Swallowcourt Limited

# Trevaylor Manor

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

| | |
|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Requires Improvement |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

We inspected Trevaylor Manor on 26 January 2016, the inspection was unannounced.

Trevaylor Manor is part of the Swallowcourt group and is a registered nursing home for up to 81 older people. At the time of the inspection 74 people were living at the home some of whom were living with dementia. 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 in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Trevaylor Manor was last inspected in July 2014, there were no concerns at that time. Since that inspection the service had grown and another building, previously registered as a separate service had been become part of the care home. This building, known as The Coach House, and the lower floor of the main building were used to accommodate people who required a secure environment. People in The Coach House had the opportunity to participate in day to day activities independently, for example there were tea and coffee making facilities. These areas were run by a unit manager and staffed separately. The Coach House was completely self-contained with its own kitchen and laundry facilities. It was a light and airy building with a high standard of décor, friendly and open staff and people appeared happy and well cared for.

The registered manager had oversight of the rest of the service which comprised of the middle and upper floors. People in this part of the service were more likely to have higher physical needs and need support to move around. This was done safely and staff used the appropriate equipment when necessary. However, we saw some incidences where staff did not communicate with people while supporting them to move. The interactions we observed throughout the day were largely task based apart from during an organised activity session and the lunch time period.

The registered manager was supported by a deputy manager and the unit manager. Nursing staff were supported by trained specialist health care assistants who helped with the administration of medicines. There was also a keyworker system in place. Keyworkers are members of staff with responsibility for managing and arranging care for a named individual. There were sufficient numbers of staff to meet people's needs.

People and relatives told us they considered Trevaylor Manor to be a safe environment and that staff were skilled and competent. The premises were in a good state of repair, clean and odour free. There was signage around the building to support people to move around independently. Systems in place for the ordering, administrating and storage of medicines were robust.

Pre-employment checks such as disclosure and barring system (DBS) checks and references were carried out. New employees undertook an induction before starting work to help ensure they had the relevant

knowledge and skills to care for people. Training was regularly refreshed so staff had access to the most up to date information. There was a wide range of training available to help ensure staff were able to meet people's needs. Additional training was being organised for supporting people whose health needs might lead to them behaving in ways which could be difficult for staff to manage.

People were supported and encouraged to take part in a wide range of activities organised in the service. There were three full time activity co-ordinators employed who had responsibility for organising activities both within the service and outside. People were supported to maintain personal important relationships. If people did not have any family or close friends efforts were made to identify an advocate to represent their views if required.

Systems were in place to monitor people's health and well-being regularly and effectively. When there were changes in people's health this was quickly identified and action taken to address the issue. Staff were confident the systems in place to keep them up to date with people's changing needs were effective.

There were systems in place to assess and monitor the quality of the service. These included regular audits of all aspects of the service, care reviews and staff meetings. Swallowcourt were working to make links with the local communities.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe. There were enough staff to meet people's needs.

Systems were in place to support the safe management of medicines.

Staff were trained in how to recognise abuse and were confident any concerns would be acted on..

### Is the service effective?

Good

The service was effective. Staff were well trained and regularly supervised.

New employees carried out a thorough induction which included training and shadowing more experienced staff.

Staff demonstrated an understanding of the underlying principles of the Mental Capacity Act.

### Is the service caring?

Requires Improvement

The service was not entirely caring. Slings and continence products were communally used.

Interactions between people and staff were largely task based.

Staff were aware of what was important to people and supported them accordingly.

### Is the service responsive?

Good

The service was responsive. Care plans were informative and up to date.

There were three full time activity co-ordinators and people were supported to take part in a range of activities.

Relatives told us they could approach management with any

concerns.

## Is the service well-led?

Good

The service was well-led. There were clear lines of responsibility and accountability within the service.

Staff meetings were held regularly to allow staff to air their views regarding the running of the service.

The management team were working to establish links with the local community.

