities at the service such as quizzes, music and visits from entertainers. The service employed three activities coordinators who also undertook care duties and there was a mini bus which could be used to take small groups of people out for day trips. One staff member told us; "Activities can be tough if we are short staffed. We fit in activities when we can". Activities were not always personalised. Staff did not always adapt their approach to include people in activities. For example, we saw a singer was visiting the service. Some people were joining in, singing and dancing, whilst others were not being engaged with. Not everybody was able to participate due to their physical or cognitive needs. These people remained in armchairs in the room. Some people did not appear to be enjoying the activity. One person who was

trying to get up throughout the activity was ignored by staff. People had personal activity plans in place which detailed what they enjoyed doing. Often however, the activities they had participated in did not reflect what they had stated as their preferred activities and interests in their activity plan. For example, one person's file indicated that they enjoyed fishing, but there was no evidence to suggest staff had tried to help them maintain this hobby, either by actual participation in it, or for example subscribing to a magazine about it.

The service did not always promptly respond to people's health needs. Some people living at the service had diabetes. Information about managing the condition was found in several different areas of their records but there was no single care plan specifically focussed on diabetes. This made gaining a clear oversight of the person's condition more difficult for staff.

There was a system in place for receiving and investigating complaints. Relatives confirmed they knew how to make a complaint and felt any concerns raised would be dealt with to their satisfaction. We saw that any concerns raised had been investigated promptly.

Daily handovers took place to help keep staff informed if people's needs changed and provide them with clear information. Staff kept daily records detailing the care and support provided each day and how people had spent their time.

Inadequate

Is the service well-led?

Our findings

There were systems in place to monitor the quality of the service at Trevaylor Manor, however these systems had failed to identify or to address in a timely way, many of the areas of concern identified at the inspection. This included concerns with risk management, infection control, staff supervision, MCA and DoLS and with the way in which care was provided to people who were vulnerable. Medicines were not stored at the correct temperatures and staff were not aware of the procedure to follow if there was a medicines error. Medicines audits were infrequent and we only identified audits of MAR charts. People did not have quick access to pain relieving medicines as there was no stock of homely remedies. We saw no evidence of auditing processes from senior managers to provide oversight of the service or to raise standards.

Despite the cognitive abilities of some people living at the service, there was access to hazardous items in the environment which could have caused serious injury. The systems in place to mitigate the risks were insufficient.

At the last comprehensive inspection in January 2016 we found that continence products and slings were shared. We also found that interactions between people and staff were task based. We wrote about this in our inspection report. At this inspection, we found that no action had been taken to address these concerns.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Trevaylor Manor is owned by Swallowcourt Limited. Swallowcourt Limited runs a number of services within the county of Cornwall. There is a clearly defined management structure and regular oversight and input from senior management. There was a registered manager at the service who was supported by a deputy manager, unit managers, nursing staff, senior staff and health care assistants. Some staff told us they did not feel supported by management. Comments included; "The managers are not caring" and "There is a lack of support and communication." We also found that morale at the service was generally low. Comments from staff included; "It isn't as good as it used to be. Things are really going downhill fast"; "Morale is not good, we are often short staffed at night, a lot of agency"; "Staffing at the Coach House is low and with only one nurse it is difficult sometimes."

During the inspection, we noticed that staff engaged with some people and we saw some examples of caring interactions. However, we found that when people were more difficult to engage with, they were often not acknowledged or interacted with for long periods of time. There appeared to be a culture within the service where some people were routinely left to call out or to remain in quiet areas such as lounges or their bedrooms, without attempts by staff to communicate with them or to comfort and reassure them.

We found concerns relating to how staff learned from previous incidents. Despite the fact that we alerted staff to one person found in their room on a bare, plastic mattress with their legs through the bars of their bedrails, they were found again in this condition later during the day. In addition, despite a choking incident which occurred at the service, the managers did not appear to have sufficient safeguards in place to

manage choking risks.

People were not involved in the day to day running of their home. There were no arrangements in place for relatives' or residents' meetings. People we spoke with were not aware of who the registered manager was. Comments included; "No, I don't know who the manager is and I don't want to know" and "I'd talk to [staff member's name] if I needed to talk to someone."

The service had not informed us of all notifiable events in line with their legal obligations. For example, we looked through incident reports and found numerous incidents had occurred between people living at the service, including incidents of physical assault. We checked our records and staff also told us that these had not been alerted to the commission. This meant the service was not operating openly and transparently.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents the service had not notified the Commission of notifiable incidents as required by law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent was not appropriately sought or recorded. Relatives consented to elements of people's care and treatment without the correct legal authority to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Restrictions were not always a proportionate response to risks posed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor the quality of the service were not effective.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect and their confidentiality was not maintained.

The enforcement action we took:

impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from risks within their environment. There was not a clear protocol for responding to choking risks. Risks to people's health were not effectively monitored or addressed.

The enforcement action we took:

condition on registration