Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Trevern

72 Melville Road, Falmouth, TR11 4DD

Tel: 01326312833

Date of Inspection: 16 January 2015

Date of Publication: February 2015

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖ Action needed
Safety and suitability of premises	✖ Action needed

Details about this location

Registered Provider	Cornwall Care Limited
Registered Manager	Miss Rebecca Louise Palmer
Overview of the service	Trevern is a care home with nursing for up to a maximum of 40 predominantly elderly people.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 16 January 2015, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

We gathered evidence against the outcomes we inspected to help answer two of our five key questions: Is the service safe? Is the service responsive? We gathered information from people who used the service by talking with them.

Below is a summary of what we found. The summary is based on our observations during the inspection, speaking with people using the service, observing interactions between staff and people, and from looking at records.

Is the service safe?
From the two outcomes we looked at during this inspection we found the service was not safe. The environment was in need of some attention. Internal windows were not clean. Items were stored inappropriately in corridors and bathrooms.

There was no effective process for assessing and monitoring the risks to people within the premises to identify issues that required attention within the home.

Staff were clear on the action they should take if they had any safeguarding concerns.

Is the service responsive?
From the two outcomes we looked at during the inspection the service was not responsive. People did not always experience care, treatment and support that met their needs. Care plans were not reviewed to reflect changes in people's needs.

People were not always provided with the correct incontinence product and communally used toiletries were found in all bathrooms.

There was very little meaningful activity for people

You can see our judgement on the front page of this report.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 25 February 2015, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Some of the people who used the service were not able to comment in detail about the service they received due to their healthcare needs, so we spent two hours observing care provided both before and during lunch in a dining area of one of the units. People were asleep or watching the TV. There were no activities going on for people to occupy their time. The registered manager told us there were pre planned activities including arts and crafts from external providers and church groups attending every other week in the main house. The staff in the laundry told us they encouraged some people to help fold laundry as an activity.

We saw staff placing clothing protectors over two people's heads without explaining to them first what they were about to do. Although we observed some caring and sensitive interactions between staff and people who lived at the home, we also saw staff move two people without any explanation. One person had their wheelchair moved from behind without any warning by the staff. This did not respect the person.

Staff supported people with their meal. Staff spoke to people when they gave them their meal but did not actively engage the person in conversation during the meal and sat largely in silence. Lunch was not a social occasion for others who were able to eat independently, people ate without conversation. The television was on in the room and there was also quiet music in the background. Staff left the people sitting in the dining area alone. Following lunch one person requested to be moved to a more comfortable chair. This person asked four times before staff arrived to move them. This person felt unwell following this transfer and told staff they were about to be sick, staff were unsure where to locate a bowl for this person and there was a considerable delay in this person being supported. This did not help to maintain this person's dignity.

During our inspection we walked around the three units which made up the home. We found unnamed continence products in all the bathrooms and toilets in the home. We were told staff used these for anyone who needed a pad change when in the toilet with staff. This did not ensure people would be provided with the correct product they had been assessed as requiring to meet their individual needs. However, we were shown the storage cupboard where there were individually named continence products, which were then transferred as needed in to people's rooms. One of the units was a dementia care unit. There was no clear signage in this unit to support people's needs and encourage independence. Doors were not personalised to aid recognition. There were two rooms marked 'bathroom' one of which was the only operational bathroom for this unit, and

contained a large amount of unnamed toiletries. The registered manager told us, "don't know whose those are." Communally used toiletries did not respect peoples' dignity. There was one assisted bathroom and a shower/wet room in this part of the home.

We looked at three care plans. One person had not been able to have a bath or shower for eleven months due to the home not obtaining the appropriate bathing equipment to meet the person's needs. This person's family told us "they keep saying they are looking into it, but nothing happens. Hopefully something will come soon." The care plan for this person did not provide clear guidance and direction for staff as it stated,"(the person) is able to be bathed and showered if they would like." The care plan also stated the person was, "to have full bed bath to occur 3-4 (times) weekly and hair wash." Staff did not record the care they provided every day, there were gaps in these records for 12 and 13 January 2015, with the last entry made at 2.20pm on 14 January 2015. Staff had not recorded that this person had received regular full bed baths. This person's health care needs had changed recently and the home had appropriately requested the support of the Acute Care at Home team who were visiting at the time of this inspection. There had been no review of this person's care plan to take account of the recent change in their health. This person required a replacement recliner chair as the one they were using was assessed on 20 March 2014 as "too big" and they were "sliding to the side" and "falling out" of the chair. Whilst the records showed the person was having regular contact with community occupational therapists a replacement chair had not been actioned by the time of this inspection. The care plan stated; "requires repositioning four hourly". We checked the re positioning charts and found the person was moved between three and 12 hourly. We discussed with the registered manager and asked if any other records were available, they were not. The registered manager they told us; "It's probably true we have been short of staff." The Acute Care at Home team told us this person's healthcare needs were improving and they were not concerned about the care provision. This person's pressure relieving mattress was reported "bed deflated" on the morning of the inspection. The registered manager was not aware of this incident, no report had been made about the risk to the person, and no further checks were recorded on the mattress to reduce the risk of a reoccurrence. We checked this person's bedroom and found the mattress to be appropriately inflated. This did not ensure staff were informed to provide appropriate care for this person.

In the laundry we found a large amount of "lost" property. We were told "these are unnamed" and staff would attempt to find the owner of the clothing "occasionally". Family were invited to check the laundry for people's clothing when visiting. One relative told us, "I have found (the person's) clothes there with the name clearly on it, it's quite annoying." This did not respect people's dignity.