# 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.

This inspection took place on 26 January 2016 and was unannounced. The inspection was carried out by two adult social care inspectors, a specialist advisor with a nursing background 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 the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed previous inspection reports and other information we held about the home including any notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we looked at six people's care plans, Medicine Administration Records (MAR), nine staff records and other records in relation to the running of the home. We spoke with the registered manager, unit manager, deputy manager, human resources officer and Swallowcourts head of elder care. We also spoke with eleven other members of staff. We spoke with nine people who lived at Trevaylor Manor and three relatives. Following the inspection we contacted three external healthcare professionals to ask them about their experience of the care provided at Trevaylor Manor.

Due to people's health needs we were not able to communicate verbally with everyone to find out their experience of the service. We spent some time observing people in communal areas using the Short Observational Framework Inspection (SOFI) tool. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

# Is the service safe?

## Our findings

People and their relatives told us they considered Trevaylor Manor to be a safe environment. A relative said; "I feel comfortable about things." External healthcare professionals also told us they considered Trevaylor Manor a safe service. One commented: "I believe they provide a safe and caring service."

Staff received training in safeguarding adults when they joined the service. This was refreshed at regular interviews to help ensure staff had access to the most up to date information. Staff told us they had no concerns about any working practices or people's safety. They would be confident to report any worries to the manager and believed they would be dealt with appropriately. If staff felt their concerns were not being taken seriously they knew where to go outside of the organisation to report concerns. "Say no to abuse" leaflets were available for people, relatives and staff throughout the building. These contained the number for the safeguarding team at Cornwall Council.

Care plans included risk assessments which identified what level of risk people were at from various events such as falls and pressure sores. The assessments contained guidance for staff on how to minimise identified risks. For example, there was information on how staff should support people when using equipment and how many staff would be required to support each activity.

Some people had risk assessments in place to guide staff on how they should support people when they became anxious or distressed. For example, it had been identified that one person was very fond of dogs. If they became agitated talking to them about dogs could be an effective way for staff to diffuse the situation and reduce the risk of them behaving in a way which others could find distressing.

When people required assistance from staff to move around the building or transfer from standing to sitting they were supported safely. Staff carried out the correct handling techniques and used equipment such as walking frames or wheelchairs as appropriate to the individual person. Where people required a higher level of help, for example a hoist to move from a wheel chair to a chair, staff worked together to help ensure it was done safely.

When any accident or incident occurred it was recorded in people's daily logs. In addition an incident sheet was completed to allow management to carry out audits of these events and identify any patterns or trends. We looked at one person's daily logs and saw there were four occasions in November 2015 and five in December 2015 when they had become agitated. This had resulted in the person behaving aggressively either towards other people or staff. Only two of these events had been recorded on incident sheets. This showed staff were not adopting a consistent approach to identifying and recording incidents. Any analysis would not have taken all relevant information into account. We discussed this with the management team who agreed they would address this with staff.

Staff had completed a thorough recruitment process to ensure they had the appropriate skills and knowledge required to provide care to meet people's needs. Staff recruitment files contained all the relevant recruitment checks to show staff were suitable and safe to work in a care environment, including Disclosure

and Barring Service (DBS) checks. A member of staff commented; "We've recruited really well. We've got some good people."

The provider had developed a new role within the service for Specialist Health Care Assistants, (HCA), to assist the nursing staff with the administration of medicines. This demonstrated the provider was able to use innovative methods to help ensure the management of medicines was carried out efficiently and safely. At the time of the inspection there were nine Specialist HCA's in post. We spoke with a Specialist HCA who spoke knowledgably about various aspects of the role including the process following any medication error, the recording of homely remedies on individual Medicine Administration Records (MARS), the use of body maps and the process for the destruction of medicines. They had received appropriate training and completed practical competencies which were signed off by the unit manager including supervised medication administration. This was evidenced in staff training records. The unit manager told us supervised medicines administration would happen as many times as needed before the Specialist HCA was signed off as competent.

We checked a sample of MARs and saw there were no gaps in the records. This indicated people were receiving their medicines as prescribed. MARs had people's photograph at the front of the chart. This protects people from the risk of receiving the wrong medicine. Oral medicines were issued in blister packs and corresponded to the prescription chart. Medicines were stored in a trolley and either locked in a clinic room or secured to the wall. All medicine requiring disposal was recorded and returned to the pharmacy safely. Weekly audits were carried out by a trained nurse and countersigned. These were up to date.

There was evidence of medicine which is administered when necessary (PRN) for example zopiclone, lorazepam and paracetemol, being prescribed at regular intervals with times that suggested regular administration. On some occasions this had been for longer than three days and suggested a need for medical review and consideration of the need for regular prescription. We discussed this with the deputy manager who said in these circumstances they asked the GP to review a person's medicines but it might take a couple of days to catch up. They told us they would follow this up immediately. There were clear guidelines for staff as to when they should administer or offer when required medicines. This helped ensure staff were consistent in their approach when deciding to administer PRN medicines.

There were systems in place to help ensure the safe ordering, receipting, checking, administration, storage and disposal of controlled drugs. There was an ordering book and daily checks and after each administration, totals were tallied and checked by two registered nurses. All administration of controlled drugs was signed by two trained nurses.

There was evidence that consideration of covert medicine is a multidisciplinary team decision. There was one covert medicine plan which had not been signed by the GP, however this was not implemented. We saw another covert medicine plan which had been signed by the GP. This demonstrated there were systems in pace to help ensure the correct procedures were followed.

People were supported by sufficient numbers of suitably qualified staff. The service was spread over three floors and a separate unit which meant staff had to be organised effectively to ensure all areas of the service were appropriately staffed. The HR manager told us they were developing a dependency tool specifically for Trevaylor Manor in order to ensure the specific requirements associated with the layout of the building were taken into account. In the meantime the registered manager had increased staffing numbers. People's needs were met quickly and call bells were responded to in a timely fashion. Staff told us there had been low staff numbers during the summer but things had improved recently. One commented; "It's taken the pressure off." The staff team was relatively stable and some had worked at the service for several years. One

member of staff told us; "We have pretty good staff retention, a lot have been here five years plus." During the day there were two nurses on duty on the upper floors, two on the ground floor and one in The Coach House. There was only one qualified nurse on duty at the service during the night time. However, they were supported by SHCA's and there were systems in place to help ensure the nurse could be called upon at any time from wherever they were in the building. In addition to nursing and care staff there were three full time activity co-ordinators, a team of kitchen and domestic staff, a maintenance worker and a gardener.

Good

# Is the service effective?

## Our findings

People were cared for by staff who had a good understanding of their needs and were skilled in delivering care. There was a robust system of training in place to help ensure staff skills were regularly refreshed and updated.

Newly employed staff were required to complete an induction before starting work. This included familiarising themselves with the service's policies and procedures and completing the Care Certificate. This replaces the Common Induction Standards and is designed to help ensure care staff have a wide theoretical knowledge of good working practice within the care sector. There was also a period of working alongside more experienced staff until such a time as the worker felt confident to work alone. The induction process had recently been restructured to give new employees a more thorough range of training before starting to work independently.

Swallowcourt had three in-house trainers to enable them to deliver a structured and regular programme of training across the organisation. Training in areas identified as necessary for the service was organised centrally and staff alerted when refresher training was required. An external professional told us; "The staff training in general seems to be well organised at the Swallowcourt homes." Some people living at Trevaylor Manor could become anxious or distressed due to their health condition. This sometimes resulted in behaviour which was difficult for staff to manage. For example, in one care plan there was evidence of the use of hand holds to manage behaviours that might be difficult for staff to manage. No-one had received training to enable them to deal with this effectively. We discussed this with the manager and head of elder care. They told us it had been identified that staff required additional training to meet people care needs and the provider was in the process of commissioning appropriate training for all staff.