The registered manager and five members of staff spoke knowledgeably about people they provided care for. We saw and heard some positive interactions between staff and people throughout the home. Staff were not rushed and provided support in a calm manner.

In the care plans we reviewed we saw risks had been recognised and assessed, these had been reviewed although not every month as we were advised this was the policy. We were told the service had been "short on staff recently." This was being addressed by recruiting new staff and altering the shift patterns to create a shift from 11.00am - 19.30pm to ensure staff were always available to meet people's needs.

Staff were aware of people's preferences and dislikes. We saw in some peoples' care records life histories had been created with people and their families. Life histories assist

staff to understand a person; they are useful in ascertaining how peoples past can reflect who they are today. This enables care delivery and care plans to be tailored to the individual's needs.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) provide a legal framework that protects people who lack the mental ability to make decisions about their life and welfare. We discussed DoLS with the registered manager in respect of the recent high court judgement which changed the circumstances under which authorisations should be applied for. 28 people who lived at the home had authorisations requested from the DoLS team in September 2014. However, one person was noticed during the inspection who did fulfil the new criteria for a DoLS application and this had not been done. The registered manager told us "it slipped my mind." The provider was not meeting the legal requirements relating to the MCA and DoLS and people did not have their rights protected.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Care and treatment was not planned and delivered in a way that ensured people's safety and welfare.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

During the inspection we walked around the home which comprised of three units. The main house, with two floors was the oldest part of the home, the 'flats' and the 'wing' were a more modern extension to the main house. The flats, as they were known by staff, were no longer flats, but had been refurbished to be more suitable for the needs of people living in them and contained en-suite toilets. The 'wing' contained a dementia unit.

The windows on the outside of the house were in need of repair, with peeling paintwork and old wooden window frames. The inside of the house was well decorated. In the main house we noticed the windows of several bedrooms in the main house were cloudy and it was not easy for people to see out of the windows. This was because the windows were very dirty on the inside and this was obscuring a view out. The registered manager told us they had a regular window cleaner who did the outside of the windows but did not clean the insides.

There was a bathroom on the ground floor, we were told this was not used and had not been used for more than 11 years. The toilet in this bathroom was used by one person.

There was a bathroom on the first floor which we were told was "not suitable for our clients" as it was a domestic bath, but the toilet was regularly used by people.. This bathroom contained boxes of new paper towel dispensers. The cleaning schedule records in this room had not been completed since 07 January 2015 and the soap dispenser was empty. This did not respect people's dignity and the inappropriate storage of such items in this room could pose a risk to people using it. On this floor there was one bathroom available for 10 people.

In the corridor of the first floor of the main house we saw a large box of supplement drinks cartons. We were told by the registered manager they belonged to a person who "died before Christmas" and did not live on that part of the home. The registered manager was not aware of the presence of this box or also one foot plate from a wheelchair and a pro-pad cushion which were also there, and stated, "I don't know why they are here." This storage of these items in the main corridor could pose an obstruction risk to people using the corridor. We visited several bedrooms in the main house. We found the light fittings above people's beds and over the sinks were not always working, it was suggested by the manager that the bulbs needed changing.

In the 'flats' there were 13 bedrooms over two floors. There was one bathroom available for 13 people to use and a 'wet room'. In another part of the home there was a dementia unit. We saw two rooms marked 'bathroom', one was not used as a bathroom but stored equipment. This did not support people with cognitive impairment to recognise the correct

room to use. There was one bathroom for 16 people on this unit. In this bathroom the toilet was white with a white seat and immediately next to the toilet was a white chair which closely resembled the toilet. This did not support people with cognitive impairment to recognise the correct equipment to use.

In a drawer in the main corridor of this unit was a pair of slippers, a broken DVD player and a dressing. The registered manager was unaware of the presence of these items or to whom they belonged. These items were easily accessible to people on the unit and could have posed a risk to people, some of whom were independently mobile.

There was no personalisation on the dementia unit. Bedroom doors were not easily identifiable for people with dementia. One person's bedroom did not contain their name or any identification at all. There was no decoration on the walls to help orientate people with dementia to different parts of the unit.

The home had not had a housekeeper since 01 December 2014. However, other than the dirty inside of the windows in some bedrooms, the home appeared clean and mostly odour free.

The registered manager and deputy manager had not previously identified the concerns raised during the inspection. The audits undertaken of the premises had not identified the concerns raised at this inspection. The registered manager told us the home was well supported by senior operational management and maintenance staff employed by the provider.

We were told staff reported defects and faults in the maintenance book. We looked at the maintenance book and found all reported faults and issues had been addressed by the maintenance person in a prompt manner. None of the issues found at this inspection had been reported as an issue. This meant processes and procedures were not adequate to assess and monitor the premises, and therefore people were not protected from the risks associated with this.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The provider did not ensure that service users and others had access to premises, where the regulated activity is carried on, that protected them against the risks associated with unsafe or unsuitable premises.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care and treatment that is inappropriate or unsafe, by means of the planning and delivery of care and where appropriate treatment in such a way as to ensure the welfare and safety of the service users. Regulation 9 (1) (b) (i)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The provider did not ensure that service users and others had access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises by means of adequate maintenance.Regulation 15 (1)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 25 February 2015.

CQC should be informed when compliance actions are complete.

This section is primarily information for the provider

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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