Staff received regular supervisions and annual appraisals. They told us they felt well supported by management and were able to ask for additional support as needed. Supervision records showed they were an opportunity to discuss working practices and identify training needs. For example, in one set of records we saw the member of staff had asked for some specific training. The supervisor had signed to indicate they would arrange the training as soon as it became available.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications for DoLS authorisations had been made to the local authority. Training on the MCA

and DoLS was included in the induction process and in the list of training requiring regular updating. We saw evidence that mental capacity assessments and best interest discussions had taken place when necessary and in accordance with the legislation.

Staff demonstrated an understanding of the principles underpinning the MCA. One told us; "I always assume capacity and put the resident at the centre." Another said; "When people can't make decisions for themselves you have to make sure the decisions are made in their best interest." Guidance for staff in care plans emphasised the importance of allowing people choice. For example, one person was sometimes resistant to receiving personal care. The care plan stated; "Allow freedom of choice. Give clear and concise explanations before and during care interventions."

We observed the lunch time period in the dining room using SOFI. There were plenty of staff available to help people who required assistance. Staff worked to help people maintain their dignity. Interactions between staff and people at this time were friendly and we saw staff encouraging people to eat. People and relatives told us the food was usually of a good standard and the portions were generous. They told us there was always a choice of meals and if anyone wanted something other than that offered it could be provided. One person told us; "The food is the best around. There is a choice of two meals at lunch and dinner." We spoke with the assistant chef on duty who said they were aware of people's dietary needs and preferences. They commented; "We have various health needs to cater for. I make cakes and pastries for service users with dietary problems. We cater for all needs." The kitchen was well equipped and clean.

People had access to external healthcare professionals such as dentists, chiropodists and GP's. Care records contained records of any multi-disciplinary notes and any appointments.

The building was in a good state of repair and free from odours. We found the environment to be clean and bathrooms were well equipped with hand wash and paper towels. Bedroom doors had nameplates with people's names and photographs on them. Bedroom, bathroom and cupboard doors were all painted in different colours. This meant people were more easily able to identify rooms. This is especially important for people whose memory may be deteriorating. One room was being adapted so relatives could stay overnight with their family member if they wished. It was to be equipped with a small fridge and facilities to prepare snacks and simple meals to allow people privacy and independence.

Since the last inspection the service had developed and an adjacent and separate building, known as The Coach House and previously registered as a separate service, had been become part of the care home. The Coach House and the lower floor of the main building were used to accommodate people who required a secure environment.  People in The Coach House had the opportunity to participate in day to day activities independently as it was completely self-contained with its own kitchen and laundry facilities. It was a light and airy building with a high standard of décor and modern furnishings. In addition to the main lounge there was a room  which had been used a sensory room. However the unit manager told us this was not used often and they were considering how they might put it to better use. A relative described the unit as; "amazing." One person showed us their room and told us they were happy living there.

Requires Improvement

# Is the service caring?

## Our findings

Not everybody was able to verbally communicate with us about their experience of care and support at Trevaylor Manor. Those people we did speak with were complimentary about the care they received. Relatives were also happy with the care provided. Comments included; "Staff here are nice and friendly" and "This has been the best care he has ever received, physically and mentally." An external health care professional told us; "I am impressed by the genuine affection which most of them [staff] seem to have for the residents."

Some people required equipment to move them safely and staff used hoists and slings to do this. We saw hoists and communally used slings in the corridors throughout the service during this inspection. Sharing slings does not respect people's dignity and can be an infection risk. There were unnamed continence products in the shared toilets. These products were being used communally. This meant people were not always being provided with the product they had been specifically assessed for and this did not respect their dignity. The registered manager agreed such products should not be used communally and that carers should only use the product that had been specifically provided for each person according to their needs. They said they would address this immediately.

We saw staff in two areas of the service preparing for lunch. People were given clothes protectors to use without being asked if they wanted them. This showed people's preferences were not always considered. We saw some incidences where staff did not communicate with people while supporting them to move using equipment such as a hoist. This did not demonstrate respect for the person. Apart from a period of organised activity we saw little evidence of interaction between staff and people in the upper floors of the service. What interaction there was tended to focus on tasks rather than social interaction. This was different to our observations in the lower floor and The Coach House where staff were seen to spend time chatting with people and asking about their well-being. One relative described The Coach House as; "a stimulating environment."

People told us they were able to make day to day decisions about how and where they spent their time. There were various areas of the building where people could choose to sit watching the television, listening to the radio, taking part in activities or sitting quietly with a newspaper. Other people chose to spend most of their time in their rooms. One of the activity co-ordinators told us they tried to encourage people to join in activities and mix with other residents if possible.

People's bedrooms were decorated to reflect their personal tastes and preferences. People had photographs on display and personal ornaments in their room. Some people had chosen to bring their own furniture and bedding into the service. This meant they were able to arrange their bedroom to satisfy their own preferences. Staff were aware of what was important to people and supported them accordingly when people had lost the ability to do so for themselves. A relative told us; "She [family member] has always been a very elegant lady and they've kept that continuity. They help with her clothes and make up."

Relatives told us they were able to visit whenever they wanted and were always made to feel welcome by

staff. People were supported to maintain family relationships. A tablet computer had been purchased to enable people to maintain contact with friends and family using video conferencing technology. If people did not have any family contact or support efforts were made to identify someone else to help them make decisions or act on their behalf. For example, Independent Mental Capacity Advocates (IMCA) had worked with some people. An IMCA we spoke with told us staff took time to; "sit and talk things through." On the day of the inspection a befriender was visiting someone in the home and they were leaving for a trip out. A vicar visited the service regularly. In addition people were supported to attend a church service in the local community every two months.

Care plans contained information about people's personal histories. This is important as it helps staff gain an understanding of the person and enables them to engage with people more effectively. One person had not been living at Trevaylor Manor for very long. We saw a relative had been involved in putting together information to create a life history for inclusion in the care plan.

Good

# Is the service responsive?

## Our findings

People who wished to move into Trevaylor Manor had their needs assessed to help ensure the service was able to meet their needs and expectations. The service was split into two with The Coach House and lower floor area offering a secure environment for those who needed it. Staff working in The Coach House were equipped with walkie talkies so they could easily communicate with the rest of the service if necessary. There were also internal and external telephone systems throughout.

There were systems in place to help ensure staff were aware of people's needs at all times. Care plans were an accurate and up to date record of people's needs and daily logs were consistently completed. There was a handover between night staff to staff arriving on shift in the mornings. Another handover and update on individual residents took place at 2:00pm and again at 8:30pm. The unit manager told us; "There's a lot of communication."

Care plans were detailed and contained information about a wide range of areas. For example, there were sections on mobility, communication, social needs and night time routines. This meant staff had a complete picture of any issues which might have an impact on people's well-being. The care plans were regularly reviewed to help ensure the information remained up to date and relevant. The plans were signed either by people or their representative. In addition to the main care plan people had bedroom files in their rooms. These contained daily logs and monitoring forms which were completed every time staff delivered any personal care. A member of staff told us; "The bedroom folders are good. It's easier because you document everything. Things are recorded straight away."

The service responded well to any changes in people's needs and worked with other healthcare professionals. For example, one person had developed a pressure sore over a period of time. A tissue viability nurse (TVN) visited regularly to help monitor this. As treatment had not so far been successful a new approach was being taken to try and address it. The registered manager told us they would discuss this with the family first and ensure they consented to the treatment. Another person had fallen on several occasions. Analysis of the incident sheets had shown they were more at risk of falling in the early afternoon. The unit manager told us they were trying to encourage the person to take an hour after lunch to relax to see if that would help. There had also been a review of the person's medicines which were gradually being reduced. The care plan was being updated accordingly and a relative was involved in these decisions.

Communication logs were kept to record any conversations with relatives or external healthcare professionals such as social workers or community nurses.

People had access to a range of activities which were chosen to reflect people's interests and preferences. Three full time activity co-ordinators were employed and they were able to plan and organise group activities as well as spend one to one time with people. Activities included exercise sessions, live music and sing songs, film afternoons and visits from entertainers and animal groups. There were also organised activities outside the service including a lunch club, stable trips and trips to local attractions. An external healthcare professional commented; "I am particularly impressed by the activities for the patients and the

length members of staff go to in aid of keeping patients safe and happy."

The organisation's head of elder care engaged with local community groups to develop joint working which could benefit all. For example, a charitable organisation was working with the service and a primary school to develop a project which involved pupils visiting the service. The pupils identified specific topic areas and worked one to one with people to find out more about their experiences and share memories. Local residents were invited to events such as the annual summer fete.

There was a replica 1950's shop in the grounds. This was equipped with memorabilia and original food packages which had been donated by a supermarket chain. The head of elder care told us it was used regularly in the summer months. They told us; "It's a place to come and spend time. It jigs the memory and promotes conversations."

There was a complaints policy in place which outlined the timescales within which people could expect to have any concerns addressed. There were no complaints ongoing at the time of the inspection. Relatives told us they would approach a member of the management team if they had any worries.

Good

# Is the service well-led?

## Our findings

There were clear lines of accountability and responsibility within the service. The Coach House, and the lower floor of the main building were used to accommodate people with advanced dementia. These areas were run by a unit manager and staffed separately. The registered manager had oversight of the rest of the service which comprised of the middle and upper floors. People in this part of the service were more likely to have higher physical needs. The registered manager was supported by a deputy manager. Nursing staff were supported by trained specialist health care assistants who helped with the administration of medicines. An external healthcare professional said; "[The registered manager] seems to have the ability to keep the home running smoothly and efficiently while still maintaining a friendly environment for the staff to work in."

The registered manager and unit manager both told us they were well supported in their roles and worked well together. They met regularly to discuss any issues and provide each other with peer support. They also received support and supervision from the head of elder care and other members of Swallowcourt's senior management team. The registered manager commented; "There is great support within the team." Staff meetings were held regularly and these were an opportunity for staff to air any grievances and for management to communicate any developments or changes within the service.

The head of elder care told us the new Specialist HCA role gave carer's an opportunity for career development that had not previously been available. An external health care professional told us they believed the system was an improvement, they commented; "Having something to aspire to will, I hope, provide an incentive to carers."

The atmosphere in the service was calm and quiet. Call bells were answered promptly and staff dealt with people's needs efficiently. The unit manager described the service philosophy as; "Person centred, flexible, a team. We want it to feel a place where relatives, loved ones and staff are all working together."

The service was located in a rural setting with limited public transport links. In order to maintain a good rate of staff retention the provider worked with staff to accommodate their needs by providing flexible working shifts. Staff turnover was low and staff described themselves as; "A strong close team."

Swallowcourt had recently started producing a newsletter which was circulated to families to keep them updated of any developments. People, relatives and professionals were asked for their views of the service provided by means of an annual questionnaire.

There were systems in place to monitor the quality of the service provided. Audits were carried out over a range of areas, both internally and by external auditors. Monthly audits were carried out by managers or deputy managers from another Swallowcourt home. Each audit was based around one of 12 regulations in the Health and Social Care Act, for example safe care and treatment or premises. Over the course of the year all areas were covered. Audits by external contractors were carried out twice a year. These were also based on the regulations.

Checks were completed on a weekly or monthly basis as appropriate for fire doors and alarms, emergency lighting and Legionella checks. Hoists and slings were regularly serviced to ensure they were fit for purpose.